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Moving Away from Understanding:
Personal Therapy in Contemporary Doctoral Education

by

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B.A., Merrimack College, 2007
M.S., Antioch University, 2010

DISSERTATION

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2013

Keene, New Hampshire



Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

**MOVING AWAY FROM UNDERSTANDING:
PERSONAL THERAPY IN CONTEMPORARY DOCTORAL EDUCATION**

presented on June 26, 2013

by

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Abstract

Personal therapy has never been a training requirement for clinical psychology in the American Psychological Association (APA). This became more evident when the field of Clinical Psychology at the Boulder Conference over 30 years ago in which personal therapy was omitted as a requirement of doctoral education because there was a lack of sufficient empirical evidence to support such a mandate in the United States. While there has been research in the field of psychodynamic theory on personal therapy, the stance taken during the Boulder Conference (and to some extent the Chicago and Vail Conferences thereafter) continues to be the standard in regards to the training of psychologists. This has resulted in new psychologists having limited understanding of themselves and, at times, difficult or impaired relationships with their clients. This dissertation will look at the original psychoanalytic writings on training analysis and will use these points to explain the more recent literature on the utility of personal therapy, particularly in countries that still require it. In addition to these main points, the arguments against personal therapy will also be included to help showcase both sides of the issue. Using three major studies on personal therapy, this dissertation will use the themes found in the literature review to see if there is still a justification for not requiring personal therapy, as well as providing personal opinions on why the field has moved away from self-understanding and towards a predominantly outcome-focused approach to psychotherapy.

Keywords: Personal therapy, training analysis, doctoral education, psychologist education

“But where and how is the poor wretch to acquire the ideal qualification which he will need in this profession? The answer is in an analysis of himself, with which his preparation for his future activity begins”

-Sigmund Freud (1937)

Analysis Terminable and Interminable

Chapter 1

Statement of the Problem

The goal of this dissertation is to look directly at the role of personal therapy (i.e., therapy that a clinician receives while receiving their graduate education) and what has prevented the field as a whole from incorporating it into a standard of education. So why is it that the American Psychological Association (APA, 1976) has never required personal therapy even though the practice has widely been viewed as an immensely advantageous tool for developing psychotherapists (Bike, Norcross, & Schatz, 2009; McEwan & Duncan, 1991; Norcross et al., 1988; Pope & Tabachnick, 1994)? The intent of this dissertation is to explore this very question by exploring not only the history of personal therapy but also to look at the research on the practice over the past 20 years to see if it is still a viable option for contemporary education.

While Psychoanalysis has had a requirement for trainees' personal therapy since its creation and continues to do so with its code of ethics (American Psychoanalytic Association, 2012), clinical psychologists have never had such a requirement in the United States. The issue has been debated over the past several decades and it continues to be an area of contention. While theorists and researchers have found that personal therapy can be immensely beneficial in the training of psychologists (see Chapter 3), there remains an absence in the APA's policy on personal therapy. The furthest that the APA has gone in regards to making any statements on mandates would be their 2002 ethical code addendum, stating that psychologists must take appropriate measures when personal problems threaten to interfere with competent work performance (2002). In other words, the stance on requiring therapy is based purely within reparative exploration, a tool to be used when a clinician's personal life becomes so overwhelming that it impacts the clinical work.

This stance is immensely helpful but it does not go far enough. According to Pope and Tabachnick's (1994) survey of over 475 psychologists, 69.7% of those surveyed believed that therapy should become a part of the education of clinical psychologists. This study (which will be further explored in Chapter 5) is just one of many that have represented the need for personal therapy in doctoral training based on popular psychologists' opinion. If most psychologists believe this, then why has personal therapy not become a mainstay in the education of Western psychologists¹? To answer this we will have to look at the history of doctoral education over the past 80 years and how this has influenced the changes within doctoral education.

History of the Problem

Over the past 120 years, significant changes have been made in the ways in which mental health practitioners have been trained. At the time of Breuer and Freud, the new field of insight-based therapy for resolving hysteria was entirely located within the medical field, fostering the birth of psychiatry as a practice for relieving intrapsychic stress distinct from physiological medicine (Freud & Breuer, 1966). Eventually Freud became estranged from Breuer, and developed his own approach to therapy, which he labeled psychoanalysis, in an attempt to differentiate analytic treatment from other approaches at the time, such as Charcot's hypnosis (Breger, 2000). As Freud's approach started to garner attention he began to train other people under him in the art of psychoanalysis, creating the need to categorize what was necessary in the training of psychoanalysts. Even though Freud wanted to be different from his medical peers, he remained firmly within the medical camp throughout most of his life, as evidenced by the fact that beginning psychoanalysts were still required to have graduated from

¹ It is important to note here that the term "Western psychologists" refers to psychologists trained in North America. Many countries, such as Britain [Grimmer & Tribe, 2001] continue to require psychotherapy of its doctoral candidates.

prestigious medical schools and to have attained their doctorates in medical sciences. Once Freud found followers, (i.e., Adler, Jung, Rank, and Ferenczi; Breger, 2000), he started to write about the additional requirements for psychoanalysts, including formal analytic training that included personal analysis (Freud, 1926).

The field of psychotherapy in North America has made several changes since Freud's era. The 1949 Boulder Conference on the training of clinical psychologist eliminated many of the requirements that psychoanalysts needed and created new requirements for clinical psychologists, and thus created two distinct professions: psychologists and psychoanalysts (Wampler & Strupp, 1976). The overall goal of the Boulder Conference was to look at what should be included in the training of psychologists through the lens of empirical support in an effort place a priority on being a scientist first and a practitioner second (Peterson, 1997). A casualty of this approach was the idea of incorporating personal therapy as a requirement in the training of psychologists, which the attendees of the Boulder Conference agreed lacked sufficient empirical evidence to be included as a Core Curriculum training requirement.

Two other conferences (the Chicago Conference in 1963 and the Vail Conference in 1973) moved away from the Boulder Conference in many respects, but continued to maintain the stance that personal therapy is not warranted as a mandated inclusion for training (Peterson, 1997). Peterson wrote about the distinctions between these two major meetings. First, the Chicago Conference, which created a split between counseling (therapy-centered) and clinical (research focused) PhDs, focused on the need within the field to address the disadvantages of the scholar-practitioner model. This would lead to the creation of the Psy.D. degree at the University of Illinois in the summer of 1968 and to the Vail Conference. Delegates of the Vail Conference rejected the scientist-practitioner model of the Boulder Conference, which ranked

empirical research above practice, to the practitioner-scholar model, which privileged direct clinical service over the science of psychology. The Vail Conference, which led to the formation of Psy.D. training programs, allowed more freedom in regards to how many could be admitted to programs and in their educational models. The requirement of personal therapy for trainees was not included in Vail's curricular suggestions.

In fact, no recommendations on personal therapy or the evaluation of individual psychologist's personality traits was mentioned in the APA's (1973) summary of the Vail Conference recommendations. While the move from the Boulder Conference allowed programs to be less restrictive in regards to empirical support, there still seemed to be a lack of consensus in regards to standards of training. According to Pope and Tabachnick (1994) while there are many reasons for this (e.g., monetary and time-constraints on students), the primary reason continues to be the lack of empirical support, a stance that I will be contesting throughout this dissertation.

Rationale and Implications

The rationale for this theoretical dissertation is to assess whether or not clinical psychology programs should require their students to experience personal psychotherapy. My argument will include four discussions: First, I will review the literature on personal therapy in psychoanalytic training to help create a theoretical foundation for the dissertation. While this section will focus on psychodynamic theory, the concepts discussed will be applied throughout the dissertation as possible atheoretical benefits (e.g., one does not need to be a classically trained analyst to benefit from understanding countertransference).

Second, the literature review will be used to inform the possible benefits of personal therapy that have been found over the past 20 years. I will compile evidence that supports the

concept of personal therapy as essential to psychotherapy training by clearly delineating the history of why this was required in the past, what research has been conducted over the past 20 years on the use of personal therapy, and how several key empirical studies have supported these claims. Third, I will then compile literature on the possible disadvantages of personal therapy to assess for whether or not such a mandate may be more detrimental than positive. Lastly, I will include an integrative discussion of what has been covered in Chapters 1 through 3, followed by recommendations for predoctoral training based on three major studies that had been compiled over the past three decades, most notably Pope and Tabachnick's (1994) survey of APA members. These three studies are going to be used due to their large participant base (over 150 surveyed per study) and will be used to see if the themes present in chapters two through three are present in the field of psychotherapy.

Key Terms

It will be important to make two distinctions for the remainder of this dissertation, and that is the difference between psychoanalytic therapy and psychological treatment. The first camp (which will include the terms psychoanalysis, training analysis, and psychoanalytic treatment) will directly reference therapy in which the clinician meets with the client at least three times per week and uses any therapy within the analytic field (e.g., classical analysis, object relations therapy, ego psychology, etc.; Singer, 1970). The other set of terms (e.g., psychotherapy, clinical psychology, therapy, and counseling) will be used to describe the work done by psychologists, which in regards to individual work, would encompass many different theoretical approaches and would meet once to twice per week (Singer, 1970). It will be important to keep this distinction in mind as the analytic camp continues to require personal psychoanalysis of its candidates while psychologist programs do not.

Lastly, it will also be important to delineate the terms clinician-in-training and practicing therapist. For the purposes of this dissertation, the clinician-in-training will refer to the therapist who is currently in graduate school working towards a degree in psychotherapy, while practicing psychologist will refer to someone who has completed their degree. This distinction will help to make clear the roles that are present in personal therapy, as the clinician-in-training will be the client and the practicing psychologist will be the one providing the therapeutic services.

Chapter 2: Freud and the Foundation of Training Analysis

In order to understand the research on personal therapy, it will first be necessary to delve into the theoretical underpinnings of why personal training analysis was originally required in psychoanalytic training. At its birth, psychoanalysis did not require personal therapy as no one was available to treat the founding clinicians. Even Freud engaged in what he called “self-analysis” (Anzieu, 1986), or explored his own countertransference reactions to his clients through self-exploration and personal writings. It was after Freud’s visit to Clark University in 1909 (Jacoby, 2009) where was asked by a student how a doctor could become a psychoanalyst that he started to think about the training of future analysts. He responded to this question by saying “by studying one’s own dreams” (Freud, 1910a, p. 33). It was after this point that Freud and his followers began writing about training analysis in the hopes of setting standards for future training of psychoanalysts.

Later that year Freud wrote his *The future prospects of psycho-analytic therapy* (1910b), a paper that first mentioned the concept of training analysis. Freud expanded upon the idea of requiring training analysis in the hopes that psychoanalysts could further enhance their practice and be more open to exploring client presentation. To this end, Freud stated (wrote) that:

No psycho-analyst goes further than his own complexes and internal resistances permit; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients. Anyone who fails to produce results in a self-analysis of this kind may at once give up any idea of being able to treat patients by analysis. (p. 145)

One of Freud's objectives for this text was to introduce the necessity of training analysis in that its primary purpose was to help foster a process of self-exploration and awareness within an analytic frame.

Self-analysis became a pre-requisite for beginning one's training as a psychoanalyst in analytic institutes, predominantly the Zurich and Budapest schools of thought. Freud later wrote that it was "one of the many merits of the Zurich school of analysis that they have laid increased emphasis on this requirement, and have embodied it in the demand that everyone who wishes to carry out analyses on other people shall first himself undergo an analysis..." (Freud, 1912e, p. 116). This helped to serve at least two purposes: (a) analysts would become more emotionally and intrapsychically balanced, and (b) they would understand how psychoanalysis worked from their direct experience with a trained professional. By being in this position, the training analyst could learn what it was like to be the client while also understanding how their own personal dynamics influenced their work.

It was around this time that others started to write about the requirement of training analysis in conjunction with psychoanalysis as Freud's students started to branch off and write on their own. Ferenczi and Rank (1925) added to the literature by making a distinction that Freud had not yet made: the difference (or lack thereof) between clinical psychoanalysis with patients and training analysis with beginning clinicians. Both Ferenczi and Rank wrote about this as there was some confusion in the field about whether or not the requirements for successful completion of psychoanalysis would be different depending on who was in treatment. To this end, Ferenczi and Rank made it clear that "the correct didactic analysis is one that does not in the least differ from the curative treatment" (p. 88), indicating that there should be no clinical difference between clinical and training analyses.

In 1937, Freud wrote his seminal work, *Analysis Terminable and Interminable*, a paper that eventually became the cornerstone of the rationale for the pre-requirement of training analysis for analytic training programs. Freud used this paper to move from the tradition of text- and self-analysis to intensive psychoanalysis with another clinician for the purposes of learning psychotherapy. Freud would continue to use this tradition as an example of why analysis should be required, stating that “the reader is ‘stimulated’ only by those passages which he feels apply to himself, i.e. (sic), which refer to conflicts that are active in him.” (p. 251); that is, reading about theory was not sufficient. This indicated that clinicians would be more likely to see what they wanted in their clients based on their personal knowledge, resulting in clinical work that was only stimulated by the therapist’s senses of curiosity or identification. In order to work with this, analysts in training could reflect on increasing their capacity for “ego-modification” (p. 258) and would get at the roots of their resistances.

According to Freud, if psychoanalysis were successful with an analyst in training, the trainee’s resistances could be greatly diminished and there would be an increased capacity for exploration and understanding of unconscious phenomena. Freud (1937) stated that “...success very largely depends upon the analyst’s having profited by the lesson of his own ‘errors and mistakes,’ and got the better of ‘the weak points in his own personality’” (p. 265). By understanding one’s personality, the analyst could then differentiate between the intrapsychic phenomena of the client and the inner-workings of the therapist’s own thoughts and beliefs. Along these lines, Freud also stated, “The analyst... is really impeded by his own defects in his task of discerning his patient’s situation correctly and reacting to it in a manner conducive to cure” (p. 266). If the analyst had not received his own analysis then, it was argued that he would not be able to help the patient “correctly;” that is, the therapist’s reactions would be based in his

or her needs rather than in the client's needs, distorting what the client is actually presenting in the room.

