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Psychotherapists with psychiatric challenges : an exploratory study of their transference, supports, and their professional identity development

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ABSTRACT

This exploratory study was undertaken to explore psychotherapists who possess a variety of psychiatric diagnoses found in the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR*). This study was also to explore how psychotherapists experience transference to clients who possess similar diagnoses or symptomatology, as well as to explore what connection, if any exists, between the psychotherapist's support system and their professional identity development. This research was also envisioned as a way to develop a voice for professionals who may not speak out about their personal experience within the mental health system due to fear of stigmatization and discrimination.

The sample size consisted of thirteen psychotherapists (N=13), including ten Master's level social workers, two Doctoral level social workers, and one doctor in psychiatry. All participants were actively practicing psychotherapy and each had a history of participating in psychotherapy as consumers with various diagnoses. All participants reported a variety of years as consumers, a variety of years of practice, and diverse theoretical orientations.

The findings of this research revealed different levels of empathic attunement ranging from identifying with clients and their pain to overidentifying with clients. Participants were identified as having either high or low levels of clinical insight as measurement to their professional development. Participants revealed various levels of disclosure of the personal experience as consumers, ranging from minimal or indiscriminate levels, limited levels, or maximum levels of disclosure based on how much the participants disclosed to friends, family, personal therapists, and colleagues/supervisors.

Participants also identified various ways mental health professionals could help fight the stigmatization of the mental health field. Three major themes revealed systemic approaches, political approaches, and personal approaches. Each participant outlined various responsibilities that current and future psychotherapists participant in to fight stigma.

PSYCHOTHERAPISTS WITH PSYCHIATRIC CHALLENGES:

AN EXPLORATORY STUDY OF THEIR TRANSFERENCE, SUPPORTS,

AND THEIR PROFESSIONAL IDENTITY DEVELOPMENT

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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I would like to dedicate this thesis to all who receive mental health services. With work and dedication, you can become anything. No mountain is too high to climb. Use your supports and know you can accomplish all you desire. I give this advice to my unborn child as well. Do not ever forget that you can be anything you want. Thank you.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Many mental health professionals practice with the belief of us (providers or psychotherapists) and them (consumers). No one is exempt from experiencing firsthand mental health challenges. With this in mind, members of the mental health profession are not exempt from carrying a psychiatric diagnosis, therefore nor are they exempt from the discrimination and the experience of stigma that often comes with it.

The purpose of this study is to explore views of psychotherapists who possess a variety of psychiatric diagnoses found in the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR*), their transference to clients who possess similar diagnoses or symptomatology and to explore what connection, if any exists, between the psychotherapists' support systems and their professional identity development. This research is also envisioned to develop a voice for professionals who may not speak out about their personal experience within the mental health system due to fear of stigmatization and discrimination. This research questions the validity of the us and them dichotomy.

The literature review of this paper outlines general definitions of psychotherapists, Massachusetts Department of Mental Health's criteria for disability due to a psychiatric diagnosis. It introduces the concepts of transference and countertransference, support system, and professional identity development. Once all concepts are defined, it outlines the reasons for this research and how it contributes to the

social work field. The study identifies potentially different views for professionals of looking at psychiatric challenges.

Chapter 3 outlines the methodology of this project. In this chapter, there is a breakdown of the sample characteristics, participant recruitment, design and procedure, and data analysis. Chapter 4 presents the findings. Chapter 4 identifies four of the main findings as well as their subgroups within the findings. This chapter also identifies findings that are idiosyncratic to other findings within this project or those that are not supportive of previous literature. Chapter 5 discusses the findings in relation to previous research. This chapter identifies the research limitations of this project as well as ideas for future research and recommendations for current and future psychotherapists.

CHAPTER II

LITERATURE REVIEW

This paper begins with outlining definitions of psychotherapist, psychiatric diagnostic criteria, transference and countertransference, support system, and professional identity development. Then it turns towards a brief overview of the history of the mental health system beginning in the 1840's in England until the 1990's in the United States. Next, it introduces current statistics of those who experience a diagnosable mental health challenge. A general critique of the mental health system's design of a medical model follows. Finally, there is an exploration of topics historically researched regarding the idea of the professional identity development of psychotherapists as well as the psychotherapist as a consumer. The exploration will be completed by a summary of each area previously addressed in this paper.

This critique outlines some of the reasons why the medical model is not adequate for the mental health system. It explains how pathologizing symptoms allow for the continuation of stigmatization. Within this system, there are psychotherapists who choose to speak out regarding their personal mental health challenges despite the known stigmatization and discrimination they may endure. There is a brief outline of some experiences self-disclosed psychotherapists have. This reflects the reality that psychotherapists also experience mental health challenges.

This study utilizes a psychodynamic approach to psychotherapy addressing countertransference and transference. This analysis utilizes the complex therapeutic

3

relationship between the psychotherapist and client. The exploration of the interaction between the psychotherapist and client allows for a better understanding of the complexities of transference and countertransference.

Although there is important literature regarding psychotherapists' transference and countertransference experiences, there is minimal literature regarding the interaction among the psychotherapist's support systems, countertransference or transference, and their professional identity development (Mackey & Mackey, 1994). This research explores a scarcely explored topic. It is beneficial for all mental health professionals - those with personal history of psychiatric challenges and those without. The exploration of these topics will offer a more comprehensive evaluation of how they are interwoven.

Definitions

Psychotherapist

Psychotherapist is a word that includes a variety of professional positions. It is common to have the term psychotherapist interchangeable with therapist, clinician, clinical psychologist, clinical social worker, clinical nurse specialist, and psychiatrist just to name the most common titles. Several other degrees and licenses may fit under the definition of psychotherapist. To accurately use the term psychotherapist, the individual must obtain a Master's degree or higher and obtain required licenses to practice. Psychotherapists primarily interact with clients through some level of talk and communication. The role of the psychotherapist varies depending on what discipline they study. The intention of this study is to view each interviewed psychotherapist through a psychodynamic lens regardless of his or her theoretical orientation.

4

Psychotherapists train and practice a variety of theoretical disciplines. The theoretical orientation each psychotherapist follows may vary from psychodynamic, to cognitive behavioral, or systems-oriented to name a few. There are varying levels of education that psychotherapists possess. For this study, the focus will be on psychotherapists with a master's degree or higher, who currently or in the past year have possessed a license to provide psychotherapy and who have provided psychotherapy to clients in individual or group therapy, family therapy, or couples therapy.

Lieberman (1987) offered a description of psychotherapy as "a treatment of psychological disturbances and mental distress, or of problems of coping with life because of personal discomfort or maladaptative affecting the self or others" (p. 370).

Psychiatric Diagnostic Criteria

The Department of Mental Health in each state has diagnostic criteria for individuals applying for disability due to psychiatric challenges. In order to establish specific parameters regarding participation in the study the Department of Mental Health's criteria were utilized. The Commonwealth of Massachusetts' (n.d.) web site outlines the various *DSM-IV-TR* psychiatric diagnoses that qualify the possible status of disability. The specific diagnostic criteria for participation in the study are one or more of the following diagnoses:

> Schizophrenia and other Psychotic Disorders (excluding psychotic disorders due to general medical condition and substance-induced psychotic disorders); Mood Disorders (excluding Dysthymia and mood disorders due to a general medical condition); Anxiety Disorders (excluding anxiety disorders due to a general medical condition and substance induced anxiety disorders); Eating Disorders; and Borderline Personality Disorder.

The Commonwealth of Massachusetts established these criteria due to the increased

levels of impaired functioning that frequently accompany these diagnoses. These

diagnoses will inform the criteria of eligibility to participate in this study.

Transference and Countertransference

The terms transference and countertransference evoke a variety of definitions.

Kernberg (1965) detailed two different concepts of countertransference. The first,

classical countertransference is, "the unconscious reaction of the psychoanalyst to the

patient's transference" (p. 38). This suggests the psychotherapist has experiences in

response to a client's reactions. This can also suggest the psychotherapist's personal

experiences are displaced onto the client.

The second, totalistic countertransference is, the "total emotional reaction of the

psychoanalyst to the patient in the treatment situation" (Kernberg, 1965, p. 38). More

specifically, "the conscious and unconscious reactions to the patient in the treatment

situation are reactions to the patient's reality as well as to his transference, and also to the

analyst's own reality needs as well as to his neurotic needs" (Kernberg, 1965, p. 38).

This suggests countertransference is the psychotherapist's reactions to the client, to the

client's reactions, to his or her own feelings.

This study will partially focus on the noticeable reactions or triggers the

psychotherapist notices in themselves in response to specific situations or feelings the

client has described, such as unresolved unconscious conflicts and deficits due to the

psychotherapists personal psychiatric experiences. Every psychotherapist possesses a

library of personal experiences. As psychotherapists bring their personal experiences in

the room, the dynamic of the therapeutic environment alters (Benedek, 1953).

This study will utilize the psychodynamic perspective of transference. The definition of psychodynamic is "any forces, internal or external, that have an impact on mental and emotional development" (Berzoff, Flanagan & Hertz, 2004, p. 5). It originally derived from the classical psychoanalytic approach. The unconscious holds important information that informs our daily lives. Much of an individual's experiences influence our present realities (Berzoff et al., 2004). As an individual transfers a feeling from someone in their past to someone in their present, it is called transference. It is the psychotherapist's role to understand these transferences and utilize them in the clinical approach.