Freud believed that the need for analysis should not end after training. He also wrote in *Analysis Terminable and Interminable* (1937), "Every analyst ought periodically himself to analysis to enter analysis once more, at intervals of, say, five years, and without any feeling of shame in doing so" (p. 266). The goal here was to ensure that the analyst was always in a state of mind to do proper and correct analysis. Freud acknowledged that, even for analysts, life happens and that people can get worse. By starting analysis every few years, the analyst could not only ensure that he was in a space to do good analytic work, but this also prevented the analyst from believing that they had perfected their approach.

After Freud, Ferenczi (1955) was the most influential contributor to the expectation that psychoanalysis be required of all trainees in psychoanalysis. He believed that if the analyst had an extensive knowledge of the self (in addition to knowledge of how psychoanalysis works), then therapy would be completed in the most effective way. Ferenczi, like Freud, believed that beginning analysts needed to know their own intrapsychic workings in order to understand others. Once this understanding was acquired, the analyst would be able to carry out the therapy to its natural conclusion, meaning that the client would be able to understand his or her own unconscious workings without impingement from the therapist. It is because of this essential importance that Ferenczi called the requirement for personal analysis the "second fundamental rule" (p. 88). He thought it one of the few tenets of psychoanalysis upon which all could agree. Freud (1937) went on to write more about who should be admitted to training, and how analysts are sometimes capable of avoiding the treatment, but those points are for another publication.

The purpose of dedicating space to *Analysis Terminable and Interminable* is to point out the ramifications it had on the analytic training community and why it was important for analysts to undergo their own therapy. Training analysis was not included in analytic training not just to show a model of how the treatment is provided, but also to create a space where clinicians can foster a fundamental understanding of themselves so as to improve their clinical skills. By increasing their understanding of countertransference, their own internal life, and to more aptly understand the concepts of psychoanalysis through personal therapy, it was argued that clinical trainees were more prepared to succeed in the field of psychotherapy. To follow is a discussion of the more recent writings on personal therapy and the publications within the field of training clinical and counseling psychologists, in order to see if these theoretical points are supported by research.

Chapter 3: Literature on Personal Therapy for Therapists

Published discourses on psychotherapy and personal therapy are too numerous to be covered in this dissertation. For the sake of brevity, I will write about the six major themes that are most common in the compiled literature databases: (a) the understanding of primary experience, (b) using countertransference, (c) comprehending the therapeutic alliance, (d) exploring the process of supervision and parallel process, (e) professional development, and (f) self care. While building on Freud's aforementioned requirements, all six of these areas help to make the reasons for requiring personal therapy more concrete and explicit.²

Using Primary Experience

One of the more discussed areas in the literature on use of personal therapy in training would be the utility of personal therapy as primary experience. Overall, what primary experience means (at least for the purpose of this dissertation) is the understanding of how therapy works by being in the position of the client. The articles in this section will explore the notion of the therapist being in the "client's chair" in personal therapy (i.e., assume the responsibility of being the client rather than the clinician) and how this influences the clinical work.

Wilner (1990) wrote about this subject in great length with the hopes of pointing out the usefulness of personal therapy. Wilner stated, "...therapists must permit themselves to get caught up in patients' psychological systems (to participate) and later emerge from them in order to be able to comment upon the interaction between patient and therapist" (p. 59). What Wilner meant was that, to understand the needs of the client, therapists must become involved in their internal worlds and that they need to be able to differentiate between the therapist's and client's

² For a brief synopsis of the publications used in this chapter, please see Table 1 in the Appendix

experiences (see the next section on Countertransference for more on how personal therapy impacts this component). Wilner calls this process “living out” (p. 59) the primary experience, which allows the clinician (and in his work the supervisor as well) to understand what is happening in the room. By being in the position of the client (i.e., the therapist-in-training is receiving therapy rather than providing it), the therapist can understand what it feels like to be bored, impatient, and angry with the therapist, and can then move to a position of being able to emerge from the discussion about the process in the room without harm.

Grimmer and Tribe (2001) completed a qualitative study on counseling psychologists in training and found support for Wilner’s (1990) theory. Grimmer and Tribe found that therapists who had been in their own personal therapy “obtained a greater understanding of the therapeutic process of their clients through reflection on their own experience” (p. 292). By being in the role of the client, therapists learned not only what it was like to receive services, but also could adapt to when services did not go well as they knew what it was like to have negative experiences. Grimmer and Tribe found that among their participants, therapists learned how to better cope with clients who (a) had feelings for the therapist, (b) struggled with boundary issues, and (c) could see the impact of non-verbal body language and behavior, all because of the fact that they had experienced these difficulties from first-hand experience during their personal therapy.

Provides a model of therapy. Personal therapy as primary experience also does something that few training programs do anymore: model how therapy can be done. In other words, personal therapy models the material learned in graduate school by seeing how a real therapist works rather than watching a psychologist on tape or in mock-therapy. Giovazolias (2005) wrote about this in his self-exploratory paper, stating that personal therapy had contributed to his learning process by seeing how a trained professional applied the models and

theories that he was learning. Giovazolias also stated, “Being a client also increased my awareness of the potential power imbalances that may exist in a therapeutic encounter, and the possible impact this may have on the therapeutic process,” (p. 164) aspects of his training that he had read about but never truly understood until he was in the position of the client.

Provides depth. Macran, Stiles, and Smith (1999) also write about primary experience in regards to deepening the work by their interview study of 7 psychologists who had sought their own treatment. Rather than assuming therapy was just a tool to be used, the interviewed therapists believed that personal therapy helped them to both understand and feel how deeper psychotherapy worked, and they expressed the benefits of sitting with someone who could tolerate doing this type of therapy. When looking at the major themes across the psychologists, Macran, Stiles, and Smith found that “personal therapy seemed to hone their abilities to understand more deeply and to appreciate communications that were unvoiced” (p. 42). This qualitative study helped to point out yet another beneficial aspect of understanding primary experience in that it assisted the interviewed psychologists in seeing how their personal therapist could put words to what was not being spoken about (e.g., prosody, non-verbal body language, manifestations of the unconscious in interpersonal patterns, etc.).

A question of ethics. Some writers have even argued that it would be ethically irresponsible if therapists did not understand what it was like to be the client (Ross & Roy, 1995). It is from this position that Oteiza (2010) wrote about “experiencing the world of the client” (p. 226), stating that it should be fundamentally required to have therapists learn this position. When Oteiza interviewed psychotherapists to see if she could find similar findings, she had one therapist in the study say that it is “ethically important in relation to justice and equal treatment, in that therapists should experience the same process they offer to clients” (p. 292).

These findings were thematically present in most of the people she interviewed, indicating that personal therapy was believed to be fundamental to understanding clients.

Another area that is relevant to explore would be relationship competency. Unlike most competencies that can be listed and evaluated separately, relationship competency is a substrate of the core values of a clinician (e.g., emotional, cognitive, and cultural understanding) cannot be evaluated solely on its own (Mangione & Nadkarni, 2010). In their publication on the role of relationship competency throughout doctoral education, Mangione and Nadkarni found that relationship competency was both something that a clinician could have upon starting their education and something that could be developed throughout their education. For this to develop during their education the clinician in training must be in a space where “faculty, supervisors, and administrators are also working towards competency” (p. 78). If a student were to have trouble in this domain the authors suggested that the requirement of therapy could be used to alleviate the concerns at hand. This could only be done though if the department made the problems clear to the clinician-in-training, if the program assisted the student in finding an affordable therapist, and if the boundaries between the clinician-in-training’s therapist and the school was made clear.

Relational competency has also been incorporated by the Council of Chairs of Training Councils (2004) as an area of professional development that is just as necessary as ethical or professional competencies. The model proposed in their 2004 publication stated that, alongside professional development concerns, functioning (as measured by emotional, psychological, and interpersonal dilemmas) should also be assessed and evaluated in regards to the clinician-in-training’s overall functioning. The CCTC even stated that teachers, supervisors, and training staff have a:

... professional, ethical, and potentially legal obligation to: (a) establish criteria and methods through which aspects of competence other than, and in addition to, a student-trainee's knowledge or skills may be assessed (including, but not limited to, emotional stability and well being, interpersonal skills, professional development, and personal fitness for practice); and, (b) ensure—insofar as possible—that the student-trainees who complete their programs are competent to manage future relationships (e.g., client, collegial, professional, public, scholarly, supervisory, teaching) in an effective and appropriate manner. (p. 2)

If students were to struggle within this domain, then the CCTC suggests that personal therapy be used as a form of remediation to assist the clinician-in-training throughout their interpersonal difficulties. While this may not be the standard for many doctoral schools, the CCTC's model calls for an approach incorporates relational competency in the hopes that it will not only create better clinicians, but will also help protect “the public and the profession” (p. 1) from unethical practice. In summary, the personality and interpersonal functioning of the clinician-in-training is just as important as their academic or professional functioning, and if there were a deficit in this area, then personal therapy would be a fundamental tool in assisting the clinician in his or her development as a psychologist.

Improved clinical performance. There is research to support that primary experience in personal therapy improves clinical performance in regards to correct implementation of theory and practice. The studies by Hamilton and Kivlighan (2009) and Wiseman and Shefler (2001) describe this in regards to the skill of recognizing the quality of care. In Hamilton and Kivlighan's study, they looked at “core conflictual relationship themes” (CCRTS; p. 312) to see if personal therapy had any impact on awareness of how the therapist works. One of the primary

findings was that by being in therapy therapists could differentiate between their wishes and the wishes of the clients. Without personal experience in therapy, which enhances the therapist's understanding of the meaning of a client having a different goal than the therapist, a negative transference could result (a living out of personal experiences through projection onto the therapist; Pine, 1931), as well as projective actions that could rupture the therapeutic alliance. The findings in the study were that when therapists had more therapy, they were less likely to project their own wishes and interrupt the client's own process, which made their practice more consistent and allowed the client to direct the work.

Wiseman and Shefler (2001) wrote about similar findings when they interviewed five Israeli psychologists. What they found across all interviewees was that personal therapy allowed the therapist to experience some of the ways that therapy helped to facilitate change and whether or not they could expect to be treated the same way as their clients. One of the examples of this was therapy length (the amount of time spent in the room) and session limits (the amount of sessions one was allowed to have). Although some of the therapists believed going into their clinical practice that there should be session limits, Wiseman and Shefler found that these therapists had started to change their minds when they began expecting their therapists to give them more time. Wiseman and Shefler call this awareness the "royal road to improving self-knowledge" (p. 134), meaning that personal therapy is one of the few methods by which one can understand the limits of time from the client's perspective. In other words by being in personal therapy the clinician becomes more aware of how to use time and can be more understanding of how it feels when clients become frustrated with ending sessions. Both of these studies found that the primary experience of personal therapy had not only improved the clinical work but also assisted in further enhancing the clinician's practice.

Awareness of Countertransference

Another area of study, particularly within the psychodynamic and psychoanalytic groups, is the impact of personal therapy on understanding countertransference (i.e., the evocation of strong feelings that the therapist has in relationship to what the client is doing in the room; McWilliams, 2004) and how the client interacts with the therapist in the room. Since therapists do not typically disclose their own personal history so as to not influence the work (McWilliams, 2004), personal therapy is one of the few avenues through which this kind of knowledge can be explored. Even though this type of awareness is more prominent in psychodynamic training, this realm of inquiry can be easily applied to other theories. It is because of this that the writing in this section will try to be as atheoretical as possible, in the hopes of showing that personal therapy can increase countertransference awareness across psychotherapy modalities.

MacDevitt (1987) performed one of the larger studies on personal therapy and countertransference by surveying 185 doctoral-level psychologists to see if there was a connection between the two. MacDevitt found support for such a connection, stating:

Number of hours of personal therapy makes its own sizable and independent contribution to the variance of countertransference awareness and to the variance in perceived professional value of therapy received. ... These findings lend support to the notion that personal therapy for therapists is an experience that leads to greater professionally relevant self-awareness and better professional functioning. (p. 701)

This meant there was a considerable difference between people who had only seen a therapist once or twice in their career and someone who saw a therapist weekly for a year or more, indicating that personal therapy that lasted for a longer term had an increased benefit in regards

to awareness of insight in the moment. It is important to clarify one important finding though: MacDevitt did not find any clinically significant differences between models of education, clinician-in-training's theoretical orientation, or the practicing psychologist's theoretical orientation, meaning that being in therapy garnered an increased capacity for insight and introspection regardless of theoretical training.

In a smaller study, Grimmer and Tribe (2001) found similar utility in personal therapy in regards to countertransference when they had interviewed seven psychologists. Amongst the interviewees, all 7 endorsed items of being able to acknowledge what the client was contributing to the therapeutic relationship, stating, "participants cited a number of effects of being able to distinguish between their own issues and those of their clients..." (p. 294). These effects were: (a) being able to understand what the client was presenting, (b) an increased awareness of countertransference, (c) the prevention of burnout by preventing over-identification, and (d) maintaining appropriate boundaries. In regards to countertransference, Grimmer and Tribe found that most clinicians reported having an increased awareness of how they related to their clients based on their own personal experiences and could separate these out in the room.

Murphy (2005) expanded upon the ideas of maintaining boundaries and increasing capacity for countertransference awareness by interviewing therapists who had at least 40 hours of therapy to see if they were more likely to be aware of personal issues. What Murphy found was that his participants all stated that, by being in therapy, they learned how important an awareness of their own issues was and how to facilitate this openness. What Murphy did not find though was a belief that these issues needed to be resolved, finding that only insight into such problems helped the therapists work and understand their clients. The two main themes across Murphy's qualitative study were, "Unresolved personal issues often emerge in the

foreground during counseling training, counseling practice or personal therapy and [that] Counseling training can raise issues in relationships with others on the course (i.e., in education) and in personal life” (p. 29). In summation, personal therapy assisted therapists in becoming preemptively aware of their own problems, creating a more open space for countertransferential awareness and presence with the client. This study did not look at the extent to which issues should be explored, which could result in a similar predicament that the original APA addendum created (i.e., that personal therapy is only needed as a tool to resolve problems rather than act as an exploratory exercise).

Another area of countertransference awareness is being able to sit with strong emotional reactions, both from within the therapist and from the client. To explore this concept, Rake and Paley (2009) asked whether or not personal therapy had an impact on being able to sit with difficult and overwhelming affect. Among their 8 interviewees, all placed importance upon how difficult it was to sit with strong affect when they were in their own therapy. When the transition from client to therapist occurred then, the therapists in the study were able to better understand the presentation of the client and could separate their feelings from the clients. Rake and Paley stated, “[the] process enabled the realization that strong emotional reactions were bearable and could be survived.... [and those therapists] felt more able to tolerate and not be frightened of the strong emotional reactions of their patients” (p. 285). By being aware of these strong emotional states, the therapists were better attuned to what the client was feeling and were less likely to confuse these for countertransferential reactions.

It is this process that Macran, Stiles, and Smith (1999) named “listening with the third ear” (p. 426), meaning that personal therapy could be a tool through which personal feelings and the client feelings could be separated and understood. Without this “third ear” clinicians could

be less likely to make the differentiation between their reactions and their clients and could risk making interventions based on their personal affect rather than the client's. Among the seven psychologists that Macran, Stiles, and Smith interviewed, each of them found examples of when they were "dragged in" (p. 427) by their clients' overwhelming affect, with one participant even stating that it got so difficult that he started to confuse his intrapsychic phenomena for his client's. By being able to make the separation between the therapist-in-training's and the client's feelings, the work will have more effective interventions.

Wounded healers. There is one other concept that occurs in the writings of countertransference awareness that is of particular importance, and that is the desire to be the "wounded healer" (Barnett, 2007; Oteiza, 2010; Rizq & Target, 2010; Strozier & Stacey, 2001). There are whole publications on this theme in training, so for the sake of brevity, I will try to provide a quick summation. People who tend to fall into the category of the "wounded healer" tend to have more insecure attachment styles and a strong desire to heal the patient. Rizq and Target looked at this phenomenon directly by studying attachment style and client needs, and found that therapists who were insecurely or ambivalently attached tended to have more instances of resistance in the room, leading to a decrease in awareness of what the client was presenting and feeling.

The idea is that poor attachment styles result in therapists who are closed off to their clients' needs and are blinded by their own desire to help them (Barnett, 2007). Clinicians in psychotherapy could develop an increased awareness as to why they want to "rescue" their clients (Strozier & Stacey, 2001, p. 190), can be more effective at being attuned to their clients' needs (Rizq & Target, 2008a), and can be more conscientious of their personal issues while simultaneously abandoning the fantasy of being healthy and fulfilling the role of savior (Oteiza,

2010). From an ethical perspective, personal therapy can also help protect the public from wounded healers (i.e., from sexual boundaries with clients) as personal therapy could help to ensure that we maintain beneficence, the first ethical code for all psychologists. These statements also seem to support Freud's original (1937) belief that not everyone needed to be psychologically sound to practice analysis, but that psychologists in training need to be aware of their own issues and how these influence the work.

Therapeutic Alliance

Whereas countertransference awareness resides in the therapist's attentiveness to his or her reaction to the client, therapeutic alliance is more indicative of how the client and therapist work together. Like most of the writings in this field, personal therapy has been shown to have a positive impact on therapeutic alliance and can help to facilitate a closer working connection between therapist and client. According to Macran et al. (1999), personal therapy helps therapists orient themselves to issues of humanity, power, boundaries, and limitations, while also orienting the client to feeling trust, respect, and patience. By being in the role of the client (another example of primary experience), the therapist can learn to better work with clients and give them the space to feel safe and comfortable in therapy. While this foundation serves as an effective overall summation, it will be important to go into more detail about how personal therapy can impact the therapeutic alliance.

Moller, Timms, and Alilovic (2009) addressed this by looking at how personal therapy impacted therapist openness in the room. Moller et al. interviewed 37 psychologists in training and asked them whether personal therapy had any impact on their ability to be open and transparent with their clients. One of the primary themes that they found across these interviews was that personal therapy increased therapists' capacities for openly discussing "complex

dynamics” (p. 377) in the room with their clients, meaning that they were more comfortable with talking about relationship dynamics as they occurred in-session (an awareness that is particularly helpful in dynamic and system therapies). Therapists also found that, with improved psychological functioning after personal therapy, they felt an increased capacity and ability to safely and openly engage the complex relational patterns that became a part of the therapeutic work.

Norcross (2005) found similar findings in his study on psychologists in training, stating, “...the experience of personal therapy has several positive effects on the therapy relationship, specifically in facilitating empathic ability and decreasing dislike of patients” (p. 842). The psychologists who were in training were able to use personal therapy to better understand the relationship dynamics that resulted in negative views of the clients because they could more openly empathize with their struggles. Norcross also found that personal therapy helped to point out the importance of the therapeutic alliance, making it a central component of what is talked about in the room and in training (i.e., in supervision, an aspect of this literature that will be addressed later). Unlike other articles in this review though, Norcross seemed to avoid going into detail about what was helpful for those in training, creating a more blanket statement about the utility of personal therapy rather than making an empirically sound argument supporting it.

Personal therapy can also increase how positively or negatively the therapist views the work and the progress that has been made in the room. According to Orlinsky and Rønnestad (2005), “Clinicians with no experience of personal therapy showed the lowest rate of felt progress and the highest rates of regress and stasis [whereas] practitioners who were currently in therapy showed the highest rate of progress and the lowest rates of stasis” (p. 121). This finding by Orlinsky and Rønnestad was also shown to impact the therapeutic relationship, as therapists

who believed that little progress was being made tended to have less empathy for their clients and more difficult alliances. It is important to note a limitation of this study though in that the progress being evaluated is subjective and is measured using self-reports, indicating that there is little statistical or objective evidence to support the claims.

It is important to make a distinction here though between empathy and warmth. While most of the aforementioned studies directly discuss warmth and openness to the client, these findings are not the same as therapist empathy. In fact, Peebles (using a study of 17 psychologists who received personal therapy in training; 1980) was able to show that the “[n]umber of hours of personal therapy experience was found to be significantly related to empathy ... and genuineness ... [and] A positive, though not significant, relationship was found between hours of personal therapy and warmth.” (p. 260). This finding, which was self-reported by the therapists in the study, tended to be present across most of the literature found in this review, indicating that warmth was more of a personal trait rather than a clinical one that could be taught and internalized.

In their study on professional psychologists within Britain’s Division of Counseling Psychology, Rizq and Target (2008a) found that “personal therapy is valued as a vehicle for a genuine, often extremely intense relationship with the therapist, through which participants become able to establish authentic emotional contact with themselves and their clients” (p. 29). What this meant was that therapists who had engaged in personal therapy self-reported being able to create more intense connections and attachments to their clients, resulting in the therapists feeling like the treatment was more real as the relationship became important. Rizq and Target also pointed out that personal therapy did something that was monumentally important, and that was to make therapists in training believe that what they were doing was

creating real relationships. Once therapists started to believe that real attachments could be formed to clients by receiving their own treatment, they started to treat their clinical relationships as more than just constructed alliances (e.g., a doctor treating a patient), resulting in shifts in both beliefs about how therapy works and how they related to their clients.

From the client's point of view. All of these studies have focused on the therapists' perspectives of the treatment, something that did not go unnoticed by Gold and Hilsenroth (2009). In their study on therapeutic alliance they surveyed clients directly and found that clients did not rate therapists who had been in therapy as having stronger alliances than therapists who had not. What they did find though (they surveyed both clients and therapists using self-reports) was that therapists who had been in personal therapy felt like there were less disagreements with their clients and that they felt more comfortable in the space. Even though clients did not report having poorer therapeutic alliances, Gold and Hilsenroth still believe that personal therapy is important, stating, "an enhanced understanding of the therapeutic process helps therapist trainees to work more collaboratively with their clients to develop the goals and tasks of the treatment" (p. 168). In other words, even though clients may not rate their therapists differently based on their use of personal therapy (which could also be due to clients not knowing how therapy works from the clinician's perspective), the process is still important in regards to therapeutic collaboration.

Supervision and Training

In regards to training psychologists, the area of writing on personal therapy is most commonly found in writings on supervision. Particularly in regards to psychodynamic and analytic thought, personal therapy is a tool that can augment and deepen the supervisory relationship and can assist in the training of clinical and counseling psychologists. Even though

the writings on understanding the self and supervision are vast, this section will attempt to quickly sum up some of the major points on how personal therapy impacts supervision and training new clinicians.

Parallel process. The first area of how personal therapy impacts supervision is the idea of parallel process, which means that similar clinical patterns occurring between therapist and client emerge in supervision between supervisee and supervisor (Frawley-O’Dea & Sarnat, 2001). To address this in doctoral training, Frawley-O’Dea and Sarnat discuss the need for a fine balance between teaching theory and treating the supervisee. From a psychodynamic perspective, if the work is to understand the countertransference in the room and the parallel process within the supervision, then treating is a necessary part of teaching.

If this becomes too much for the supervisory relationship, then it should be suggested that the therapist seek personal therapy to help ease this process. Since the goal of personal therapy is to “explore as fully as possible the genetic origins and range of potential meanings attributable to the transference-countertransference constellations emerging in the dyad...” (Frawley-O’Dea & Sarnat, 2001, p. 140), what is learned from the treatment can be directly applied to the supervisory dyad. This can be expanded to other theoretical perspectives though as parallel process is not unique to insight-driven approaches (i.e., isomorphic structures in systemic theory; Koltz et al., 2012) and can be detrimental to the training process if it is not understood (Raichelson et al., 1997).

Wolkenfeld (1990) also makes another argument about parallel process: that it is not unique to beginning clinicians. Since this phenomenon can happen even to experienced analysts who have undergone their own intensive psychotherapy, it is important to continue learning about yourself to ensure that the parallel process is understood (hence Freud’s [1937] call to ask

analysts to periodically re-enter therapy). Wolkenfeld also wrote about the similarities between supervision and personal therapy, stating that both (a) are helping processes, (b) require the use of the self, and (c) rely on the need for being able to identify multiple simultaneous processes. He even goes so far as to say that the teaching of skills and theory are not sufficient in the realm of training psychologists, stating, “The capacity for independent learning, the use of one’s own unconscious, the freedom to attend in a relaxed fashion, and the tolerance for ambiguity are all critical objectives of the supervisory process...” (p. 102), indicating that personal therapy can be a useful adjunct for understanding the processes that occur in the clinician-in-training’s own supervision. It is interesting to note here that research has also been done on session length and supervisory awareness. The study completed by Williams, Coyle, and Lyons (1999) found that therapists who had more than 40 sessions of personal therapy had a significantly increased capacity for being able to understand their own processes in their direct clinical work and to use this information in their own clinical supervision.

Personal therapy has also been shown to increase awareness around gender transference (i.e., sexualized transference that can take place between clients and therapists of opposite genders), an area of theory that both Lewis (1990) and Mendell (1990) expand upon. According to Lewis, the role of transference is relevant to both personal therapy and supervision, but in a slightly different fashion. In analysis the transference is to be expanded (i.e., made explicit and explored) and is the core therapeutic component for change, whereas in supervision the clinician-in-training’s countertransference can become an obstacle to learning if it is not resolved. Lewis wrote that gender transference in supervision can be such an obstacle, as an unawareness of how gender impacts relationships can make both the supervisory and the therapeutic relationship disingenuous and confusing. When this becomes the case and

supervision is no longer sufficient for training (as is defined by the supervisor), then personal therapy could become the avenue by which intense transference should be explored, especially when it is too difficult to do directly with the client or supervisor. This weakness of the literature is also a disadvantage of psychodynamic theory as a whole, where gender is perceived through a very traditional lens, and the influences of social constructs that have come to shape our work today (e.g., delineating gender and sex and also discussing same-sex supervisory and clinical dyads) are ignored. Therefore, the concept of gender-transference is very limited in its meaning and should not be applied too broadly.

Because of the need to be aware of these processes, Mendell (1990) wrote directly about the importance of being able to understand developmentally and culturally informed patterns, particularly in regards to dealing with the opposite sex. One method of doing this is by being in cross-gendered supervision (i.e., the supervisor and client are the same gender and the therapist/supervisee is the opposite) as it can help make the transferential patterns unambiguous. If there is a same-gendered pairing between supervisee and supervisor though (or if a supervisor does not focus on gender or issues of diversity), personal therapy can help facilitate an understanding of the patterns that remain implicit or unconscious.

Professional Development

Personal and professional identity. Personal therapy has also been shown to have a large impact on beginning clinician's and psychologists-in-training's sense of professional identity. In regards to professional development, being in therapy has been shown to improve clinicians' abilities to view themselves more positively as therapists and how this assists them in being more comfortable in the field of mental health care as a whole. Even though the research in this field can be broadly applied to all of the previously written subjects (i.e., a more positive

sense of self could improve therapeutic alliance and countertransference awareness), the findings in this section will try to focus primarily on how personal therapy impacts the incorporation of professional identity.

Daw and Joseph (2007) did this by surveying 48 psychologists, two thirds of which were in personal therapy. Of the therapists who had been in personal therapy, there was an increase in understanding of how therapy worked, which resulted in increases of feelings of personal gain in their practices. Overall, Daw and Joseph found, “Through personal therapy therapists learnt experientially, and as a result they believed that they had deeper understanding of theories, models, and therapeutic processes” (p. 231). This process is even more important than in the training of psychologists, as personal therapy helped psychologists deepen their understanding of interventions and applications of theory.

Oteiza (2010) helped to expand this further by going into depth about how personal therapy helped her feel more comfortable as a psychotherapist. What she wrote about was fourfold: that personal therapy helps psychologists (a) admit that both they and their clients are human, (b) respect clients’ sense of pace and “personal rhythm,” (c) to feel comfortable being guided by their clients, and (d) feel more comfortable with being challenged. Since these difficulties are expected of beginning clinicians (Bernard & Goodyear, 2009), the understanding of these issues could help ease the transition from fledgling practitioner to psychologist.