Support System

Sarason and Sarason (1982) have defined a support system as "help that would be available to an individual in difficult or stress-arousing situations" (p. 331). Psychotherapists find support through a variety of systems. Some utilize personal support from friends and family, others may utilize professional support from colleagues (Bruce, Conaglen & Conaglen, 2005; Corrigan, Holmes & Luchins, 1995; Coster & Schwebel, 1997; Sarason & Sarason, 1982). Many psychotherapists consult with colleagues when faced with sensitive situations. Consultations with professional peers can help problem-solve or even better understand the client's experiences as well as offering assistance in how to address the situation therapeutically (Bruce et al., 2005).

This study will explore the support systems participants utilize and how these support systems have influenced their professional identity development. This study will also explore how participants utilize their support systems, assessing the importance of

personal and professional support systems regarding support around transference towards

clients.

 Professional Identity Development

Professional identity development is the psychotherapist's growth in experience,

confidence, and competence (Mackey & Mackey, 1994; Williams, Judge, Hill &

Hoffman, 1997). A maturation process assists the professional growth. The maturation

process is apparent in the level of higher order psychotherapy skills such as timing,

appropriate interventions, and overall understanding of the client (Williams et al., 1997).

Brott and Myers (1999) identified the professional identity development evolves

over time and experience. They suggested that the development begin during graduate

school, evolves upon entry into the profession, and continue as the professional identifies

with their role in the profession. As the professional internalizes their role, Brott and

Myers suggested the individuals begins the process of understanding their individualized

personal guidelines, therefore their personal style begins to emerge in their work.

Theoretical Approach

Different theoretical lenses are utilized while working within the context of

societal structures. Some psychotherapists focus on specific theoretical orientations such

as cognitive behavioral therapy or dialectical behavioral therapy. These two therapies are

goal oriented and task based. There are other theories connected to psychodynamic

concepts. Berzoff, et al. (2004) stated, "[p]sychodynamic theories represent

approximations of human experience, metaphors that have developed within particular

cultures, during particular social times, and with particular social values" (p. 9). Each of

the psychodynamic theories addresses the idea that individuals are not independent of

context. It is important to view each person and each situation with a complex lens of identifying all contextual pieces. This study will utilize the psychodynamic structural lens when exploring each participant as well as each of the transference experiences.

History and Politics of the Mental Health System

This section covers a brief overview of the history and politics of the mental health system beginning England in the 1840s and continuing through the 1990s in the United States. It outlines the beginning of the consumer-survivor movement and name three key pioneers who headed the movement in the United States. It covers the progress of the deinstitutionalization process as well as the ramifications due to the process.

It begins the exploration of psychotherapists who also have experienced their own psychiatric challenges and how the various accrediting agencies influence how each discipline of psychotherapy views professionals with psychiatric challenges. This is followed by an outline of how the Americans with Disabilities Act helped shape the approach regarding individuals both as providers and as consumers are treated due to whatever impairment is present. Next, this section covers the statistical reality of how many American adults personally experience psychiatric challenges. There is a brief exploration on the mental health system and how it has been based on the medical model and how the mental health profession often carries a stigmatizing quality. Finally, there is an outline of various personal accounts by select professionals' experiences of the mental health profession from the consumer role.

History: 1840s until 1990s

Throughout history, most societies have documented extensive methods of managing individuals who suffer from various mental health issues. Voices of the

psychiatrically challenged were rarely heard. People with psychiatric challenges often

experienced labels such as lunatics, crazy, insane, or mentally ill (Bartlett, 1998;

Bassman, 1997; Fisher, 1994; Frese & Davis, 1997; Jamison, 1995, 1998, 2006). Many

treated those who suffered from mental health challenges as subhuman, often confined to

inhumane conditions of living (Bartlett, 1998; Bassman, 1997; Frese & Davis, 1997).

Others with mental health challenges may have adapted to the world around them. Many

of the great composers, artists, and writers from the 20th century (e.g., Ernest

Hemingway, Virginia Woolf, Mark Rothko, and Charles Mingus) suffered from various

mental health challenges (Andreasen, 1987; Kottler, 2006).

In 1845, the Alleged Lunatic's Friend Society was established in England,

beginning the consumer-survivor movement (Frese & Davis, 1997). Twenty years later,

following the Civil War, the United States began developing a consumer-survivor

movement. Elizabeth Packard, Elizabeth Stone, and Clifford Beers were the pioneers in

the United States who forged ahead, beginning and strengthening the movement (Frese &

Davis, 1997).

Elizabeth Stone and Clifford Beers found themselves outside institutions in which

they previously resided. Using their first hand experience they began drawing interest

and attention to the horrific conditions individuals endured within institutions. Beers

(1927) detailed the abuse he and other patients experienced behind psychiatric institution

walls. He founded the National Committee for Mental Hygiene, which now is known as

the National Mental Health Association. The movement began with a few voices,

expanded and was heard by many (Frese & Davis, 1997). Other groups were founded in

response to the National Committee for Mental Hygiene and some independently. Two

names of the earlier groups were the Insane Liberation Front, organized in Oregon, and the Mental Patients' Liberation Project, organized in Boston and New York (Frese & Davis, 1997).

The movement began to fight against the stigmatization and discrimination of those who reside in psychiatric institutions, many of which were labeled as crazy or insane (Bartlett, 1998; Bassman, 1997; Fisher, 1994; Frese & Davis, 1997). The movement began the deinstitutionalization process. During the 1970s and 1980s the deinstitutionalization movement began gaining momentum (Anthony, 1993; Frese & Davis, 1997; Jansson, 2005; Lavine, 1981). This movement consisted of removing individuals from the psychiatric institutions.

In 1963, President Kennedy signed the Community Mental Health Centers Act, shifting funding away from psychiatric hospitals towards the building of community mental health centers (Lavine, 1981). President Kennedy proposed developing preventative programs that would assist individuals with psychiatric difficulties, avoiding the need for additional services. The citizens were not ready for such a radical change (Lavine, 1981). The Community Mental Health Centers Act of 1963 allocated funds for the building of the structures; however, there was a lack of funds to address the staffing issues, and to develop programs. It was not until 1965 that funds were available for staffing of the community mental health centers in order to address outpatient needs (Lavine, 1981).

Many state hospitals closed, allowing previous patients more freedom to control their own lives (Frese & Davis, 1997). Unfortunately, when the psychiatric patients were released from the state hospitals, there was little assistance supporting them in this

transition (Anthony, 1993). Anthony went on to criticize the lack of policy

implementation preceding the deinstitutionalization movement. Many individuals

released from psychiatric hospitals lacked the skills to obtain housing, jobs, and

education. Poor planning regarding deinstitutionalization required communities to take

responsibility of the needs of the recently released psychiatric patients; leading to the

beginning of the development of various community support systems and programs

(Anthony, 1993). Not all psychiatric patients were in need of such complex assistance,

some joined proactive groups who worked toward increasing psychiatric patients rights

(Anthony, 1993; Frese & Davis, 1997).

In the early 1970s, released patients began to realize they had been denied basic

rights. This began the launching of the psychiatric patients' liberation. Individuals with

mental health challenges began to gather, strategizing how they would gain their rights

back. They were no longer willing to allow society's labels to authorize discrimination

against them. Throughout the 1970s and 1980s, groups began forming across the United

States in the fight for regaining their power (Anthony, 1993; Frese & Davis, 1997;

Lavine, 1981).

Impaired Psychotherapists

  American psychological association. During the 1980s, the Board of Professional

Affairs of the American Psychological Association (APA) began to analyze the lack of

consistency of defining impairment in psychotherapists as well as the lack of consistent

standard of treatment for impaired psychotherapist as well as consistency in

consequences (Laliotis & Grayson, 1985). The APA began analyzing the more

12

sophisticated structure of the American Medical Association's (AMA) standard of care and policies regarding consequences (Laliotis & Grayson, 1985).

The APA adapted the AMA's policy to meet the differently complex needs of the mental health profession. The Board of Professional Affairs "established a steering committee on distressed psychologists" (Laliotis & Grayson, 1985, p. 84). This committee, established in 1981 designed a program that would "provide peer/support services to members of APA who are in distress" (Laliotis & Grayson, 1985, p. 84).

The Board determined that impairment would represent some form of obstacles or interference that conflicts with professional functioning, directly resulting from substance dependency, mental illness, or some form of personal conflict (Laliotis & Grayson, 1995). Kutz (1986) criticized this definition, suggesting it is too broad. Kutz (1986) suggested the definition should be specified to include "physical handicaps, substance abuse, sexual misconduct, psychosis, depression, and poor judgment" (p. 220).

The APA had difficulty developing a comprehensive program that would address the specific needs of impaired psychologist. During the 1983 APA annual convention, they announced they were developing a program. During the 1984 APA convention, they presented the proposal of a comprehensive program developed to address needs of impaired psychologists (Laliotis & Grayson, 1985). In 1985, when Laliotis and Grayson published their study, not all fifty APA state organizations had adopted this proposal.