Trainee remediation. Whereas Daw and Joseph’s (2007) and Oteiza’s (2010) writings focused on clinicians in training, Elman and Forrest’s (2004) survey focused on the views of training directors’ perspectives on personal therapy as a form of remediation. Even though some students found this to be more punitive than helpful (this will be addressed later on when discussing the negative impacts of personal therapy), Elman and Forrest found that personal

therapy helped struggling students improve their attendance and their focus on progress, both of which were labeled as essential skills for a psychologist in professional practice.

Personal therapy also has been shown to improve psychologists' abilities to separate their personal lives from their therapy sessions, a skill that not only assists in countertransference management, but also professional identity. Grimmer and Tribe (who surveyed trainee counseling psychologists; 2001) found that personal therapy not only helped counseling psychologists be more comfortable with ambivalence and understanding what was happening in the room, it also increased their confidence in "the ability to make use of the self in the therapeutic relationship with clients [and] to challenge theory" (p. 294). By being able to challenge their understanding of their professional knowledge, beginning clinicians felt more comfortable with their role and more open to be inquisitive about what they did not understand.

In one of the larger studies on the use of personal therapy, Guy et al. (1988) surveyed 318 psychologists to see how effective therapy was as a component of training. What they found in regards to professional identity was that the type of therapy provided to the student directly impacted how confident the therapist was when providing that type of work. In other words, if a therapist sought regular individual psychotherapy, then he or she would feel more comfortable with being in the role of an individual therapist. Guy, Stark, and Poelstra offer a possible alternative explanation for the benefit of personal therapy: "Such individuals may recognize the importance of their own emotional health for the integrity of the treatment that they provide" (p. 475), suggesting that people who are drawn to a certain type of professional identity may have already believed it beneficial prior to starting therapy.

It is important to note that personal therapy may not necessarily mean individual treatment. Lennie (2007) explored this by trying a group-therapy approach to assess for personal

development and psychotherapeutic learning. What she found was that, when in group therapy during training, therapists were better attuned to (a) gender differences, (b) self-awareness, (c) how to work with colleagues and within a team, (d) how to give and receive honest feedback, and (e) how to become aware of one's own behaviors within a group setting. This study also helped to point out that individual therapy need not be the standard, a point that is generally assumed by most writers when publishing about personal therapy for trainees.

By being aware of the aforementioned factors (i.e., gender differences, self-awareness, team work, receiving feedback, and behavioral awareness), clinicians could start to move from the education phase to the authentication phase (Murphy, 2005). According to Murphy, trainees in therapy eventually felt more validated and authentic as a therapist and felt that this transition was easier and less stressful. Murphy further expands upon this by talking about a two-tiered approach to validation: "The experience of personal therapy for the becoming counselor is able to offer confirmation of the self as a valid and acceptable tool for practice, and experiencing personal therapy is a way of having the approach validated as an effectual psychological intervention" (p. 30). In summation, Murphy's research has shown that personal therapy can greatly improve a therapist's sense of professional development and identity as it provides a meaningful form of validation that is difficult to find in traditional training. Whereas Murphy called this the authentication phase, Wiseman and Shefler (2001) labeled it as the transition from "imposterhood" to selfhood, indicating that personal therapy had a direct impact on the creation of a "secure sense of professional self-identity" (p. 134). By acknowledging and owning this role, therapists were more capable of being empathic with their clients, could understand how they impacted their processing, and could be both spontaneous and authentic in the room.

Self-Care

Lastly, and certainly not least, is the impact of personal therapy on self-care. Since psychotherapy is a profession of stress, worry, and sitting with difficult emotions, it is important to be able to engage in self-care practices that ensure the utmost quality of care of being provided (as per the APAs requirements for “taking required measures;” 2002). While self-care is usually spoken about in loosely graduate education and is not a core component of graduation (no one needs to prove they engage in self-care to graduate), it is rarely labeled and directly addressed as a necessity (Dearing, Maddux, & Tangney, 2005). The goal of this section is to look at how beneficial personal therapy can be in regards to self-care practices and how it results in longer-term positive effects.

In one of the larger surveys on self-care and personal therapy, Stevanovic and Rupert (2004) asked 286 licensed therapists about personal care practices to see what was the most beneficial. While the survey addressed a wide range of such activities (e.g., using vacation time, engaging in leisure activities, taking regular breaks), one of the more prominent practices was engaging in personal therapy, particularly amongst female therapists. The survey found that people who engaged in personal therapy, as well as the many other activities listed, were able to maintain “career sustaining behaviors” (p. 301), meaning that they felt more satisfied and content with their job over a longer period of time.

While Stevanovic and Rupert’s (2004) study helped to point out the utility of personal therapy as personal care, one of the drawbacks of the survey was that it did not explore direct causality (i.e., they just stated that personal therapy lead to increased capacities for sustaining positive work behaviors). Dearing et al. (2005) do not omit this in their survey though as they directly explore the impact of personal therapy on self-care practices. Due to the fact that therapists report high levels of distress, depression, substance abuse problems, difficulties with

relationships, and feelings of isolation, Dearing et al. were concerned that "...high levels of personal distress experienced by mental health professionals and psychotherapy trainees may result in a decreased ability to provide optimum care to clients" (p. 323). In response to this concern, they surveyed 262 therapists to see if personal therapy could not only increase self-care practice but could also increase their ability to help their clients. What they found was that personal therapy greatly increased both the capacity for self-care practices (e.g., the therapist could take more time for him or herself) and help-seeking attitudes, which (based on self-reports) had a direct impact on their feeling more prepared and present in their direct clinical work with clients.

Individual therapy is not the only approach though to attain these findings. Like Lennie (2007), who used group therapy for psychotherapists in training, McNamara (1986) also offered another approach that was different from individual therapy: a supervisor-driven form of self-management that became a part of the training model. (It is important to clarify here though that McNamara labeled this in-lieu of personal therapy, but that it met the same purposes in a shorter period of time.)

To do this, supervisors asked their supervisees to pick something that they wanted to change (e.g., behaviors, habits, thoughts, or difficult emotional responses) and would then agree to work on it both on their own time and in supervision together. What McNamara (1986) found was that those students who engaged in this form of self-management approach had "greater awareness of the demands placed on clients and the difficulties they have in working on programs of their own choosing were recognized as important facets of their own and potentially other clients' phenomenology" (p. 373). What is meant was that therapists were able to realize that they could facilitate change in themselves and improve their own personal practices.

Rizq and Target (2008b) further expanded upon these findings by doing an interpretive phenomenological approach study on 9 counseling psychologists who had used personal therapy in their own practice. What Rizq and Target found was that, by being in personal therapy, there were increases in personal cohesion (i.e., putting thoughts about experiences into a more coherent narrative), “feeling and being real” (p. 136), and feelings of safety and confidence in the work. In other words, personal therapy created a space in which psychologists had an increased capacity for self-reflexivity, resulting in work that was less stressful for the practicing clinician. While Rizq and Target do not directly state that this resulted in increased capacity for self-care, the argument could be made that if a clinician feels safer, has more confidence, and is more present in the room, then self-care practices are being used (i.e., there are decreased levels of burnout).

Burnout. Lastly, it is important to discuss the effects of personal therapy on burnout, as this tends to be one of the primary ways of evaluating the effectiveness of self-care practices. Linley and Joseph (2007) and Wiseman and Egozi (2006) have done surveys on burnout and personal therapy, both of which found similar results. In Linley and Joseph’s study (in which they surveyed 156 therapists), they found that personal therapy lead to increases in personal growth and positive changes while simultaneously decreasing burnout.

While this was to be expected, Linley and Joseph (2007) also found two other interesting themes in their survey: That these findings were especially important amongst therapists who stated that they themselves had trauma histories, and that therapists reported having an increased capacity for burnout over the course of decades. In other words, the longer someone had been a therapist, the more likely they were to report feeling burned out by the work and finding negative outcomes in the treatment. This finding supports one of the aforementioned points by Freud

(1937) in that therapists should return to therapy periodically across their career to ensure quality of care.

Wiseman and Egozi (2006) also completed a survey on personal therapy and burnout, but did so with a different population: Israeli therapists. What they found supported many of the findings in Linley and Joseph's (2007) study in that therapists who had undergone their own personal psychological treatment reported less burnout than those who abstained. Specifically, Wiseman and Egozi stated, "regarding difficulties in the various tasks of the school counselor, those who had had therapy reported a lower level of difficulties in the various counseling domains" (p. 343). Even though the causality cannot be determined (i.e., whether or not therapists who are more resistant to burnout use treatment more effectively or treatment helps to foster burnout resiliency), it is clear from both of these studies that there is a correlation between the two.

In summation, personal therapy has been shown to have many advantages that deem it a worthwhile endeavor for education of mental health practitioners. It has been shown to increase self-care practices, improve self-esteem and self-value, create a space where a model of effective therapeutic practices can be observed, and to decrease burnout while increasing job satisfaction. It is important to note that there are few studies that showcase a correlation between personal therapy and client outcome, a finding that the next chapter will explore in-depth, as it is one of the primary arguments against the requirement of personal therapy.

Chapter 4: Literature on the Limitations of Personal Therapy

In addition to expanding up the benefits of personal therapy it will be just as necessary to label the possible negative impacts that can take place with such a practice. After reviewing

articles written over the past ten years on the subject, three major themes became present. First, personal therapy can have a personal impact on the clinician-in-training separately from academic stress, including financial and time constraints in addition to negative impacts on personal development. Second, that personal therapy can create educational or systemic restraints; in other words, that personal therapy creates limitations within academic institutions that outweigh the possible benefits. Lastly, that there is little research showing that personal therapy has an impact on client outcome, making it a potentially useless tool in regards to training clinicians.³

Impact on the Clinician-in-Training

Personal therapy for clinical trainees creates several concerns that can impact their clinical work. Dearing et al.'s (2005) survey of 262 graduate students in clinical and counseling psychology helped to label some of these overarching concerns as the purpose of their survey was to assess for what leads to students reaching out for help. The four overarching themes that came out of this study in regards to what assisted seeking personal therapy were availability, accessibility, acceptability, and affordability. Out of these four themes, the two most prominent categories to doctoral candidates were availability and affordability. When clinical trainees were asked to rank their biggest concerns in the survey (the Likert scale ran from 1 to 5 with an ascending impact), the two biggest concerns were cost (M=3.74) and time (M=3.28), meaning that the two biggest roadblocks to personal therapy were the cost of sessions and the amount of time needed to complete therapy in an already busy and chaotic academic workload.

Given that personal therapy costs money and time, clinical trainees have also found other ways of getting their personal needs met, resulting in a diminished need to seek personal therapy.

³ For a synopsis similar to that of Chapter III's publications, please see Table 2

In a study that surveyed 119 American mental health workers who had never sought personal therapy (Norcross et al., 2008), most reported seeing little to no need for such a requirement. The most common reason for not wanting personal therapy was “I dealt with my stress in other ways” and “I received sufficient support from friends, family, or coworkers”, both answers of which had means of 4.04 with a Likert scale of 5 (1 being unimportant and 5 being very important), meaning that the majority of the participants believed that stress management and personal needs could be attained through other means, such as reliance upon loved ones, spiritual counseling, or the implementation of self-care practices.

Personal therapy could also have a negative effect on the clinician-in-training’s view of the field if there were to have a negative experience in personal therapy. In McEwan and Duncan’s (1991) study using a random sample of 185 therapists from British Columbia, 83% of the participants thought that personal therapy could have at least one negative impact on training, and of these clinicians, 44% believed that a bad experience in personal therapy (i.e., treatment with a poor clinician) could result in diminished returns in therapy. What the authors found among these participants was that, if the personal therapy experience was a bad one, that clinical trainees could experience a gradual decrease in clinical functioning as they remained in personal therapy. Out of these 83%, McEwan and Duncan also found a subset of participants that feared not only having a bad experience in personal therapy but that they would also either (a) drop out of school, (b) become indoctrinated by their poor personal therapist, or (c) would have an increase in stress levels that would make them less efficient in their training. It is important to note though that only 41% of the sample had actually been in therapy, indicating that over half of the responses came from people who had not been in therapy themselves and had only reported fears that they had in regards to seeking services.

Another possible disadvantage, from the clinician's perspectives, is the fear of releasing or acknowledging problems that they are not yet ready to process. In Wheeler's (1991) study of 52 counselors in Britain, it was found that several therapists found personal therapy to be both disturbing and destabilizing in regards to their direct clinical practice. Wheeler wrote that "Therapists concerns, previously repressed, [were] brought into focus, which may inhibit full attention being given to the client and their concerns" (p. 199). This meant was that therapists within the study found that personal therapy was actually more detrimental than positive as they were required to go through an explorative process that they were not yet prepared for. By being required to be in therapy, several clinical trainees found that their personal therapy was impeding their work as they focus of their training shifted to themselves.

Both Linley and Joseph (2007) and Rake and Paley (2009) expand upon this notion by surveying therapists on the emotionally draining aspects of personal therapy during training and how this could negatively impact direct clinical work in practice. Linley and Joseph, who surveyed 156 therapists on the impact of personal therapy on training, found that personal therapy could have what they labeled as a "deleterious effect" (p. 397). By both being in personal therapy and also providing therapy clinicians found that they had experienced compassion fatigue, vicarious traumatization, and increased levels of burnout. Linley and Joseph argue that, by being in a space where one has to process their own traumas while having to help others with theirs, that the "vicarious exposure [could] lead to posttraumatic growth" (p. 387), meaning that the clinician-in-training could actually destabilize through personal therapy rather than improve.

Rake and Paley (2009) found a similar finding in their IPA study of eight therapists in training on the relationship between therapeutic alliance and personal therapy. What Rake and

Paley found was that “There was a sense from participants that the experience of the training therapy could have a personally unsettling impact and consequently potentially have an unfavourable effect on their own therapeutic practice” (p. 288), phenomena they came to coin as a “dissolving process.” Overall, 6 out of the 8 participants noted that their own change processes had created a sense of destabilization, which they felt had directly impacted the work as they were simultaneously treating clients during the same time period. One of the few positives that came out of this finding was the notion that therapists would not want to replicate what they found to be disturbing in their personal therapy in their direct clinical work, but this seemed to be outweighed by the sense of feeling negatively and detrimentally impacted by their own explorative process.