Laliotis and Grayson (1985) initiated a study to investigate the existence of programs and policies that pertain to impaired psychologists. It was determined after investigating all fifty states there was a significant variation among states as to what is

included in the definition of impairment as well as the availability of programs and

consistency of policies regarding the consequences of impairment.

One argument against establishing programs directed toward impaired

psychologists was the probability of limited use. Psychologists are small in numbers

compared to physicians, therefore some states reported the effort to develop the programs

might not be worth it. Laliotis and Grayson (1985) suggested "joining with other

disciplines such as social work, counseling, or medicine and jointly offering services

could be a sensible alternative" (p. 93). All fifty APA state organizations have some

level of definition of impairment coupled with some form of licensing requirement and

consequences of impairment (Laliotis & Grayson, 1985). As of this study, there was very

little consistency regarding this matter.

National Association of Social Workers. The National Association of Social

Workers (NASW) addressed the realities of impaired social workers in their Code of

Ethics (1999). Ethical standard 4.05(b) regarding impairment stated:

> Social workers whose personal problems, psychosocial distress, legal
> problems, substance abuse, or mental health difficulties interfere with their
> professional judgment and performance should immediately seek
> consultation and take appropriate remedial action by seeking professional
> help, making adjustments in workload, terminating practice, or taking any
> other stops necessary to protect clients and others (p. 23).

Any personal experiences that interfere with the psychotherapist's professional

performance must be addressed immediately. The Code of Ethics (NASW, 1999) also

outlined in the ethical standard 2.09 the responsibilities of all social workers who interact

with an impaired colleague. The NASW created a hotline for consultations regarding

ethical dilemmas.

Outlined on the national NASW website (NASW National Website, n.d.), the

organization currently has fifty-six different chapters, representing the each state as well

as territories of the United States. The Massachusetts chapter created a support network

called Social Workers Assistance Network (NASW Massachusetts Chapter Website,

n.d.). This network offers professional consultation as well as referrals for any social

worker who require support around personal problems. This service supports the

individual social worker in acquiring appropriate professional supports.

Americans with Disabilities Act. In the early 1990s the Americans with

Disabilities Act forced the U.S. Federal government to require states who benefit from

federal funding for mental health, to have consumers on all mental health boards allowing

for consumers' voices to be heard. The American Medical Association (AMA) also

deemed it unlawful to discriminate due to mental health challenges, ensuring the rights of

the individuals (Fisher, 1994; Frese & Davis, 1997).

Statistics

Today, according to the National Institute of Mental Health over twenty-six

percent of American adults suffer from a diagnosable mental health challenge (NIMH,

n.d.). In 2004, this translated to 57.7 million adults. Within the twenty-six percent with

diagnosable mental health challenges, some of the specific diagnoses are mood disorders

at 9.5%, schizophrenia at 1.1%, anxiety disorders at 18.1%, and attention deficit,

hyperactivity disorder at 4.1%, all in adults. As prevalent as mental health issues are,

only 6% suffer from a serious mental health challenge (NIMH, n.d.).

Studies regarding mental health professionals revealed eleven percent to fifty-

seven percent of those surveyed have or are currently experiencing depression (Deutsch,

1985; Pope & Tabachnick, 1994; Thoreson, Miller & Krauskopf, 1989). In two of the studies, two percent consistently reported suicidal behavior or ideation (Stadler, Willing, Eberhage & Ward, 1988; Thoreson et al., 1989). Studies outlined more female then male mental health professionals attempt and succeed at suicide (Deutsch, 1985; Stadler et al., 1988; Thoreson et al., 1989). Studies also indicated occasionally mental health professionals have suffered from psychotic or bizarre behavior (Deutsch, 1985; Katsavdakis, Gabbard, & Athey, 2004).

Mental Health System Based on the Medical Model

The design of the mental health system is based on a medical model (Anthony, 1993; Bar-Levav, 1976; Bassman, 1997; Fisher, 1994; Laliotis & Grayson, 1985). Unfortunately, this model focuses on treating the symptoms or the illness, not promoting recovery and empowerment (Anthony, 1993; Bar-Levav, 1976; Bassman, 1997; Fisher, 1994; Laliotis & Grayson, 1985). This model defines the individual by their symptom or mental health challenge, limiting other defining attributes the individual may possess.

Similar to the medical profession, individuals as consumers of the mental health field frequently are called by their diagnosis. It is common to hear, "John, the schizophrenic," instead of "John, who has schizophrenia" (Fisher, 1994). There are strong inferences in this practice of labeling. People became known as their diagnosis instead of their symptoms being seen as part of them (Fisher, 1994). Individuals with psychiatric challenges are often seen as sick, not as people who have additional life challenges to maneuver around (Fisher, 1994). The stigmatization that accompanies the sickness is vast (Anonymous, 1981; Anthony, 1993; Bar-Levav, 1976; Bassman, 1997;

Burton, 1973; Cain, 2000; Fisher, 1994; Frese & Davis, 1997; Jamison, 1995, 1998, 2006; Shannon, 1995).

Psychotherapist's colleagues often criticize psychotherapists who receive treatment if they publicize their challenges (Bassman, 1997; Fisher, 1994; Frese & Davis, 1997; Jamison, 1995, 1998, 2006). Looking at the psychotherapist with mental health challenges through a medical model suggests there are limited chances of recovering from the difficulties or even possessing the ability to monitor and control the symptoms. Viewing the circumstances through an empowerment model however, creates a sense of hope (Bassman, 1997; Fisher, 1994; Frese & Davis, 1997; Jamison, 1995, 1998, 2006; Olson, 2002). Psychotherapists should be affording both clients and colleagues the sense of hope.

Those who have manageable mental health issues are able to work in the mental health field (Frese & Davis, 1997; Jamison, 1995, 1998, 2006). Individuals with many forms of addictions are not restricted from working in the field (Fisher, 1994; Thoreson et al., 1989). Individuals with strong biased beliefs, such as strong religious or political beliefs are afforded the opportunity to work in the psychotherapeutic professional field (Laliotis & Grayson, 1985). Because most diagnoses are manageable with pharmacological treatment and psychotherapy, psychiatric challenges should not automatically disqualify individuals from entering or continuing within the field of mental health (Frese & Davis, 1997; Jamison, 1995, 1998, 2006; Olson, 2002).

Stigmatization of Mental Health

Discrimination is still rampant within the mental health structure (Bassman, 1997; Fisher, 1994). Bassman (1997) stated, "Having experienced both sides of the treatment

model, I have the dubious privilege of seeing the discrimination, stigmatization, and devaluation that permeate both mass media and the mental health system" (p. 240). The mental health system has begun to change toward the empowerment model; however, there is much distance still to travel (Bassman, 1997; Fisher, 1994). Anthony (1993) discussed the process of recovering from a psychiatric challenge. Anthony went on to outline that recovering from a major psychiatric challenge is more than just overcoming the challenge; it is also overcoming the stigma diagnosed individuals had received due to their challenge.

Mental health challenges affect the person as a whole. The stigmatization may limit job opportunities, housing, medical care, and various other components of a person's life (Anthony, 1993). As individuals experience discrimination due to the stigmatization because of their mental health challenges, they frequently struggle to maintain a level of self-empowerment, positive self-esteem, and self-determination (Anthony, 1993).

Who pathologizes clients? Much of it comes from the mental health providers themselves (Anonymous, 1981; Bar-Levav, 1976; Bassman, 1997; Frese & Davis, 1997; Jamison, 1995, 1998, 2006; Olson, 2002). Many providers still subscribe to and work within the medical model structure. The mental health field originally was designed after the medical model, utilizing hospitalization and later forced medication. When a system has grown in one direction for over one hundred years, it is difficult to expect immediate changes. Many are beginning to observe the recovery or empowerment model (Bassman, 1997; Fisher, 1994). The medical model is structured in ways that focus on the

symptoms and deficits of individuals; therefore, stigmatizing the person due to their

perceived deficits (Fisher, 1994).

Personal Accounts of Select Professionals

Experts researched other areas of psychotherapists such as, psychotherapists with

major mental diagnoses, even psychiatric hospitalization (Bassman, 1997; Cain, 2000;

Frese & Davis, 1997; Jamison, 1995, 1998, 2006; Laliotis & Grayson, 1985; Shannon,

1995). Much of the literature published regarding psychotherapist's personal experiences

with major mental diagnoses revolves around personal accounts within the system as

consumers and how their disclosing their personal experiences have affected their

professions. Bassman (1997), Frese and Davis (1997), and Jamison (1995, 1998, 2006)

offered a variety of personal experiences.

Various pieces of literature recount mental health professional's personal

experiences as consumers within the mental health system (Bassman, 1997; Cain, 2000;

Frese & Davis, 1997; Jamison, 1995, 1998, 2006; Olson, 2002; Shannon, 1995).

Bassman (1997) described his personal encounter with the mental health system after he

was diagnosed with schizophrenia, paranoid type in 1969. He described his treatment

including "electroshock, insulin comas, and massive doses of mind-numbing drugs" (p.

238). He went on to earn his doctorate and has spent an excess of twenty years as a

practicing licensed psychologist. At one time, he was "the executive director of a

comprehensive mental health center" (p. 238). This is an example of an individual who

managed his symptoms and engaged in a successful career within the mental health

system.

Frese also experienced periodic negative encounters within the mental health system (Frese & Davis, 1997). He too was diagnosed in the 1960's with schizophrenia, paranoid type. He remembered during a psychological evaluation the evaluating psychologist said to Frese, "If it weren't for your illness, you could even have become a professional" (Frese & Davis, 1997, p. 243). Unlike many, Frese took this as a challenge to continue pursuing his educational goals, eventually becoming the director of psychology at Western Reserve Psychiatric Hospital (Frese & Davis, 1997). When talking about newly diagnosed psychiatric clients, Frese and Davis (1997) stated, "one of the most common messages they receive from others – professionals as well as loved ones – is to downsize their expectations" (p. 244). It is an assumption that life experiences are limited once diagnosed with a psychiatric challenge.

Jamison (1998) spoke out about the fact that she had been treated for Bipolar Disorder. She went on to write about her personal experiences regarding her years of battling the symptoms of her diagnosis:

> I received an astonishing number of letters, many of them quite psychotic and freighting, from people who simply hated the mentally ill, or who raved on about the terrible manic-depressives they had known. Others told me that I deserved my illness because I had not been a sufficiently devout Christian; yet other said that I had no business writing, teaching, or seeing patients, despite the fact that my illness was well-controlled (p. 1053).

Jamison is not alone among professionals who have manageable symptoms. Both Frese and Bassman were diagnosed with Schizophrenia, paranoid type (Bassman, 1997; Frese & Davis, 1997). If these mental health professionals are representative of all mental health professionals it may indicate that there is a larger population of

psychotherapists who have, or have had manageable symptoms connected to major

diagnoses.

Based on Frese and Davis (1997) personal and professional experiences of the

mental health system, they suggested ways to transform the mental health system towards

a less stigmatizing system. They stated:

> Psychology could make a major contribution to the recovery of people
> with serious mental illness by sensitizing itself and the public about
> pejorative stereotypes, by valuing those people's experiences and insights,
> by defending their rights and needs for quality services, by supporting
> their education and training at both undergraduate and graduate levels, by
> seeking their input on relevant issues, and by advocating their causes and
> needs before Congress, the courts, and the public. (p. 245)

This statement outlines each potential action that may assist in breaking down the

discriminating barriers and the stigmatizing experiences.

Researched Topics

This section begins by examining psychotherapists as consumers, followed by

literature on countertransference and transference. Next, there is an in-depth exploration

of literature regarding psychotherapists' supports systems. Finally, this section explores

the research on psychotherapists' professional identity development, as well as how their

experience as a consumer influences their professional identity development.

Psychotherapists as Consumers

It is important to remember that over one-fourth of the United States population

suffers from diagnosable psychiatric challenges (NIMH, n.d.). Society has stigmatized

millions of people, many of whom are mental health providers who also suffer from

psychiatric challenges. For example, researchers have investigated various aspects of

providers as clients (Bassman, 1997; Bermak, 1977; Burton, 1973; Cain, 2000; Coster &

21

Schwebel, 1997; Deutsch, 1985; Fisher, 1994; Fleischer & Wissler, 1985; Fox, Strum & Walters, 1984; Frese & Davis, 1997; Greenberg & Staller, 1981; Guy, Poelstra & Stark, 1989; Jamison, 1995, 1998, 2006; Katsavdakis et al., 2004; Laliotis & Grayson, 1985; Olson, 2002; Pope & Tabachnick, 1994; Shannon, 1995; Strozier & Stacey, 2001; Thoreson et al., 1989).

Pope and Tabachnick (1994) presented literature based on a complex and thorough study they conducted regarding how psychotherapists generally have viewed their personal therapeutic experiences. They based this study on the fact there is limited material regarding "experiences, problems, and beliefs of therapists as patients" (p. 247). They surveyed 476 psychologists, finding 400 had past personal experience participating in personal psychotherapy or are currently actively engaged in psychotherapy.

The major topics included in Pope and Tabachnick's (1994) study were demographics, theoretical orientations, major focus of personal psychotherapy, most beneficial aspect of psychotherapy, most serious harm in psychotherapy, experiences in psychotherapy, and opinions about needs for personal psychotherapy. The participants were 47.3% male and 52.3% female. Close to half the participants were in their forties. There was no additional demographic data published, therefore it is impossible to extrapolate a racial breakdown.

The major focus of psychotherapy was broken down into thirty-five different categories mentioned. Of the thirty-five categories, the top seven made up close to seventy-five percent of the total responses. The top seven areas of focus in personal psychotherapy for psychotherapists who engage or have engaged in personal psychotherapy are depression or general unhappiness, marriage or divorce, relationship

(general), self-esteem and self-confidence, anxiety, career, work or studies, and family of

origin issues (Pope & Tabachnick, 1994). This information shows the most common

reasons for treatment may stem from a variety of sources.

The top most beneficial aspects of psychotherapy, self-awareness, self-esteem,

and improving skills as therapists were the top three. Although there were only 476

participants in this study, they were not limited to single item answers, finding 517

responses regarding the beneficial aspects of psychotherapy where there were only 144

responses to questions regarding serious harm in psychotherapy. The serious harm

responses ranged from sixteen participants who indicated that there were attempts at

inappropriate sexual contact between the psychotherapist and the psychotherapist-client

to two participants who indicated that their psychotherapist lacked belief in them as a

client (Pope & Tabachnick, 1994). The serious harm responses were much fewer

compared to the most beneficial responses, "nevertheless, the finding that over one in

five (22%) reported that their experiences with psychotherapy, taken as a whole, had

been at least somewhat harmful must be taken into account" (p. 256) when training

programs are developed and licensing requirements are outlined. This information

suggests that future research on this topic would be beneficial.

One interesting finding was 87.2% of the participants indicated *absolutely yes* or

probably regarding the question "should licensing boards be able to require therapists

(e.g., who have violated professional standards) to obtain psychotherapy as a condition of

the continuing or resuming practice" (Pope & Tabachnick, 1994, p. 254). The same

participants only indicated 34.1% *absolutely yes* or *probably* regarding the question "Do

you believe that psychotherapy mandated by licensing boards as a condition of therapists

continuing or resuming practice tends to be effective" (Pope & Tabachnick, 1994, p.

254). The discrepancy between the two numbers may warrant future research regarding

views towards mandatory psychotherapy for psychotherapists.

Countertransference and Transference

One other area of research is countertransference or transference towards clients

and their life situation (Abend, 1986; Agass, 2002; Benedek, 1953; Bridges, 1993;

Hanna, 1998; Hayes, McCracken, McClanahan, Hill, Harp & Carozzoni, 1998;

Holmqvist & Andersen, 2003; Kernberg, 1965; Mintzer, 1996; Saakvitne, 2002;

Silverman, 1985; Winnicott, 1975). This area of research has offered insight into how

many psychotherapists manage their countertransference. One consistent belief regarding

transference or countertransference is the importance of psychotherapists recognizing it

within themselves when it is happening (Agass, 2002; Benedek, 1953; Hanna, 1998;

Hayes et al., 1998; Kernberg, 1965; Mintzer, 1996; Silverman, 1985; Winnicott, 1975).

Holmqvist and Andersen (2003) suggested that, "therapists who [were] new to this type

of work and those who [had] a personal history of traumatization [had] more negative

reactions" to clients with a trauma history (p. 294).

At times, the psychotherapist is unaware of their internal reactions or triggers.

Each psychotherapist's personal experiences influence the lens in which they look at their

clients and their client's experiences (Saakvitne, 2002). Freud (1937) strongly suggested

that each psychotherapist continue to participate with periodic, ongoing personal

psychotherapy.

Human interactions foster a variety of reactions within each person. Many times

these reactions go unacknowledged or recognized. Frequently, there are subtle responses

that inform each person's future interactions with a specific person or people who resemble in some way the specific person. Individuals who share common experiences frequently share a deeper level of empathic understanding. Training to become a psychotherapist helps develop a higher level of empathy for the client. This training will also assist in the recognition of transference situations. As life is experienced, individuals gain a diverse understanding of various life situations, allowing for a variety of individual emotional reactions. Psychotherapists who share similar life experiences with their clients frequently experience noticeable internal and physical reactions to their clients (Holmqvist & Anderson, 2003; Saakvitne, 2002).

Frequently, the explanation of countertransference is a response to the client's transference. People frequently experience life through a series of reminders. One experience may trigger a memory of an experience. This too happens in psychotherapy. It is common for the client to transfer unconscious feelings towards someone else onto the psychotherapist, in response the psychotherapist may experience their own response, known as countertransference (Agass, 2002; Benedek, 1953; Hayes et al., 1998; Kernberg, 1965; Mintzer, 1996; Silverman, 1985; Winnicott, 1975).

There are various different lenses when looking at the terms transference and countertransference. Hanna (1998) created literature that outlined a historical evolution regarding the various ways of analyzing the structure of transference and countertransference. The historical evolution began with the "classical position on countertransference" (p. 2).

There is an assumption that within the classical position the therapist (or analyst) must remain blank. Hanna (1998) suggested, "the psychoanalyst should remain perfectly

objective when observing the patient's transference" (p. 3). This approach required the

analyst to have completed all personal analysis on the self; therefore, there would be no

opportunity to encounter personal blind spots (Hanna, 1998). Hanna stated,

"Countertransference reactions must be eliminated because they prevent the analyst from

functioning as a scientist-observer" (p. 3).