The overall findings across these articles and studies are twofold. First, that personal therapy could cost time and money that the clinician in training cannot afford. If there is no support from the academic institution (and if there is no consistent standard in regards to the requirement of personal therapy) then clinical trainees saw no need to be engaged in an unnecessary and costly service. Second, that personal therapy could have detrimental impacts on the clinician’s intrapsychic and professional functioning. The primary finding across both of these themes is that many clinical trainees feel responsible for their education and that there is no need to take unnecessary risks if such a practice is not deemed necessary or required.

Creation of Institutional Concerns

In addition to the impact that personal therapy can have on individual therapists, some literature has also shown that such an implementation in training could be detrimental to educational institutions. Like the aforementioned costs that can be applied to an individual in

training (e.g., time and money), psychologist programs also need to utilize additional services for the requirement of therapy. The studies in this section will look at several of these concerns.

According to Elman and Forrest (2004), personal therapy can create just as much stress on training directors as it does for individual clinicians. Their study, which looked at the impacts of personal therapy as a tool for remediation with 14 training directors, broke down personal therapy into two different approaches: hands-off remediation (i.e., the director was less involved) and active involvement (i.e., the director has a closer relationship to the student being mandated to therapy). While training directors felt that hands-off approach was less intrusive, it was harder to determine whether trainees were actively using the service, making personal therapy as a mandate moot. On the other hand, active-involvement created a space in which students and directors alike were concerned about the role of confidentiality in the evaluation and whether or not their personal functioning was meeting the standards of multiple parties (e.g., the school and the therapist).

Across these studies, a large number of participants viewed remediation therapy as taxing on both the training directors and the student at hand. The student felt that their own boundaries and personal feelings of confidentiality were being exposed while the training directors felt like there was a lack of support. Elman and Forrest (2004) stated that several training directors felt that they needed “more guidance from their national peers” and the presence of “national standards to guide them through these confusing and complicated ethical dilemmas” (p. 128). Without this level of support though, training directors as a whole felt that such mandates were time consuming, ethically problematic, and resulted in a educational setting where the student in question felt unsafe.

Rizq and Target (2010) found similar levels of frustration within educational settings when therapy became a mandated part of training. Rizq and Target surveyed 12 British psychologists and use IPA to determine if there was a connection between early attachment and the utilization of personal therapy. Out of the 12 surveyed, half reported either secure or earned secure attachments, while views of the remaining six were dismissive, preoccupied, or unresolved⁴. Across both groups (secure and insecure), each individual had their unique understanding of the role of personal therapy. Rizq and Target found one consistent theme across all 12 participants: “These participants all conveyed, in varying ways, the extent to which they felt particularly diminished, disempowered or frustrated either by the imposition of a personal therapy training requirement or by the perceived status, behaviour, and emotional demands of their therapists” (p. 357). Regardless of one’s views on personal therapy and its usefulness, these clinical trainees still felt that were personal therapy a training mandate, their individual sense of agency would be suppressed. The mandate of therapy had created a sense of sensitivity to power and authority that negatively influenced the therapist’s relationship to their training in the moment.

Personal therapy also opens educational institutions to several ethical dilemmas that can impact training. Two studies by Dearing et al. (2005) and McEwan and Duncan (1991) describe the concern that personal therapy could increase the chances of an ethical code being violated. Dearing et al.’s study (they surveyed 342 American doctoral candidates in training to assess for what might keep them from engaging in services), found that most clinicians thought that personal therapy was helpful. However, 31.3% of these participants indicated that their program

⁴ Due to the scope of this dissertation the core concepts behind attachment theory will not be explained in detail. For more information, please read Bowlby’s (1978) publication on the types of attachments and the role that attachment theory plays in psychotherapy.

had a neutral view of personal therapy, and another 6.1% believed that faculty members would look negatively upon students who sought out therapy services. Clinicians in this minority were too concerned to address their worries, and out of fear of their educational programs, kept their concerns to themselves. While this may not be as problematic for stress within one's personal life, it could become problematic if what they were hiding for issues of ethical practice.

McEwan and Duncan (1991) found similar concerns in their aforementioned survey of psychologists in British Columbia. Amongst the chief concerns for students' entering personal therapy were ethical in nature; 49% reported being concerned about dual relationships, 33% thought that their safety could be at risk if their training therapists disclosed what they discussed in session, and 22% reported concerns about the impact of unnecessary therapy (i.e., whether training therapy could fall under the category of maleficence). While this study did not go into whether or not these concerns were based in any real event or real-life scenario, the fact that clinicians were so worried about ethical dilemmas suggests that they did not feel safe enough to seek therapy during their training. McEwan and Duncan did state that these concerns could be alleviated by having a consistent system in place for training therapy, but that without an educational standard, there would be too many opportunities for ethical violations.

Effect on Client Outcome

The last section of this chapter will focus on one of the primary arguments against the requirement of personal therapy in education: that there is no consistent research showing that it has any impact on client outcome. In fact, some of the literature in this section will show the opposite, indicating that such a mandate for training could be detrimental to the burgeoning psychologist. These studies will help to offer a counterpoint to the previous chapter's

publications on the utility of personal therapy, as it is also necessary to understand its potential drawbacks in regards to client care.

Moller et al.'s (2009) literature compilation on personal therapy and outcome research will help to serve as a basis for the remainder of this section. Over the course of their research, the authors found that the relationship between therapists' personal therapy and outcome is both weak and not clinically significant. They believed that this could be due to several factors. The first factor is that, due to the amount of contributing variables on outcome (e.g., therapist training, efficacy in building a therapeutic alliance, years of training), it is impossible to separate personal therapy as a singular variable to be measured. Other factors that could influence outcome negatively could be therapist pre-occupation with the self and the fear that client outcomes could be perceived as to reflect their own personal functioning, suggesting that outcome research will always be biased if it is representative of one's ability as a therapist. Overall, the authors found that the research on outcome measurement and personal therapy was largely weak due to the poor methods by which outcomes were measured.

Whereas most research in this area had focused on clinician reports, it was important to incorporate research that involved the client. Sandell et al.'s (2006) accomplished this by surveying 756 clients in Sweden who were in therapy with clinicians who had undergone personal therapy. What Sandell et al. found was similar the Moller et al.'s (2009) literature review: that there was a clinically insignificant relationship between client satisfaction/outcome and the therapists' being in therapy themselves. The most promising finding in the study seemed to be that "The most direct interpretation implies the view of training therapy as having a sort of indirect effect on the patient, with the therapist as a mediator ... Thus, therapists' training

therapy, when it has been a long psychoanalysis, is not very productive for their patients in psychotherapy” (p. 312).

What the authors (Sandell et al., 2006) meant by this was that the role of personal therapy seemed to be largely important to the clinician and that, even though most found it to be necessary to their training, the impact of such training was mostly indirect and indistinguishable to the client. It is also interesting to point out though that the authors found a curvilinear finding, meaning that the best outcomes were with people with 7 to 8 years of training and therapy and that the worse outcomes were found with clinicians with less than 5, or more than 13, years of personal therapy experience. One weakness of this study was that there was no way to assess for why clients were seeing specific therapists. Sandell et al. suggest that it was possible that more difficult clients were referred to people with more training, thus impacting throwing off the reliability of the measurement.

There is one other study that will be important to include in this section, and that would be Wheeler’s (1991) publication on the negative impacts of personal therapy. While most publications covered within this chapter have proposed that there is little-to-no clinical significance of personal therapy on client outcomes, Wheeler found in his survey of 52 British psychologists that there was a possible negative correlation between therapist predictions of outcomes and personal therapy, stating that:

Personal therapy correlates negatively particularly with the therapist prediction of the therapeutic alliance. This implies that the more personal therapy the therapist has had, the more negative they have predicted the alliance with their client to be. This could imply that they are less confident about predicting a good alliance with

their clients, or possibly that they expect more from the therapeutic relationship than their clients (p. 196).

What Wheeler meant by this was that personal therapy had come to obscure the way that clinical trainees had viewed the work with clients and eventually explained that personal therapy could displace the focus away from the client and onto the therapist. This could make it more difficult for the therapist to be attuned to the needs of the client and, if noticed by the client, could have a negative impact on client outcome. Wheeler also points out one major critique of his publication: There is no control group for psychoanalytic therapists (as they are all required to be in therapy) and assessment tools are not allowed within session. The comparison in his survey between multiple theoretical perspectives was already skewed in the direction of therapy being helpful within a certain subset of clinicians (i.e., psychodynamic clinicians).

Chapter 5: Themes Across Three Major Studies

Before analyzing these findings in the conclusion and writing about the utility of personal therapy, it will be important to look at how psychotherapists in the field have come to view the issue of personal therapy. Unlike the publications in the previous chapters that looked at specific facets of personal therapy (e.g., personal therapy's impact on countertransference awareness, self-care, outcomes measures, etc.), the studies in this chapter are broad and assess for therapist's views towards personal therapy without any specific variable being assessed. These three major studies (i.e., surveys that had over 150 participants each and a cumulative response set of over 1,300 clinicians) will be summarized and then broken down into recurrent themes as they relate to previous chapters. The first will be psychotherapists' views on the utility of personal therapy and whether or not it is helpful during training. The second theme will be the negative impacts of personal therapy and what clinicians are concerned about during training. Lastly, this section will look at the theme of mandating personal therapy, and whether or not the field believes that it should be required as a systematic rule for all clinicians. Before exploring the themes present throughout these surveys, it is important to provide a brief synopsis and overview of each.

Survey Summaries

The oldest study in this grouping is McEwan and Duncan's (1991) survey of psychologists in British Columbia. The authors, who collected a random sample of 400 licensed psychologists, ended up having 185 useable returns. The purpose of this survey was to assess for the utilities of personal therapy as a component of professional training and to help delineate the circumstances under which personal therapy had been provided by academic institutions. While this survey did use Canadian professionals, it is important to note that the standards by which the survey was analyzed used both Canadian Psychological Association (CPA) and APA standards.

The authors' overall findings were that, within the 185 surveyed, 88% reported personal therapy as having at least one benefit, 83% saw at least one risk, and 41% had undergone their own therapy during the course of their education.

The next two surveys use American psychotherapists as the core participant demographic. The older of these two was Pope and Tabachnick's (1994) survey of 476 psychologists that were members of the APA. The purpose of this survey was to assess (a) the beliefs, problems, and experiences related to personal therapy, (b) whether or not the findings were due to differences in scope and methodology (i.e., the surveyed used several interpretive methods), and (c) to gather data about additional questions. The latter were (a) whether therapy should be mandated for training, (b) should it be required for licensure, and (c) what were the biggest benefits and drawbacks are of personal therapy. Out of the 476 that responded 400 indicated that they had been in therapy at one point in their life and that 69.7% of the participants believed that personal therapy should be a part of clinical education.

This last study is also the most recent of this collection: Bike, Norcross, and Schatz's (2009) survey of 727 American psychotherapists. The purpose of their survey was to provide a follow-up to Norcross et al.'s (1988) study on the processes and outcomes of therapists in personal therapy to see if there were any major changes over the past 20 years. The authors surveyed psychologists, counselors, and social workers (counselors replaced psychiatrists in the older study due to the decrease in therapy that MDs do) and found that the incidence of personal therapy had actually increased since the 1988 study. The survey looked at (a) the reasons for being in therapy, (b) what stopped clinicians from seeking services, and (c) what had changed in the field since 1988 in regards to clinical training. Their overall findings were that 84% of

participants had been in therapy at least once in their lifetime and that most clinicians believed that therapy should be a part of clinical education.

Utility of Personal Therapy

All three of the studies seemed to break down the utility of personal therapy into two sections: the themes that were present in personal therapy during training and the gains/improvements that were a result of such treatment. In McEwan and Duncan's (1991) survey, they found that clinicians had predominately sought therapy to (a) learn empathy and understand the client's perspective, gain role models and practical information, (c) learn the professional growth of the therapist, and (d) gain personal growth outside of the role of the therapist. Pope and Tabachnick (1994) and Bike, Norcross, and Schatz (2009) found that therapists had sought treatment for more personal reasons, including treating mood disorders, processing relationship stress, gaining self-confidence and esteem, and to provide a space for self-understanding and adjusting to change-of-life stressors⁵.

The gains that came from personal therapy were plentiful in Pope and Tabachnick's (1994) and Bike et al.'s (2009) surveys. Clinicians in Pope and Tabachnick's study reported having increased levels of self-awareness and self-understanding (N=133), improved self-esteem or self-confidence (N=98), and that they developed skills as a therapist (N=77), whereas clinicians in Bike et al.'s survey reported having improved behavioral symptoms (86% improvement), cognitive insight (90% improvement), and emotional relief (92%) improvement.

These findings run parallel to Chapter 3 of this dissertation, as the themes found in these surveys support the intent of having personal therapy be a component in doctoral education. Clinicians found that personal therapy provided (a) a modeling experience from their clinician,

⁵ Please see Table 3 in the appendix

(b) a space in which their own personal problems could be resolved and separated from their clinical work, (c) a method by which self-awareness could be improved, (d) an experience that improved overall feelings of competency and self-worth, (e) self-care practices, and (f) an opportunity to decrease feelings of burnout and exhaustion. While the views on mandating therapy will be viewed in more detail later in this chapter, the majority of clinicians across all three studies found that personal therapy (either during or before treatment) was relevant to their training and important in regards to their development as a therapist.

Drawbacks of Therapy During Training

All three studies inquired into perceived drawbacks to trainees' uses of personal therapy. While the benefits seemed to be overwhelming, clinicians in all of these surveys did report having concerns that could limit their ability to seek personal therapy. In McEwan and Duncan's (1991) survey the top three concerns were that personal therapy could limit trainee awareness to other models, could create emotional and financial constraints on the trainee, and that if there was a lack of conclusive evidence about the effectiveness of personal therapy that therapists-in-training did not see the need for its inclusion.

After assessing for these overarching themes, McEwan and Duncan (1991) looked at specific concerns that clinical trainees had, and the top four were dual-relationships and ethical concerns, having a poor therapist, "other risks inherent to any therapy" (p. 192), and the risk that personal therapy could pose to clients of the clinician-in-training. Therapists in the survey were largely concerned with the potential for burnout if a clinician was in therapy while subsequently seeing client and that personal therapy could create a sense of false confidence as a result of being "therapized" (p. 191), meaning that they assumed they had been fully healed due to completing personal therapy.

Pope and Tabachnick's (1994) survey included a new array of concerns that were surprising. Out of all the risks that they labeled in their survey, the top 5 were: (a) therapist's sexual acts or attempted sexual acts with the participants (N=16), (b) therapist's incompetence (N=13), (c) emotionally abusive therapist (N=12), (d) therapist's failure in understanding the client (N=11), and (e) dual relationships and boundary violations (N=10). Another surprising finding was that 20% of the participants reported having hidden information from their therapist due to fears around confidentiality and ethics, fearing that their performance in personal therapy could possibly be used to remove them from doctoral candidacy. It is important to note though that, while 22% of the people surveyed thought that personal therapy was potentially harmful, only a select few gave reasons for such a response as these topics were included in the open ended section of the survey (hence why the most common concern only had 16 mentions across 476 psychologists).

Bike et al. (2009) found that most of these concerns carried over time as the primary reasons for not seeking therapy (in comparison to Norcross et al.'s 1988 study) remained largely the same. The three primary reasons for not seeking treatment in the 2009 study were financial constraints, stigma around seeking treatment, and ethical concerns (mostly confidentiality and the impact personal therapy could have on faculty opinions). Within all 727 participants, only 5% (N=28) had reported that therapy had done some degree of harm. While these psychotherapists are in the minority, the authors found that personal therapy had a negative correlation with the three improvement areas being surveyed (behavior symptoms, cognitive insight, and emotion relief).

The disadvantages of personal therapy found in these surveys support the drawbacks that were reported in Chapter 4 of this writing. Personal therapy across all three surveys was found

to possibly create personal concerns for the therapist-in-training (most notably financial and time constraints), the academic institution in regards to ethical violations and boundaries, and that clinicians could become overly confident or assured of themselves by being “healed” in treatment (McEwan & Duncan, 1991). Negative views of trainee personal psychotherapy may have been in the minority in comparison to positive views, but the data across all three studies support the notion that personal therapy could have detrimental impacts on training, and that if there is little-to-no empirical support stating that it is helpful for improving client outcome, the practice may do more harm than good in regards to therapist-in-training functioning.

Views on Mandating Personal Therapy

In addition to assessing for the advantages and disadvantages of personal therapy, all three surveys also assessed for whether or not clinicians believed that therapy during training should be mandated. While 66% of the participants in McEwan and Duncan’s (1991) survey found that personal therapy was either “quite important” or “essential,” the overall findings suggested that the “experience of personal therapy did not have a profound effect on psychologists’ perceptions of the benefits and risks of this type of training” (P=192). Whereas most of the clinicians found that personal therapy was helpful for their personal life, the fact that there was little-to-no impact on client outcome and professional performance (i.e., evaluations) meant that the risk far outweighed the advantages. This created a contradiction in the survey, something that the authors relegated to a desire to separate personal therapy from academic success, as everyone in the survey endorsed a single item: If therapy was available to trainees, then it must be separate from the academic work required. The authors believed that if there were a more removed approach (i.e., Elman and Forrest’s “hands-off remediation” tactic, 2004) then this imbalance could be resolved.

The survey by Pope and Tabachnick (1994) produced slightly different results. While most APA psychologists (85.7%) reported that personal therapy was helpful, there was more consistency in regards to the practice being mandated than in the previous survey. Across all 476 APA members 69.7% believed that therapy should either be “absolutely” or “probably” required, whereas only 29.6% either had no opinion or believed that it could be harmful. Another interesting finding within this survey was that, while 87.2% of participants supported using personal therapy as method of regaining licensure after remediation, only 34.1% thought that this was an effective practice. While there was no explicit question along these lines in regards to personal therapy (e.g., is personal therapy is an effective practice), this finding seems to indicate a discrepancy between the desire to mandate therapy and its effectiveness as a whole.⁶

Bike, Norcross, and Schatz (2009) dedicated less of their study to the concept of mandating therapy than the previous two, but they did include one item on the question of whether personal therapy should be required. Using a Likert scale from 1 to 5 (with increasing significance), most people within the study believed that therapy should be included as a requirement for training (M=4.0). This was consistent across all participant demographics (e.g., gender, profession, and theory), with the lowest scores coming from cognitive-behavioral therapists (M=3.68) and clinicians who had never been in therapy (M=2.78). These findings, in comparison to Norcross et al.’s (1988) study, seem to be consistent with one exception: the increase of psychiatric medications (11% sought medications in 1988 compared to 24% in 2009). The authors of the 2009 survey found that as medication usage increased, the prevalence of personal therapy decreased, indicating that more therapists were relying on anti-depressants and anxiety medications than seeking therapy.

⁶ Please see Table 4 for full details

In summary, all three surveys suggest that personal therapy should be considered to have a place in contemporary education, but also question the methods by which it could be used. As per the concerns in Chapter 4, many clinicians (particularly those in McEwan and Duncan's [1991] study) feared that personal therapy could be used as a tool against their academic or professional progress. These findings also point out yet again that, while the outcome research shows that there is a neutral (or possibly negative; Wheeler, 1991) relationship between personal therapy and outcome, there is still a desire to have personal therapy become a part of contemporary psychotherapy education.

Chapter 6: Discussion and Conclusion

Bike et al. (2009) seem to offer an exemplary summary of their survey that I will use here as a starting point for my conclusion. Even though personal therapy was found to decrease burnout, increase self-awareness and understanding, improve self-esteem, increase openness to feelings and awareness, improve personal relationships, and that it made clinicians feel like they were better therapists, the research shows that there is no direct relationship between personal therapy and client outcome. While therapists have found that personal therapy could be transformative and could have a profound impact on their lives, the lack of any empirical reasons to seek such services diminishes its importance and relevancy in modern education.

It was the original intention of this dissertation to see if such a correlation could be made in the hopes that, if personal therapy could improve outcome, that an argument could be made to make the practice a core component of American doctoral education. But even though this has not been shown (Moller et al., 2009; Sandell et al., 2006; Wheeler, 1991), this does not mean that personal therapy as a whole is not beneficial to educating psychologists. Just because there is no direct correlation between client outcome and personal therapy does not make it a wasted endeavor. According to the relational competency work done by Mangione and Nadkarni (2010) and the evaluative policies set forth by the CCTC (2004), there are other core competencies that need to be evaluated in doctoral education that are not related to client outcomes, such as the clinician-in-trainings ability to form meaningful relationships with both their clients and their colleagues. If we were to only use client outcomes as an argument for including personal therapy as a component for education, then surely there could be other competencies to remove as well. The only finding that seemed to support this would be Pope and Tabachnick's (1994) concept of using personal therapy as a method of screening doctoral candidates, a concept that

was originally a component of training analysis under Freud (1937) but has been widely dismissed as being a quagmire of ethical concerns.

The focus on outcomes also seems to blind us as a profession. Like the *My School* government website in Australia that focused purely on simplistic educational tools to garner increased academic outcomes (Hardy & Boyle, 2011), the goal of improved outcomes dwarfed individual learning styles and actually resulted in students not learning to the best of their abilities. Rather than place importance on education, the *My School* website seemed to focus on a “more valued ... generic measure of educational attainment” (p. 220). This zealous attention to outcome has even been seen in our field, as social work programs have focused on proving outcomes to merit their worth to communities (Lynch-Cerullo & Cooney, 2011), to showcase the medical approach to psychotherapy in order to validate its use to treat mental illness (Elkins, 2009), and that the focus on outcomes in empirically-supported models of psychotherapy result in clinicians missing certain core components (e.g., relationship competency) that may not be a part of the model (Wampold & Bhati, 2004). In summation, if the core argument to omitting personal therapy in training is that it does not impact client outcomes, then a large part of our field will be omitted in the course of training (e.g., relational competency). The irony is also not lost here; by focusing on outcomes and omitting interpersonal skill building and relational competency, the basis for the very nature of our clinical work would be undermined by our own approaches to education.

So if there is a desire within the field to incorporate personal therapy into training, how could we cultivate the inclusion? The first idea would be to separate personal therapy from its evaluative roots. I do not fully support this choice, because personal therapy could be an effective tool at determining who is either failing or succeeding at becoming a therapist.

However, the literature covered in this dissertation suggests that (a) the benefits of training therapy are largely relegated to personal and professional development, and (b) that programs do not need the additional stress of following personal therapists to assess for the progress of its trainees. This removal could also help to eliminate ethical concerns because clinicians would no longer need to fear dual roles and boundary containments.

A second recommendation would be the creation of a systematic acceptance of personal therapy to help alleviate the stigma of its use. Given how many clinicians avoided therapy out of the stigma that they were somehow deficient (particularly in Bike et al.'s [2009] survey), a universal requirement for at least short-term treatment could create a space in which everyone could feel safe utilizing its services. In addition to such a requirement, if institutions could create some system where therapeutic services could be less stressful on the clinician (especially in regards to financial constraints), then students would feel less personal strain to undertake personal therapy as a part of their regular schedules. This would not only help to reduce the stigma around clinicians seeking services but would also reduce personal, academic, and financial strain in an already stressful profession.

These goals may seem lofty, but they could be easily implemented if there was further inquiry into this problem to justify its costs. The first area for further inquiry would be to clearly define outcome measures and find an effective way to evaluate the role of personal therapy on client care. While the research has shown that there is no direct relationship between the two, it is my opinion that outcome measurement is simply too broad, inaccurate, and all-encompassing to be used as a method of ruling out personal therapy. While a longitudinal study on the role of personal therapy over the course of training would be helpful in this regards, it would be impossible to truly separate personal therapy out as an individual variable, so research in this

area needs to be better defined. Secondly, a newer publication on the desire for personal therapy as a required component of education should be completed. Pope and Tabachnick's (1994) study comes close to this by asking APA members about the inclusion of personal therapy, but what is needed is the APA to take a poll of its members to determine if this is a requirement that should become a part of educational institutions. Third, further publications (such as the CCTC's 2004 publication on relational guidelines in training) are needed to clearly delineate the importance of relational competency and interpersonal relationships and how personal therapy can help to further enhance a clinician-in-training's capacity to become an ethical and effective psychologist.

Lastly, it will be important to label the limitations of this dissertation. First, this writing is largely theoretical and literature based, meaning that the majority of the data is qualitative in nature and could be interpreted as not being statistically relevant in regards to quantifiable data. Further research into the use of personal therapy should utilize quantitative methods to determine to further support its empirical efficacy. It is also important to address that there is a clear theoretical orientation in this dissertation (psychodynamic) that could bias the way that the findings were interpreted. Even though I attempted to make the findings after Chapter 2 as atheoretical as possible, future publications on personal therapy could benefit from writing from other perspectives, such as systemic and cognitive thinking.

APPENDIX

Table 1 – Advantages of Personal Therapy

| Author(s) | Year | Findings |
|---------------------------------|------|---|
| Daw & Joseph | 2007 | <ul style="list-style-type: none"> • Surveyed 48 psychologists, 2/3rds of whom were in personal therapy • Therapists learned through personal therapy that they could change too, resulting in implications for personal gain in their practice |
| Dearing, Maddux,& Price Tangney | 2005 | <ul style="list-style-type: none"> • Surveyed 262 clinical psychology students who were seeking personal therapy • Psychotherapy trainees frequently have other stressors, including juggling multiple roles • Personal therapy allowed the clinicians to create safe spaces • Personal therapy can be used by programs to ensure that self-care practices are taken in to consideration. • Personal therapy also improved help-seeking attitudes, allowing therapists to reach out for assistance more readily when they are struggling |
| Elman & Forrest | 2004 | <ul style="list-style-type: none"> • 14 training directors were interviewed to see the role of personal therapy within remediation protocols • Personal therapy as remediation also helped to improve attendance and focus on progress, both of which are essential skills for a psychologist in professional practice |
| Frawley-O’Dea & Sarnat | 2001 | <ul style="list-style-type: none"> • Teach and treat balance • If the work is to understand the countertransference in the room and the parallel process within the supervision, then treating is a necessary part of teaching • If this becomes too much for the supervisory relationship, then it should be suggested that the therapist seek personal therapy |
| Giovazolias | 2005 | <ul style="list-style-type: none"> • Personal therapy had contributed to the learning process by seeing how a trained professional applied the theoretical understanding. • Giovazolias also stated, “Being a client also increased my awareness of the potential power imbalances that may exist in a therapeutic encounter, and the possible impact this may have on the therapeutic process,” (p. 164) aspects of his training that he had read about but never truly understood until he was in the position of the client. |
| Gold & Hilsenroth | 2009 | <ul style="list-style-type: none"> • No difference on patient-rated therapeutic alliance • Therapists who had personal therapy felt: |

| | | |
|------------------------|------|---|
| | | <ul style="list-style-type: none"> ○ There was less disagreement about the goals and tasks of therapy ○ More confident ○ That patients were more committed and confident in therapy |
| Grimmer & Tribe | 2001 | <ul style="list-style-type: none"> ● Found that therapists who had been in their own personal therapy “obtained a greater understanding of the therapeutic process of their clients through reflection on their own experience” (p. 292). ● Therapists learned how to better cope with clients who (a) had feelings for the therapist, (b) struggled with boundary issues, and (c) could see the impact of non-verbal body language and behavior |
| Guy, Stark, & Poelstra | 1988 | <ul style="list-style-type: none"> ● Survey of 318 therapists to assess the utility of personal therapy ● Found that therapists who engaged in personal therapy tended to specialize in individual therapy ● “Such individuals may recognize the importance of their own emotional health for the integrity of the treatment that they provide. Those preferring to explore the individual issues and problems of their clients may also be more interested in better understanding their own.” (p. 475) |
| Hamilton & Kivlighan | 2009 | <ul style="list-style-type: none"> ● A study to see if personal therapy had any impact on awareness of how the therapist works ● One of the primary findings was that therapists could, be being in therapy, differentiate between their wishes and the wishes of the clients ● The findings in the study found that when therapists had more therapy, they were less likely to project their own wishes and interrupt the client’s own process |
| Lennie | 2007 | <ul style="list-style-type: none"> ● Personal therapy may not necessarily mean individual treatment ● Lennie explored this by trying a group-therapy approach to assess for personal development and psychotherapeutic learning. ● Themes that were raised: <ul style="list-style-type: none"> ○ gender differences ○ exploring self-awareness ○ how to work with colleagues and within a team ○ how to give and receive honest feedback ○ how to become aware of one’s own behaviors within a group setting |
| Lewis; Mendell | 1990 | <ul style="list-style-type: none"> ● Both authors looked at the role of gender and its impact on supervision |