Hanna's (1998) historical overview of transference and countertransference

continue by next looking at the "early totalistic perspective" (p. 4). This perspective was

strongly influenced by early Object Relations theorists. "Totalists point out that the

boundaries between the therapist's appropriate reactions to the patient and reactions

based on the therapist's unconscious conflicts are virtually impossible to determine" (p.

4). "The recent totalistic perspective" (p. 4) altered this view. This perspective

suggested the importance of the psychotherapist enhancing his or her awareness of what

role he or she may have in the client's life.

Regarding the idea the psychotherapist participates within the clients life by

maintaining a role or identity, Hanna (1998) suggested, "If [the] repetitions go unnoticed,

patients' uses of their therapists as new objects may be severely compromised" (p. 5).

The repetitions that Hanna (1998) noted here were in regards to the client's unconscious

"compulsion to repeat developmentally archaic, traumatic, object relations, or defensive

role enactments to avoid activating traumatic states" (p. 5).

The historical analysis continued to evolve into contemporary methods of

addressing transference and countertransference. The focus began to shift from the

patient being encouraged to see life based on the therapist's reality, towards the therapist

beginning to see the client through the client's subjective reality (Hanna, 1998).

26

It is important to understand that psychotherapist's reactions to the material the client is presenting and style the client utilizes in presentation may not exclusively be a reaction to the psychotherapists' personal experience, this reaction may represent what the client has specifically induced within the psychotherapist's unconsciousness (Abend, 1986). Abend continued with, "emotional reactions of the analyst, if properly identified and understood, are of use in formulating interventions" (p. 567). As outlined, personal reactions may be influenced by both internal and external stimulation. Psychotherapists must have a heightened awareness of the various influencing factors if they wish to maintain therapeutic competency (Hanna, 1998).

Hanna (1998) also highlighted the actuality that transference and countertransference is difficult and frequently, however, not always impossible to recognize due to the unconscious disallowing accessibility. Experts suggested that the psychotherapist take appropriate measures to ensure that the transference and countertransference that is recognizable be utilized in appropriate ways. The use of these experiences often can inform what interventions to make and may even explain some of the impasses that take place. Awareness, when pertinent is important.

Support System

Some psychotherapists utilize their own therapeutic provider as a support system (Mackey & Mackey, 1994; Strozier & Stacey, 2001). Greenberg and Staller (1981) reviewed several different researchers regarding whether personal psychotherapy for therapists was beneficial or harmful for therapists and their clients. One of the first topics noted in their research was the consensus that personal psychotherapy for therapists is

27

positive, however they also outlined that there has been very little actual empirical research to back the idea up.

Greenberg and Staller (1981) reviewed eight studies regarding personal and professional implications of psychotherapists engaging in personal psychotherapy while actively working with clients. They found "two studies hint at a positive effect, four find no major differences, and two indicate a negative effect" (p. 1469). One study found a negative effect that connected engaging as a psychotherapist and simultaneously as a client may influence some form of maladaptive development. This can result in limited empathic interactions with clients.

This specific study referred to inexperienced therapists (Garfield & Bergin, 1971). This study began with eighteen participants, however successfully completed with ten. The participants were all psychology practicum students in the process of obtaining their graduate degree. Garfield and Bergin admittedly reported the significance of the small sample size.

The finding of Garfield and Bergin's (1971) research was not congruent with much of prior research. They did state regarding their findings, "suggest that personal psychotherapy, long considered by many therapists as an important prerequisite for engaging in the practice of psychotherapy, actually is negatively related to outcome" (p. 252). This is a bold statement due to the significant limitations of their sample size.

Although the research may prove it difficult to establish whether personal psychotherapy is beneficial or harmful, Greenberg and Staller (1981) did report that through a number of studies reviewed, over 50% of psychotherapists surveyed report psychotherapy as beneficial. Results from some even highly recommended personal

psychotherapy prior to entering into the field professionally (Greenberg & Staller, 1981; Mackey & Mackey, 1994; Sarason & Sarason, 1982; Strozier & Stacey, 2001). Mackey and Mackey (1994) found that only 1% of their participants found personal psychotherapy as harmful and 3% found it unimportant.

Lack of support systems may influence professional burnout. Professional burnout consists of emotional exhaustion and sense of depersonalization leading to lower levels of empathy toward others (Bruce et al., 2005). Burnout affects productivity and effectiveness of professional duties (Bruce et al., 2005; Corrigan et al., 1995; Coster & Schwebel, 1997)

Several studies have outlined a strong support system as crucial in the professional success of a psychotherapist (Corrigan et al., 1995; Coster & Schwebel, 1997; Sarason & Sarason, 1982). Sarason and Sarason (1982) determined that psychotherapists who perceive their support system as ineffectual also rate lower on tolerance regarding behavioral deviations in others.

Sarason and Sarason (1982) studied a substantial number of University of Washington students in the Introductory to Psychology class. The study explored people's tolerance for behavioral deviancy. In the first study conducted, Sarason and Sarason (1982) looked at the relation between individual's social supports and their attitudes towards mental illness. They utilized three different questionnaires on 361 students. Utilizing the *Social Support Questionnaire (SSQ),* the *Attitudes towards Mental Illness Questionnaire (AMI),* and the *Personal Problems Questionnaire (PPQ)*, Sarason and Sarason (1982) found "that there [were] significant relations among social support, how mental illness is perceived, and what people [thought] should be done about the

29

mentally ill" (p. 338). They went on to report, "subjects who report[ed] a larger number of persons on whom they [could] rely and who [were] more satisfied with their levels of social support seem[ed] to have relatively more benign, accepting, and optimistic opinions about mental illness" (p. 338).

Sarason and Sarason (1982) administered a second study with 144 University of Washington Introductory to Psychology students that utilized the *Social Support Questionnaire (SSQ),* as well as *The Life Experiences Survey (LES),* the *Anomy Scale,* in addition to the *Lack of Protection Scale (LP).* They found the data less conclusive in this study. The data suggested that "positive life changes [were] associated with both number of social supports and satisfaction with one's support level" (p. 340). There was lack of conclusive evidence regarding that negative life changes are influenced by level of social supports an individual experiences (Sarason & Sarason, 1982).

Although the participant pool was based on a convenience sample, Sarason and Sarason (1982) successfully showed the correlation between an individual's support system and their attitudes towards those with psychiatric challenges. This would suggest that psychotherapists with strong support systems might represent a more optimistic view towards their clients' life situations and prognoses. Psychotherapists' supports may influence their ability to understand and process their personal transference experiences they have within their therapeutic relationships with their clients.

Professional Identity Development

Studies on professional development of psychotherapists show before, during, or after training as psychotherapists, personal psychotherapy is helpful (Greenberg & Staller, 1981; Strozier & Stacey, 2001). Participants in the Strozier and Stacey (2001)

study reported a level of empathic understanding through countertransference to be greater than those who did not receive any personal psychotherapy. Empathic development is a benefit of personal psychotherapy; it serves as an outlet for any stirred emotions that often accompany the profession; therefore, suggesting positive developmental outcomes in psychotherapists who engage in personal psychotherapy (Strozier & Stacey, 2001). It is suggested that personal development enhances individual's levels of professional development.

Psychotherapists as Consumers

Deutsch (1985) explored ideas regarding the negative impact on the profession if psychotherapists were experiencing any level of psychiatric distress. Deutsch suggested that regardless of the severity of the psychotherapist's symptoms during a personal crisis or disturbance, their professional care for others is altered and compromised (Deutsch, 1985). Deutsch also reviewed the possibility that females who earned a medical or doctoral degree are at higher risk of developing a major affective disorder (Deutsch, 1985). Deutsch arrived at these numbers based on a study of 264 providers of diverse disciplines.

Deutsch (1985) originally attempted to recruit 642 potential participants throughout Iowa. The target return rate was forty to fifty percent; this study yielded forty-two percent return rates, which is consistent with studies of similar topics. Their gender breakdown of their sample size was not consistent with other studies. They experienced 62% of their participants as male and 38% as female. Other studies generally produce more female participants than male. One limitation to this study is the breakdown of the professional discipline. There were "[85 psychologists], 117 social

31

workers and 62 in counseling, education and a variety of other related fields" (p. 308).

There is no way in knowing what level of training or education each of the participants

had, therefore, comparing them with each other may not be conducive with establishing

consistency within their personal experiences.

Another interesting point Deutsch (1985) outlined regarding suicide rates of

mental health professionals is "that the rate for female psychologists greatly exceeded the

rate for the general population, whereas the rate for male psychologists was less than that

for males in general" (pp. 305-306).

Cain (2000) conducted a qualitative study regarding psychotherapists who

personally had been psychiatrically hospitalized and how this might have affected their

countertransference. Although Cain's sample size was small, consisting of ten

psychotherapists, the study put forth questions that had not yet been asked, such as issues

regarding countertransference therapists with histories of psychiatric hospitalization

experience while working with clients. One notable finding was all the participants in

her study revealed that their personal psychiatric experiences have helped their

professional development as well as their therapeutic relationships with their clients.