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| | | <ul style="list-style-type: none"> • Found that certain relationship dynamics occur with supervisees of opposite genders that may be better suited to personal therapy |
| Linley & Joseph | 2007 | <ul style="list-style-type: none"> • Surveyed 156 therapists on burnout factors • Personal therapy leads to increases in personal growth and positive changes and decreases in burnout • The findings also found that therapists reported having an increased capacity for burnout over the course of decades |
| MacDevitt | 1987 | <ul style="list-style-type: none"> • Surveyed 185 therapists • Personal therapy for therapists is an experience that leads to increased self-awareness and improved professional functioning |
| Macran, Stiles, & Smith | 1999 | <ul style="list-style-type: none"> • Interview study of 7 psychologists who had sought their own treatment • Found that “personal therapy seemed to hone their abilities to understand more deeply and to appreciate communications that were unvoiced” (p. 42). • Primary experience assisted the interviewed psychologists in seeing how their personal therapist could put words to what was not being spoken about (e.g., prosody, non-verbal body language, manifestations of the unconscious in interpersonal patterns, etc.). • Therapy served as a tool by which personal feelings and the clients’ feelings could be separated (i.e., listening with the “third ear” [p. 426]) |
| Mangione & Nadkarni | 2010 | <ul style="list-style-type: none"> • Relationship competency was both something that a clinician could have upon starting their education and something that could be developed throughout their education. • For this to develop during their education the clinician in training must be in a space where “faculty, supervisors, and administrators are also working towards competency” (p. 78) |
| McNamara | 1986 | <ul style="list-style-type: none"> • Implemented another form of self-care, labeled ‘supervisor-directed self-management’ • To do this, supervisees were asked by their supervisors to pick something that they wanted to change (e.g., behaviors, habits, thoughts, or difficult emotional responses) • Therapists were able to realize that they could facilitate change in themselves and improve their own personal care practices |
| Moller, Timms, & | 2009 | <ul style="list-style-type: none"> • Personal therapy increased the capacity to openly |

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| Alilovic | | <p>discuss the “complex dynamics” (p. 377) that were present between therapist and client.</p> <ul style="list-style-type: none"> • Therapists found that, with improved psychological functioning through personal therapy, found that there was an increased capacity and ability to “work effectively and safely with clients.” (p. 380) |
| Murphy | 2005 | <ul style="list-style-type: none"> • Personal therapy helped clinicians in training better understand the impact of their personal issues • The categories in full were: <ul style="list-style-type: none"> ○ Unresolved personal issues often emerge in the foreground during training ○ Counseling training can raise issues in relationships with others in school and in personal lives • Murphy discussed the “authentication phase,” meaning that the clinician eventually feels validated and authenticated as being a therapist • By being in personal therapy, this phase was enhanced and found to be more meaningful |
| Norcross | 2005 | <ul style="list-style-type: none"> • Collections of studies found that personal therapy helped to point out the importance of the therapeutic alliance, making it a central component of what is talked about in the room and in training (e.g., supervision) |
| Oteiza | 2010 | <ul style="list-style-type: none"> • Wrote about “experiencing the world of the client” (p. 226) • Found that personal therapy was viewed by most participants as an ethical standard • These findings were thematically present in most of the people she interviewed, indicating that personal therapy was believed to be fundamental to understanding clients. • Personal therapy allowed clinicians to admit that they are human too and to respect an individual’s personal rhythm |
| Peebles | 1980 | <ul style="list-style-type: none"> • Interviewed 17 psychologists • Found that the number of hours in personal therapy had a direct relationship to empathy and genuineness from the position of the therapist • Little connection to warmth |
| Rake & Paley | 2009 | <ul style="list-style-type: none"> • Personal therapy helped clinicians learn about the strong emotional reactions that clients can have in therapy • Learned first-hand the emotional impact of exploring themselves in therapy |

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| | | <ul style="list-style-type: none"> • Participants felt that they knew themselves better as a result of this process and felt more able to tolerate difficult emotions |
| Rizq & Target | 2010 | <ul style="list-style-type: none"> • Study found that therapists who knew their own attachment style were able to be more effectively attuned to the needs of their clients • Therapists who were insecurely or ambivalently attached tended to have more instances of resistance in the room • Discussed the concept of the “wounded healer” (p. 359) |
| Rizq & Target | 2008a | <ul style="list-style-type: none"> • Personal therapy helped facilitate a process by which clinicians-in-training learned that clinical treatment was a real process • This resulted in closer attachments between client and therapist due to the therapist recognizing it as a real relationship rather than a constructed one |
| Rizq & Target | 2008b | <ul style="list-style-type: none"> • IPA study of 9 psychologists • Personal therapy created an increased capacity for self-reflexivity • By being in personal therapy, there were increases in personal cohesion and feelings of safety and confidence in the work |
| Stevanovic & Rupert | 2004 | <ul style="list-style-type: none"> • Surveyed 286 therapists on the use of personal therapy as self-care • Women were more likely to seek out personal therapy in an effort to engage in “career sustaining behaviors” (p. 301) • Personal therapy was used by many people in the study to take care of themselves, especially when there was not enough time to engage in other activities |
| Williams, Coyle, & Lyons | 1999 | <ul style="list-style-type: none"> • Therapists who had more than 40 sessions of treatment showed a significantly increased capacity for being able to work with their own awareness in supervision |
| Wilner | 1990 | <ul style="list-style-type: none"> • To understand the needs of the client, therapists must become involved in their internal worlds and that they need to be able to differentiate between the therapist’s and client’s experiences • Wilner calls this process “living out” (p. 59) the primary experience, which allows the clinician (and in his work the supervisor as well) to understand what is happening in the room. • The importance of being in the position of the client (i.e., the therapist-in-training is receiving therapy rather than providing it) |
| Wiseman & Egozi | 2006 | <ul style="list-style-type: none"> • Surveyed 103 Israeli therapists |

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| | | <ul style="list-style-type: none"> • Counselors who had undergone therapy (M=2.42, SD=.74) reported less burnout than those who had not (M= 2.79, SD= .95) |
| Wiseman & Shelfer | 2001 | <ul style="list-style-type: none"> • Allows the therapist to experience, first-hand, some of the ways that therapy has changed and whether or not they would expect to be treated the same way as their clients • “Royal road to improving self-knowledge” (p. 134) and how personal therapy is the only method of learning all of the aspects of yourself • Discussed the transition from imposterhood to selfhood • By acknowledging and owning this role, therapists were more capable of: <ul style="list-style-type: none"> ○ being empathic with their clients ○ understanding how they impacted their processing ○ being spontaneous and authentic in the room |
| Wolkenfeld | 1990 | <ul style="list-style-type: none"> • Parallel process is in all clinical work regardless of years of training or clinical modality • Since this phenomenon can happen even to experienced analysts who have undergone their own intensive psychotherapy, it is important to continue learning about yourself to ensure that the parallel process is understood • Personal therapy can be a useful adjunct for understanding the processes that occur in the clinician-in-training’s own supervision |

Table 2 – Drawbacks of Personal Therapy

| Author(s) | Year | Findings |
|----------------------------|------|--|
| Dearing, Maddux, & Tangney | 2005 | <ul style="list-style-type: none"> • Most students surveyed had four factors that impacted their decision to seek personal therapy: availability, accessibility, acceptability, and affordability • On a scale from 1 to 5, 1 being playing a factor and 5 playing a large one, two obstacles (in addition to confidentiality) were endorsed by trainees: <ul style="list-style-type: none"> ○ Cost: 3.74, SD=1.36 ○ Time: 3.28, SD=1.35 • Survey 342 doctoral candidates in training to assess for what might keep them from engaging in services • While most found that seeking therapy was beneficial and that they had the support of their program, “31.3% of students indicated that they perceived faculty attitudes about students in therapy as neutral, and 6.1% rated faculty attitudes about students in therapy as below neutral.” (p. 325) • This represented a fear that was present within these training programs that went unresolved |
| Elman & Forrest | 2004 | <ul style="list-style-type: none"> • Interviewed 14 training directors to see what the impact of personal therapy as remediation was. • Elman broke down this approach by both “hands-off” and “active involvement” approaches. • While training directors felt that hands-off approaches were less intrusive, it was harder to determine whether trainees were actively using the service. On the other hand, active-involvement created a space in which students and directors alike were concerned about the role of confidentiality in the evaluation • Across both types of remediation therapy was viewed as taxing on both the training directors and the student at hand. |
| Linley & Joseph | 2007 | <ul style="list-style-type: none"> • Study of 156 therapists on the impact of personal therapy • Article focused mostly on positive outcomes but did label several areas of concern • Most notably: “Deleterious effects,” Compassion fatigue, vicarious traumatization, and burnout |
| McEwan & Duncan | 1991 | <ul style="list-style-type: none"> • 400 therapists from British Columbia were surveyed to see what advantages and disadvantages were present in personal therapy • Found that therapists could have a poor clinician, resulting in diminished returns in therapy (44% thought this happened) |

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| | | <ul style="list-style-type: none"> • Therapist in training could also drop out of school due to the increase in stress or could become indoctrinated by a bad therapist • Biggest drawback of personal therapy were: dual relationships (49%), safety of the client (whether information from therapy would be used against them in education; 33%), the impact of therapy on someone who was mandated (23%), and unnecessary therapy is unwise (22%) |
| Moller, Timms, & Alilovich | 2009 | <ul style="list-style-type: none"> • The relationship between therapists' personal therapy and client outcome is not clinically significant • They believed that this may have been due to several factors: <ul style="list-style-type: none"> ○ The amount of contributing variables on outcome (e.g., therapist training, efficacy in building a therapeutic alliance, years of training) ○ The impossibility of separating personal therapy as a singular variable to be measured ○ Therapist pre-occupation with the self and the fear that client outcomes would be representative of their own personal functioning |
| Rake & Paley | 2009 | <ul style="list-style-type: none"> • IPA study of 8 therapists in training on the relationship between therapeutic alliance and personal therapy. • Found what they coined as a "dissolving process" • Overall, 6 out of the 8 participants noted that their own change processes had created a sense of destabilization |
| Rizq & Target | 2010 | <ul style="list-style-type: none"> • Surveyed 12 British psychologists and used IPA to determine if there was a connection between early attachment and the utilization of personal therapy • Out of the 12 surveyed, half reported either secure or earned secure attachments while the remaining six were either dismissive, preoccupied, or unresolved • One theme that persisted across all 12 participants: A felt loss of agency |
| Sandell et al. | 2006 | <ul style="list-style-type: none"> • Surveyed 756 clients who were in therapy with clinicians who had personal therapy (Sweden) • Found that there was very little relationship between client satisfaction/outcome and personal therapy • Curvilinear finding: Best outcomes were with people with 7-8 years of training and therapy, whereas worse outcomes were found with clinicians with less than 5, or more than 13, years of personal therapy experience • Disadvantages of the study: no way to assess for why clients were seeing specific therapists. Sandell mentioned the idea that more difficult clients are |

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| | | referred to people with more training, thus impacting alliance. |
| Wheeler | 1991 | <ul style="list-style-type: none">• Surveyed 52 counselors in Britain to assess for whether personal therapy had an impact on therapeutic alliance• Personal therapy can become disturbing and destabilizing for the therapist• Found that there was a negative correlation between therapist predictions of outcomes and personal therapy• Disadvantage: There is no control group for dynamic therapists (they are all required to be in therapy) and assessment tools are not allowed within session |

Table 3 – Reasons for Seeking Personal Therapy

| Study | Total Participants | Topics in Personal Therapy |
|---------------------------------|--------------------|---|
| McEwan & Duncan (1991) | 185 | Learn empathy and understand the client's perspective (N=118) Gain role models and practical information (N=76) Learn the professional growth of the therapist (N=64) Gain personal growth outside of the role of the therapist (N=92) |
| Pope & Tabachnick (1994) | 476 | Depression or general unhappiness (N=120) Marriage or divorce (N=94) Relationship in general (N=66) Self-esteem and self-confidence (N=57) Anxiety (N=55) |
| Bike, Norcross, & Schatz (2009) | 727 | Marital-couple distress (N=117) Depression (N=77) Need for self-understanding (N=73) Anxiety/Stress (N=62) Adjustment problems (N=58) |

Table 4 – Inquiries on Requiring Personal Therapy (Pope & Tabachnick, 1994)

| Question | Absolutely Yes/Probably | Don't Know/Probably Not/Absolutely Not |
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| Should personal therapy be a requirement for people training to be therapists? | 69.7% | 29.6% |
| Should personal therapy be a requirement for licensure | 53.7% | 45.0% |
| Should licensing boards be able to mandate therapy as a condition for resuming practice? | 87.2% | 12.2% |
| Do you believe that therapy mandated by licensing boards as a condition for continued practice is effective? | 34.1% | 65.6% |

References

- Alves de Oliveira, J., & Vandenberghe, L. (2009). Upsetting experiences for the therapist in-session: How they can be dealt with and what they are good for. *Journal of Psychotherapy Integration*, 19(3), 231-245.
- American Psychoanalytic Association. (2012). *Standards for education and training in psychoanalysis*. Retrieved from <http://apsa.org/Portals/1/docs/Training/Standards.pdf>.
- American Psychological Association. (1976). *Training of professional psychologists: Excerpts of the recommendations of the Vail Conference*. Washington, D.C.: American Psychological Association, 441-446.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.
- Anzieu, D. (1986). *Freud's Self-Analysis: Translated from the French by Peter Graham. With a Preface by M. Masud R. Khan*. The International Psycho-Analytical Library, London: The Hogarth Press and the Institute of Psycho-Analysis.
- Barnett, M. (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: Individuals, Groups and Organisations*, 13(3), 257-274.
- Bellows, K. F. (2007). Psychotherapists' personal psychotherapy and its perceived influence on clinical practice. *Bulletin of the Menninger Clinic*, 71(3), 204-226.
- Bernard, J. M. & Goodyear, R. K. (2009). *Fundamentals of Clinical Supervision*. New Jersey, USA: Pearson Education, Inc.

- Bike, D. H., Norcross, J. C., & Schatz, D. M. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training*, 46(1), 19-31.
- Bowlby, J. (1978). Attachment theory and its therapeutic implications. *Adolescent Psychiatry*, 6, 5-33.
- Breger, L. (2000). *Freud: Darkness in the midst of vision*. New York, NY: John Wiley & Sons, Inc.
- Brenner, A. M. (2006). The Role of Personal Psychodynamic Psychotherapy in Becoming a Competent Psychiatrist. *Harvard Review of Psychiatry*, 14(5), 268-272.
- Buckley, P., Karasu, T. B., & Charles, E. (1981). Psychotherapists view their personal therapy. *Psychotherapy: Theory, Research & Practice*, 18(3), 1981, 299-305.
- Clark, M. M. (1986). Personal therapy: A review of empirical research. *Professional Psychology: Research and Practice*, 17(6), 541-543.
- Council of Chairs of Training Councils. (2004). *Recommended policy language for the comprehensive evaluation of student-trainee competence in professional psychology programs*. Retrieved May 18th, 2013, from <http://www.ccptp.org/trainingdirectorpage7.html>.
- Daw, B., & Joseph, S. (2007). Qualified therapists' experience of personal therapy. *Counselling & Psychotherapy Research*, 7(4), 227-232.
- Dearing, R. L., Maddux, J. E., & Price Tangney, J. (2005). Predictors of Psychological Help Seeking in Clinical and Counseling Psychology Graduate Students. *Professional Psychology: Research and Practice*, 36(3), 323-329.

- Elkins, D. (2009). The Medical Model in Psychotherapy: Its Limitations and Failures. *Journal of Humanistic Psychology, Vol. 49(1)*, 66-84.
- Elman, N. S., & Forrest, L. (2004). Psychotherapy in the Remediation of Psychology Trainees: Exploratory Interviews With Training Directors. *Professional Psychology: Research and Practice, 35(2)*, 123-130.
- Ferenczi, S. (1955). The elasticity of psycho-analytic technique. In *Final contributions to the problems and methods of psycho-analysis*. London: Hogarth and the Institute of Psycho-Analysis. (Original work published 1928)
- Ferenczi, S., & Rank, O. (1925). *The development of psycho-analysis*. New York and Washington: Nervous and Mental Disease Publishing.
- Frawley-O'Dea, M.G. & Sarnat, J. E. (2001). *The Supervisory Relationship: A Contemporary Psychodynamic Approach*. New York: The Guilford Press.
- Freud, S. (1910a). Five lectures on psychoanalysis. New York, NY; W. W. Norton & Company, Inc.
- Freud, S. (1910b). The future prospects of psycho-analytic therapy. In S. Freud, *Therapy and Technique*, 77-87. New York, NY: Collier Books.
- Freud, S. (1912). Recommendations for physicians on the psychoanalytic method of treatment. In S. Freud, *Therapy and Technique*, 117-126. New York, NY: Collier Books.
- Freud, S. (1926). The question of lay analysis (the standard edition). New York, NY; W. W. Norton & Company, Inc.
- Freud, S. (1937). Analysis terminable and interminable. In S. Freud, *Therapy and Technique*, 233-271. New York, NY: Collier Books.

- Freud, S. & Breuer, J. (1966; second edition). *Studies on hysteria*. New York, NY: Avon Books.
- Garfield, S. L., & Bergin, A. E. (1971). Personal therapy, outcome and some therapist variables. *Psychotherapy: Theory, Research & Practice*, 8(3), 251-253.
- Garfield, S. L., & Kurtz, R. M. (1976). Personal therapy for the psychotherapist: Some findings and issues. *Psychotherapy: Theory, Research & Practice*, 13(2), 188-192.
- Giovazolias, T. (2005). Counselling psychology and the integration of theory, research and practice: A personal account. *Counselling Psychology Quarterly*, 18(2), 161-168.
- Gold, S. H., & Hilsenroth, M. J. (2009). Effects of graduate clinicians' personal therapy on therapeutic alliance. *Clinical Psychology & Psychotherapy*, 16(3), 159-171.
- Grimmer, A. & Tribe, R. (2001). Counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development: an exploratory study. *Counselling Psychology Quarterly*, 14(4), 287-301.
- Guy, J. D., Stark, M. J., & Poelstra, P. L. (1988). Personal therapy for psychotherapists before and after entering professional practice. *Professional Psychology: Research and Practice*, 19(4), 474-476.
- Haak, J., & Kaye, D. (2009). Personal psychotherapy during residency training: A survey of psychiatric residents. *Academic Psychiatry*, 33(4), 323-326.
- Hamilton, J., & Kivlighan, D. M. (2009). Therapists' projection: The effects of therapists' relationship themes on their formulation of clients' relationship episodes. *Psychotherapy Research*, 19(3), 312-322.
- Hardy, I. & Boyle, C. (2011). My School? Critiquing the abstraction and quantification of Education. *Asia-Pacific Journal of Teacher Education*, vol. 39(3), 211-222

Jacoby, R. (2009). When Freud came to America. In *The Chronicle of Higher Education*.

Retrieved December 8th, 2012, from <http://chronicle.com/article/Freuds-Visit-to-Clark-U/48424/>.

Jones, Ernest. (1957). *Sigmund Freud: Life and work*. London: Hogarth.

Karon, B. (1990). Psychoanalysis, Psychoanalytic Therapy, and the Process of Supervision. In R. C. Lane (ed.), *Psychoanalytic Approaches to Supervision*, 147-156. New York, NY: Brunner/Mazel, Inc.

Koltz, R. L., Odegard, M. A., Feit, S. S., Provost, K., & Smith, T. (2012). Parallel process and isomorphism: A model for decision making in the supervisory triad. *The Family Journal*, 20(3), 233-238.

Lennie, C. (2007). The role of personal development groups in counsellor training: Understanding factors contributing to self-awareness in the personal development group. *British Journal of Guidance & Counselling*, 35(1), 115-129.

Lewis, W. C. (1990). Transference Issues in Cross-Sex Supervision. In R. C. Lane (ed.), *Psychoanalytic Approaches to Supervision*, 124-127. New York, NY: Brunner/Mazel, Inc.

Linley, P., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, 26(3), 385-403.

Lynch-Cerullo, K. & Cooney, K. (2011). Moving from Outputs to Outcomes: A Review of the Evolution of Performance Measurement in the Human Service Nonprofit Sector. *Administration in Social Work*, Vol. 35, 364–388.

MacDevitt, J. W. (1987). Therapists' personal therapy and professional self-awareness. *Psychotherapy: Theory, Research, Practice, Training*, 24(4), 693-703.

- Macran, S., Stiles, W. B., & Smith, J. A. (1999). How does personal therapy affect therapists' practice? *Journal of Counseling Psychology, 46*(4), 419-431.
- Mangione, L., & Nadkarni, L. (2010). The relationship competency: Broadening and deepening. In M. Kenkel, R. L. Peterson (Eds.), *Competency-based education for professional psychology* (pp. 69-86). American Psychological Association.
- McEwan, J., & Duncan, P. (1991). Personal therapy in the training of psychologists. *Canadian Psychology/Psychologie canadienne, 34*(2), 186-197.
- McNamara, J. R. (1986). Personal therapy in the training of behavior therapists. *Psychotherapy: Theory, Research, Practice, Training, 23*(3), 370-374.
- McWilliams, N. (2004). *Psychoanalytic psychotherapy: a practitioner's guide*. New York, NY: Guilford Press.
- Mendell, D. (1990). Cross-Gender Supervision of Cross-Gender Therapy. In R. C. Lane (ed.), *Psychoanalytic Approaches to Supervision*, 114-118. New York, NY: Brunner/Mazel, Inc.
- Moller, N. P., Timms, J., & Alilovic, K. (2009). Risky business or safety net? Trainee perceptions of personal therapy: A qualitative thematic analysis. *European Journal of Psychotherapy and Counselling, 11*(4), 369-384.
- Murphy, D. (2005). A qualitative study into the experience of mandatory personal therapy during training. *Counselling & Psychotherapy Research, 5*(1), 27-32.
- Norcross, J. C. (2005). The Psychotherapist's Own Psychotherapy: Educating and Developing Psychologists. *American Psychologist, 60*(8), 840-850.

- Norcross, J. C., Bike, D. H., Evans, K. L., & Schatz, D. M. (2008). Psychotherapists who abstain from personal therapy: Do they practice what they preach?. *Journal of Clinical Psychology*, 64(12), 1368-1376.
- Norcross, J. C., Strausser-Kirtland, D., & Missar, C. D. (1988). The processes and outcomes of psychotherapists' personal treatment experiences. *Psychotherapy*, 25, 36-43.
- Orlinsky, D. E., & Rønnestad, M. (2005). Current Development: Growth and Depletion. In D. E. Orlinsky, M. Rønnestad (Eds.), *How psychotherapists develop: A study of therapeutic work and professional growth* (pp. 117-129). Washington, DC US: American Psychological Association.
- Oteiza, V. (2010). Therapists' experiences of personal therapy: A descriptive phenomenological study. *Counselling & Psychotherapy Research*, 10(3), 222-228.
- Peebles, M. J. (1980). Personal therapy and ability to display empathy, warmth and genuineness in psychotherapy. *Psychotherapy: Theory, Research & Practice*, 17(3), 258-262.
- Peterson, D. R. (1997). *Educating professional psychologists: History and guiding conception*. Washington, DC, US: American Psychological Association, p. 77-93.
- Pine, F. (1931). *Drive, Ego, Object, and Self: A Synthesis for Clinical Work*. NY: Library of Congress.
- Pope, K. S. & Tabachnick, B. B. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice*, 25(3), 247-258.

- Raichelson, S. H., Herron, W. G., Primavera, L. H., & Ramirez, S. M. (1997). Incidence and effects of parallel process in psychotherapy supervision. *The Clinical Supervisor, 15*(2), 37-48.
- Rake, C., & Paley, G. (2009). Personal therapy for psychotherapists: The impact on therapeutic practice. A qualitative study using interpretative phenomenological analysis. *Psychodynamic Practice: Individuals, Groups and Organisations, 15*(3), 275-294.
- Rizq, R. (2011). Personal therapy in the psychotherapeutic training: Current research and future directions. *Journal of Contemporary Psychotherapy, 41*(3), 175-185.
- Rizq, R., & Target, M. (2008a). 'Not a little Mickey Mouse thing': How experienced counselling psychologists describe the significance of personal therapy in clinical practice and training. Some results from an interpretative phenomenological analysis. *Counselling Psychology Quarterly, 21*(1), 29-48.
- Rizq, R., & Target, M. (2008b). 'The power of being seen': An interpretative phenomenological analysis of how experienced counselling psychologists describe the meaning and significance of personal therapy in clinical practice. *British Journal of Guidance & Counselling, 36*(2), 131-153.
- Rizq, R., & Target, M. (2010). "We had a constant battle". The role of attachment status in counseling psychologists' experiences of personal therapy: Some results from a mixed-methods study. *Counselling Psychology Quarterly, 23*(4), 343-369.
- Rønnestad, M., & Ladany, N. (2006). The impact of psychotherapy training: Introduction to the special section. *Psychotherapy Research, 16*(3), 261-267.
- Ross, L. B. & Roy, M. (1995). *Cast the first stone: Ethics in analytic practice*. Wilmette, IL: Chiron Publications.

- Sandell, R., Carlsson, J., Schubert, J., Grant, J., Lazar, A., & Broberg, J. (2006). Therapists' therapies: The relation between training therapy and patient change in long-term psychotherapy and psychoanalysis. *Psychotherapy Research*, 16(3), 306-316.
- Shapiro, D. (1976). The analyst's own analysis. *Journal of the American Psychoanalytic Association*, 24, 5-42.
- Singer, E. (1970). *Key concepts in psychotherapy*. Northvale, New Jersey: Jason Aronson, Inc.
- Stevanovic, P., & Rupert, P. A. (2004). Career-Sustaining Behaviors, Satisfactions, and Stresses of Professional Psychologists. *Psychotherapy: Theory, Research, Practice, Training*, 41(3), 301-309.
- Strupp, H. H. (1955). The effect of the psychotherapists's personal analysis upon his techniques. *Journal of Consulting Psychology*, 19, 197-204.
- Wampler, L. D., & Strupp, H. H. (1976). Personal therapy for students in clinical psychology: A matter of faith? *Professional Psychology*, 7(2), May 1976, 195-201.
- Wampold, B. & Bhati, K. (2004). Attending to the Omissions: A Historical Examination of Evidence-Based Practice Movements. *Professional Psychology: Research and Practice*, Vol. 35(6), 563-570
- Wilner, W. (1990). The Use of Primary Experience in the Supervisory Process. In R. C. Lane (ed.), *Psychoanalytic Approaches to Supervision*, 58-70. New York, NY: Brunner/Mazel, Inc.
- Wiseman, H., & Egozi, S. (2006). Personal therapy for Israeli school counselors: Prevalence, parameters, and professional difficulties and burnout. *Psychotherapy Research*, 16(3), 332-347.

Wiseman, H., & Shefler, G. (2001). Experienced psychoanalytically oriented therapists' narrative accounts of their personal therapy: Impacts on professional and personal development. *Psychotherapy: Theory, Research, Practice, Training*, 38(2), 129-141.

Wolkenfeld, F. (1990). The Parallel Process Phenomenon Revisited: Some Additional Thoughts About the Supervisory Process. In R. C. Lane (ed.), *Psychoanalytic Approaches to Supervision*, 95-109. New York, NY: Brunner/Mazel, Inc.