Cain went on to report the participants expressed a deep connection with clients,

attributing this to their personal experiences. Personal experiences broaden the outlook

towards others recovery process.

It is important to note that Cain (2000) also found that some participants reported

they periodically had agendas when engaging with a client that was directly influenced

from personal experience. Cain's participants identified the idea of having an agenda as

potentially negative for the client. Although Cain's research may not maintain significant

external validity due to sample size, it did put forth research questions that were unique to the field of research.

Little research has been done regarding the psychotherapist's personal psychiatric experiences and how this has influenced their professional development in positive ways as well as how their experiences may have at times limited their professional development. It is also important to note that when reviewing much of the outstanding research, it became apparent that many researchers did no publish a complete breakdown of demographics. Most offered gender and many offered age, however very few outlined race or ethnicity. It was not uncommon to have researchers reporting that they did gather the various demographic information; it was uncommon to see this information published. This may be an interesting topic to address with future research.

Mackey and Mackey (1994) found during a study involving fifteen clinical social workers, regarding personal psychotherapy's influence on the development of the professional self, that personal psychotherapy and the development of the professional self strongly influence each other, finding it difficult by the participants in Mackey and Mackey's study to separate the personal and professional selves. Their study unfolded four additional themes. Participants reported that personal psychotherapy has influenced their *modus operandi* by looking towards their personal psychotherapist as a model. Other themes were the ability to enhance their level of empathy, their understanding the therapeutic process and the increase in their self-awareness.

Mackey and Mackey (1994) utilized a qualitative research design due to lack of qualitative research on this topic within the discipline of clinical social work. They were seeking data regarding "what significance personal psychotherapy [may] have on the

development of the professional sense of self" (p.491). This topic has been explored with other disciplines however never to this level of in-depth exploration. The participant pool were all either currently in or had previously been in extensive personal psychotherapy.

Mackey and Mackey (1994) reported that a qualitative approach was required in order to access the rich data on the topic. One limitation to the study was that the participant pool was specific to clinical social workers. The data cannot be generalized to psychotherapists from other disciplines. Future research is needed in order to establish clinical consistency.

Surroundings influence both personal and professional identity development. Individuals who become psychotherapists are not exempt from the stresses of developmental changes. "They experience successes and failures, love and rejection, and they have to adapt to societal changes in family life, gender roles, marital relationship, and economic conditions" (Coster & Schwebel, 1997, p. 6). Many struggle with the separation between the personal and professional development. As one changes the other is influenced (Mackey & Mackey, 1994).

Professional identity is a sense of understanding of what role the professional has in other's lives (Coster & Schwebel, 1997). It also helps inform the role others have in the professional's life. This identity can assist with setting limits, establishing boundaries, as well as how to maintain a balance between personal and professional relationships.

Psychotherapists with firsthand psychiatric experience frequently posses rich experiences as well as insight that others may lack (Greenberg & Staller, 1981; Jamison, 1995, 1998, 2006; Mander, 2004; Olson, 2002). The stigma of experiencing psychiatric

difficulties either encourages psychotherapists who experience mental health challenges to remain silent about their experiences or to fight against the stigma by coming out and proving the quality of psychotherapist they are (Burton, 1973; Greenberg & Staller, 1981; Jamison, 1995, 1998, 2006; Mander, 2004; Olson, 2002). Psychotherapists who choose to disclose their personal psychiatric challenges to colleagues prior to establishing a level of professional respect are at risk of experiencing difficulties developing strong positive reputations. Stigma and discrimination that frequently accompany various diagnoses often influence whether a person shares their personal psychiatric experiences with others (Anonymous, 1981; Anthony, 1993; Bar-Levav, 1976; Bartlett, 1998; Bassman, 1997; Burton, 1973; Cain, 2000; Fisher, 1994; Frese, & Davis, 1997; Jamison, 1998, 2006).

Personal experiences including personal psychotherapy (Coster & Schwebel, 1997; Greenberg & Staller, 1981; Mackey & Mackey, 1994; Strozier & Stacey, 2001) influence professional identity development. Aside from the discrimination and stigmatization psychotherapists with various diagnoses may receive, it is important to assess how these experiences inform and reflect in the treatment of others.

Much of the literature focusing on professional identity development does not include the individual's personal experiences as an influencing factor. There is limited information on how the psychotherapist's personal psychiatric history may inform specific interventions used in providing psychotherapy to their client.

Many psychotherapists experience a heightened self-awareness and frequently set limits to assure they do not push past their psychiatric comfort level. Mackey and Mackey (1994) found consistency among their participants reporting personal concern with maintaining professional boundaries as well as concerns with burnout.

Psychotherapists in this study reported that personal psychotherapy helped with maintaining professional boundaries and concerns with burnout, subsequently assisting in their professional development.

Another study found a connection in personal psychotherapy for psychotherapists in training and their professional development (Strozier & Stacey, 2001). This study outlined benefits of personal psychotherapy for psychotherapists in training. One benefit is the development of self-awareness. Strozier and Stacey (2001) found 85% of the 139 Masters in Social Work students surveyed reported personal psychotherapy was either an essential or an important part of their educational process. As individuals become more aware of their personal reactions, it is easier to begin to recognize these reactions when working with clients. It also assists in the ability to monitor internal feelings that when not paid attention to may influence unethical practice (Stadler et al., 1988; Strozier & Stacey, 2001). It is important to explore what psychotherapists report their experiences to be and how they believe these experiences have influenced their development (Anderson, & Mandell, 1989; Bradmiller, 1978; Fox et al., 1984).

Summary

Mental health treatment has been part of society for many years. There has been a variety of approaches in addressing those with psychiatric challenges. Over the years, there has been an increase in consumer-survivor participation fighting for the rights for those with psychiatric challenges. Some have offered questions as to who is qualified to assist others in need. There continues to be a stigmatization and discrimination towards those who require psychiatric assistance.

More recently, there have been successful psychotherapists who have shared their own personal struggles with psychiatric challenges (Frese & Davis, 1997; Jamison, 1995, 1998, 2006). Those who spoke out about their personal experiences inevitably have faced the stigmatization and discrimination by their colleagues. There are psychotherapists who support those with personal psychiatric experiences in participating as providers in the mental health profession (Burton, 1973; Jamison, 1995, 1998, 2006). Some psychotherapists view life experiences as an asset or strength. This study will explore the experiences through a strengths perspective theory. It will utilize a psychodynamic lens to view psychotherapists' experiences.

This qualitative study will explore consumer experiences with psychotherapists' reactions to clients' symptoms and diagnoses in the context of a therapeutic relationship; personal and professional support systems; professional experiences with colleagues regarding their mental health challenges; and how each of these experiences has influenced their professional identity development.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore views of psychotherapists who possess a variety of *DSM-IV-TR* psychiatric diagnoses and their transference to clients who possess similar diagnoses or symptomatology, and to explore what connection, if any, there is between the psychotherapist's support system and their professional identity development. An aim of this research is to assist professionals in speaking out about their personal experiences within the mental health system who may not automatically speak out due to fear of stigmatization and discrimination.

Sample Characteristics

Selection criteria required that participants have personally experienced, or at the time of the study be currently experiencing, the mental health profession from a consumer position. Each participant has received a *DSM-IV* diagnosis such as Schizophrenia and other Psychotic Disorders, Mood Disorders, Anxiety Disorders, Eating Disorders, and Borderline Personality Disorder. Each participant has a completed master's degree or higher in social work, psychology, nursing, or psychiatry; and at the time of the study currently working or within the past year worked as a psychotherapist. There was no other demographic criterion required to participate.

Participant Recruitment

The selection procedure initially consisted of a snowball sampling design. There were two methods of recruitment utilized. The first was utilizing the word-of-mouth

technique. I asked many professional psychotherapists of various clinical backgrounds to pass my recruitment flyer on to any psychotherapist they believe may meet my criteria or who may know others who meet my criteria (see Appendix A). The second utilized email contact with alumni of the School for Social Work. The email (see Appendix B) was distributed through the Alumni Office to all Smith College School for Social Work alumni throughout the United States.

Potential participants were given the opportunity to contact me directly, using the contact information provided with each advertisement. Each potential participant was screened by being asked direct questions regarding the specific criteria to confirm they qualified to participate in the study (see Appendix C).

Once I screened and identified a qualifying participant I established a phone interview time. Each participant received a letter of invitation and an Informed Consent form via email (see Appendix D and Appendix E). Each participant was told that a signed copy of the Informed Consent form would have to be returned to me prior to the interview date. They were given the opportunity to mail or fax the form to me.

There were a surprising number of responses to the original request for participants. Initially there were over fifty email or phone responses to the request for participation. Due to the time limitations of the researcher and the project deadlines, there was a forced limit on the number of participants interviewed. After screening in the order they contacted me, I determined that the first seventeen to qualify would be invited to continue participation in the study. Of the seventeen, thirteen were successfully interviewed. Twelve of the participants directly responded to the request sent through the

Smith College School for Social Work Alumni office, and one was recruited through word of mouth.

The sample size consisted of thirteen psychotherapists (N=13), including ten Master's level social workers, two Doctoral level social workers, and one doctor in psychiatry. All participants were actively practicing psychotherapy and each had a history of participating in psychotherapy as a consumer. The years practicing psychotherapy ranged from 2 to 43, the average being 12.6 years. The years in personal treatment ranged from 2 to 23, averaging 11.6 years. One participant was hospitalized once for three months, another was hospitalized briefly on two different occasions, and another was hospitalized too many times to identify and estimate. Ten participants had never been hospitalized.

The sample consisted of ten women and three men ranging in age from 24 to 67. There were three participants in their twenties, three in their thirties, three in their forties, two in their fifties, and two in their sixties. There was limited diversity in race and ethnicity. One participant identified as African American, one Latino/Jewish, one Caucasian/Jewish, and nine Caucasian. Geographically there was much diversity. Several states were represented within the sample. One participant was from Connecticut, one from Kentucky, one from Maine, two from New York, one from Wyoming, one from Pennsylvania, one from Oregon, one from Michigan, one from Washington D.C. and three from Massachusetts.

There was a variety of theoretical orientations the participants reported utilizing. One person reported not utilizing any specific orientation; others identified utilizing an "eclectic" mix of orientations. Some specifically identified orientations were Object

Relations, Feminist Theory, Family Systems Theory, Cognitive Behavioral Theory, Narrative Theory, Self and Ego Psychology, among others. Some participants reported utilizing only one theory; others utilized several different theories.

Each participant was asked to identify what *DSM-IV* diagnoses they have carried either in their past or at the time of the study. Most participants identified more than one diagnoses. Four participants had experienced posttraumatic stress disorder; nine, major depressive disorder; seven, anxiety disorders (including generalized anxiety disorder, panic disorder and obsessive-compulsive disorder); one, borderline personality disorder; two, eating disorders; one, alcohol abuse; one, sexual disorder; one, adjustment disorder; and one, dysthymia disorder.

Each participant was asked to identify the populations and settings they had worked in during the course of their clinical career. They had worked in a diversity of settings such as community mental health, residential facilities, in-home, hospital, and private practice. The populations they served were equally diverse. Some worked with families; others, with individuals; yet others, with couples. There was work with adults, children, and adolescents. Some client populations included immigrants, individuals with substance use disorders, eating disordered behavior, character makeup disorders, the homeless population, the Deaf population, GLBTQ, and domestic violence victims among others.

Design and Procedure

This is an exploratory research project. This cross sectional mixed method design consists of a demographic and preliminary questionnaire and a flexible semi structured exploratory interview (see Appendixes F and G for demographic and preliminary

41

questionnaire as well as the interview guide questions). Qualitative research methods were likely to gain access to deeper information that may not have been explained or representative in numbers (Rubin & Babbie, 2007). A survey with close-ended questions would not have gotten at the essence of each person's personal experiences and would have limited the results. This is the reason why semi structured exploratory interviews was utilized.

Each participant in this study explored how their personal psychiatric experiences have influenced their therapeutic interventions and how this has informed the psychotherapist's professional identity. Participants were asked to reflect on specific experiences within therapeutic relationships that they had been aware of their internal reactions toward their clients or the content of their client's presentations and how this had informed their interventions.

Each interview began with the participant being asked a series of seven demographic and preliminary questions (see Appendix F), during which the interviewer took written notes. Once this was complete, the main interview began. This interview contained five main questions with a few probing questions as needed (see Appendix G). The interviews ranged from thirty minutes to one and one-half hours, with an average time of forty-five minutes.

Each participant was informed prior to the interview the possibility of emotionally triggering discussions. Each participant was encouraged to end or postpone the interview if experienced heightened negative emotions. I checked in periodically with the participants to ensure the participants emotional status and safety of the participant.

Because participants were psychotherapists I assumed they would have access to resources, therefore, I did not provide them with a list of resources.

All information provided by participants remained confidential. To ensure the confidentiality of all participants, all data have been assigned a number that corresponds with each participant (e.g. Suzy Smith will have #1, Jane Doe will have #2, and so on), with the list of assigned numbers kept in a separate location. All assigned numbers as well as any subsequent information will remain under lock and key for a period of three years, per Federal regulations, then all data will be destroyed.

Each interview was completed using recording equipment and a telephone. Using a micro-cassette recorder, all interviews were audio recorded for the sole purpose of data accuracy. Each participant was reminded of the audio recording. All transcription of the recorded interview is held in confidence by both the transcriber and this interviewer. Prior to transcribing, the transcriber reviewed and signed a confidentiality agreement (for sample agreement, see Appendix H). A proposal for this research project was submitted to the Smith College School for Social Work Human Subjects Review Board for approval (see Appendix I for approval letter from the Human Subjects Review Board).

Data Analysis

All data have been analyzed manually with the organizational assistance of a computer. All data have been coded using an open coding and memoing methods. Throughout the coding phase, patterns began to arise and were noted. These patterns were analyzed further, allowing specific themes to develop.

Throughout the data analysis quotes were edited for repetitions and unnecessary filler, this was indicated in the findings section by utilizing the ellipses. Care was given not to alter the meanings of the quotes.

CHAPTER IV

FINDINGS

Thirteen psychotherapists were interviewed regarding their personal experiences within the mental health system as consumers and how their experiences have influenced their professional identity development. Several themes developed when the data were analyzed. This chapter will outline the main themes by giving examples.

First, distinctions between the different levels of empathic attunement participants have developed over the years ranging from identifying with clients and their pain to overidentifying with clients. Second, findings regarding each participant's level of professional development is explored. Two significant sections of development became apparent, those who experience a higher level of clinical insight and those who experience a lower level of clinical insight.

Another finding revealed three different levels of participants' disclosure of their personal experiences as a consumer in the mental health system. Some disclosed their experiences at a minimal or indiscriminate level; others, at limited levels; yet others, at maximum levels. These levels were assessed based on how much the participants disclosed to friends, family, personal therapists, and colleagues/supervisors. Some revealed minimal disclosure to friends; others disclosed to everyone; yet others to a select few.

Another theme that surfaced during the interviews was how participants viewed the responsibility of each psychotherapist regarding how to fight the stigmatization

within the mental health system. Three major themes revealed systemic approaches, political approaches, and personal approaches. Each participant outlined various responsibilities that current and future psychotherapists participant in to fight stigma.

Most participants identified consistent themes through the interviews, however, there were isolated incidences where topics were not consistent with the major themes, and therefore there is one final section for other findings, allowing idiosyncratic findings to have a place to be represented.

Empathic Attunement

Participants expressed a range between empathic attunement, from identifying with clients and their pain, to overidentifying with the clients. This range influences the therapeutic process on various levels. One participant spoke of a high level of empathic attunement. She stated

> I think that after my length of…experience in treatment, as well as my experience as a therapist, that I think I can honestly say that it provides with a bit more empathic attunement to their distress, feeling safe, whatever you want to call it.

Another participant stated, "I think I have a very empathic way of listening that is influenced by my own experience." The same participant went on to say, "I pretty much let people tell their stories and I'm pretty able to separate it out from how I solve my problems."

Participants also identified with their clients pains. One responded to her own reactions as a level of over identifying with their clients. She said

> I think I do too much support and not enough pushing…that comes from my own [need for] support when I was…in therapy…in other words, almost over empathizing with their fear about it and not…always giving them the push that they need or taking a little bit longer than I would like to realize that they need to be pushed.

Another said, "I have a lot of empathy for people who are frightened." This participant went on to say, "I think…with depression…I know exactly what it feels like. I do know and that certainly helps with my empathy." This participant spoke about her own connections between the pain she had felt and her ability to connect with the clients' pain.

Another participant reflected on her own history of battling symptoms of an eating disorder. This participant said, "I feel huge compassion and identification and I can get it in a way that someone who has not been there…I don't think can…because it's such a visceral physically demanding set of symptoms and it's painful." This level of identification was consistent throughout the interviews.

Other participants reported levels of identifying with the clients' pain. One said, "I may not be able to identify with the actual behavior of drug addiction but I think the aftermath and what happens to that individual's impairment I can definitely identify with and that's just pain."

Participants reported having more tools to work with clients who have a history of similar symptomatology as themselves. One participant said, "I will suggest things that maybe have helped me …like journaling or…talking to people." The same participant went on to say in reference to working with individuals who experience psychotic symptoms, "Like telling clients to work on blocking their negative thinking or ways to distract the voice." This participant described the inability to know first-hand if the tools are helpful due to never having to personally utilize them, yet she understood from clinical experience these tools have been reportedly helpful to some.

Another participant reported she utilized as interventions with clients the reading

materials she personally received during her own treatment. Regarding interventions

when working with similar symptomatology versus those clients with different

presentation than the psychotherapist, one participant said that

> I think actually I'm a little bit more narrow…When I work with…ADHD I'll kind
> of…pull out everything I know…I open up the whole tool box and I notice that
> I'm a little bit more narrow when I work, especially with depressed clients.

This participant identified as a person who has struggled with depressive symptoms for

years. She was using this example because she did not identify personally with ADHD

yet she did identify with depression.

Most participants reported a hyperawareness level of their personal internal

reaction while working with clients with similar symptomatology. One participant said,

"There's a small red light in my mind that's going, 'okay…watch your boundaries'."

This participant expressed a level of awareness when internal triggers were affected.

Another participant said, "I've been glad to say that so far…I haven't confused them with

me or been unable to fully attend to their story because I was in some way caught up with

my own."

> When working with clients with similarities, another participant said

> I tend to really guard myself a little bit more or watch my inner reactions a lot
> more than with a client who doesn't have the kind of history that I have so I feel
> myself really self-monitoring a little bit more during the session because I feel
> myself beginning to react…I have to kind of watch my transference.

The same participant went on to say, "I really need to question whether or not the

intervention that I'm proposing or that I'm giving is a result of the transference that I'm

feeling."   Another participant said, "I notice my body sensations very carefully, I

notice…my thoughts as much as I can in terms of…times that I might think, 'oh yeah, I felt that way'."

<center>*Professional Development*</center>

There appeared to be connections between the numbers of years they have been psychotherapists, number of years each participant has participated in personal psychotherapy, and their level of professional development. Each interview unfolded a variety of levels of clinical insight. These levels of clinical insight split into higher and lower levels. The connection between years as a psychotherapist and years as a consumer are outlined below.

Clinical Insight – Higher Levels

Seven of the participants represented a higher level of clinical insight during their interviews evidenced by their view of the role as a clinician and their awareness of their impact on clients. These participants ranged from three to forty-three years of experience as psychotherapists, with the average being eighteen years. The same seven participants reported twelve to twenty-three years of personal psychotherapy, averaging close to seventeen years of treatment.

Each of these interviews revealed heightened levels of clinical insight. The interviews remained focused on the participant's clients and much of how their personal psychotherapy has allowed them to work more closely with the clients and maintain a higher level of presence with the client's issues rather than focus on their own personal issues. One participant stated

> I've always had a collegial approach to developing a therapeutic alliance. It's very important to me that we're working together, that we're looking at the

<center>49</center>

problem together, that it's not one up, one down, and it's not adversarial, that the clients feel I'm in their corner and that we're doing it together.

This participant spoke of the client as an active member in treatment. She did not see herself as an expert; rather, she saw clients as their own experts when addressing their own issues, therefore, she fully included clients in the treatment planning.

The participants focused on their experiences with maneuvering through their personal psychiatric challenges rather than focusing on the challenges themselves. Although the participants did offer a variety of levels of personal accounts within the experiences with their psychiatric challenges, the tone of their recounting their experiences was not driven by what could be interpreted as raw emotion, rather experiences in response to emotions. One participant referred to this approach as a psychotherapist evolving over time and experience, stating

> I think I'm much more compassionate…just globally and I think I have…a better understanding of…the complexity of whatever it [was] like for me the depression piece, some of the complexities that go into it. I think before that I tended to have a more simplified somewhat…cookbook kind of way of understanding depression…I think that that shifted from my own experience.

One participant spoke about how she reached out for supports and what the support was focused on. She said, "I don't necessarily obviously talk to [my supports] about my work, my clients. I certainly do talk to [my supports] about my own feelings about my work." This participant was representative of the participants with a higher level of clinical insight. They reported a higher level of personal understanding of internal triggers and sought supervision at higher rates. It appeared the more personal psychotherapy the participants had, the more likely they spoke of the strengths gained by working in psychotherapy rather than the content of psychotherapy itself.

Psychotherapists who had experienced more years of personal psychotherapy as well as more time as a psychotherapist reported a higher level of understanding as to when it is appropriate to refer a client to another provider. This suggests there is a strong level of insight regarding personal limits and anticipating what the best treatment for their client is. One participant said

> I can think of a few people early on in my career, and again, I think this is fairly normal for most younger therapists of all disciplines but, I can think of a number of people I worked with early on that were probably…over my head [clinically]. Looking back on it there are a couple of people, I can think of that I probably should have referred out to more experienced therapists. …serious deficits in my knowledge and experience base…I think that's something I can honestly say I would have done differently now, or wished I had done differently.

The same psychotherapist later spoke about specific incidents in the past four or five years where she had said, "I don't think I am the best therapist for [potential client] precisely because of my own identification with them or the situation." Later she stated, "I was very pleased that I would be able to recognize [my limits] immediately and actually take action…and in a way that I think they felt cared for…without me having to disclose why." This psychotherapist directly connected her personal experience in the field to her level of clinical insight. It should be noted this psychotherapist has had fourteen years of personal psychotherapy with three providers, in addition to sixteen years of clinical work in the field.

Clinical Insight – Lower Levels

Six of the participants presented with much lower levels of clinical insight evidenced by their limited ability to engage during the interview about how their experiences have influenced their professional career and more about how they felt and processed (or not) their emotions and experiences. The experience of these participants as

psychotherapists ranged from two to eight years, averaging four years of experience. Their personal psychotherapy ranged from two years to twenty years. One participant had twenty years; the remaining five had two to four years of personal psychotherapy. Each participant had a minimum of four different providers, suggesting limited therapeutic work done with each provider.

When asked how she responded to transference or countertransference feelings during session with clients, one participant responded with, "I've tried to avoid it. I've tried to ignore it." [later saying,] "I just try to ignore what might be going on for me." Another participant responded to the same question with

> Normally…if I'm having a bad day…I just kind of sit back…I lounge in my chair…but…when I had a client that is similar, a lot of similar symptomatology…I'm engaged, I'm awake…I'm into it. Sometimes I wonder if I am into it too much.

Another participant spoke specifically of interactions with a particular client. This participant said, "Sitting with her I just have a much bigger understanding and a lot less judgment around her actions or lack of actions because of her depression." This same participant spoke later about her difficulty participating with her own treatment. She said she had never followed through with her own treatment and rarely saw the same psychotherapist for more than three months before ending abruptly.

One participant spoke of tools she used with clients who experienced depressive symptoms. She said, "I really push positive affirmations because that's what…got me out of my depression." This participant focused heavily on her own personal struggles throughout the interview. There was limited insight regarding the connection between her own work and the work she had done with their clients. The same participant

reported she felt a sense of being "stuck" if her client who experienced depressive symptoms did not respond to Cognitive Behavioral Therapy.

One participant said related to her coping with her own trauma history, "I think it led me to being probably much more transparent than…some people would say is allowed in the therapeutic relationship." The same participant later referred to work she did as a clinician for a group therapy session. She said, "I literally…started crying when we were all meeting and I said…'you know, I can really identify with that, this is ridiculous how we as women are continually silent individuals being labeled'." This individual expressed strong emotions regarding the mental health system's limitation about self-disclosure. She went on to say

> You have to be careful of…how much you share but why is it that people who've gone through addiction can go out and be case managers, be therapists and share about their own addiction…why can't I share about my sexual trauma…in a tasteful way to share just a little bit?

She continued with, "I'm very mindful but I get ticked off because there are women, actually every woman I've met is a trauma survivor. They've experienced some form of trauma. Why can't I talk about [my trauma]?" Multiple participants reported having difficulty not saying "me too" to clients when listening to clients' internal struggles through various situations.

Disclosure of Mental Health History

The interviews uncovered a connection between the number of years of personal psychotherapy and the level of disclosure to friends, family, personal psychotherapists, and colleagues/supervisors regarding each participant's personal mental health history. Each participant was assessed for their individual level of disclosure with their various

support systems, such as personal, professional (colleagues/supervisors), and professional (personal psychotherapists). The results are organized into three different categories: (a) minimal disclosure/indiscriminate disclosure, (a) limited disclosure, and (c) maximum disclosure.

Minimal Disclosure/Indiscriminate Disclosure

Four participants identified as exercising minimal or indiscriminate levels of disclosure about their personal psychiatric experiences in the mental health system. Those who exercised minimal disclosure chose not to share their personal histories with most of their supports. One had not even shared her experiences with her personal psychotherapist or her partner. One participant who indiscriminately disclosed reported that she was honest with everyone that she worked with about her personal psychiatric history, at times offering full details early in professional relationships. Of the four, each had experienced a range from two to four years of personal psychotherapy, three with four different providers and one with six.

When referencing whether she share personal information at work with colleagues and supervisors one participant reported, "I really tried to stay away from mixing those two". The same participant later discussed her experiences with her colleagues' disclosing. She said, "I think the other people really met with positive results but I tend to take it with a grain of salt. You never quite know when it's going to backfire." This participant expressed herself with a tone of distrust for others. Even though she had witnessed positive results with others' disclosing, she still did not trust that it would not affect her later if she disclosed.

Another participant talked about the level of disclosure used in her workplace. She said, "I've definitely told them my story." One participant referred to their level of disclosure as minimal. She said, "I have a tendency to kind of keep things close." This participant had not fully disclosed her personal experiences to anyone. She reportedly had a partner and four different psychotherapists. This participant had begun to share limited history with more recent supervisors; allowing complex discussions of countertransference to take place. Sharing information has been a struggle for this participant.

Limited Disclosure

Three participants identified as exercising limited levels of disclosure about their personal psychiatric experiences in the mental health system. These participants disclosed some of their personal psychiatric history to only a fraction of their supports. One participant had two years of personal psychotherapy, with several providers identified. One participant had twelve years of personal psychotherapy, with four providers identified. The last participant had twenty years of "off and on" personal psychotherapy with several providers identified.

One participant only utilizes her spouse as her outlet for her disclosure. She reportedly had not included her supervisor in any level of disclosure, even when discussing transference and countertransference. Another participant reported an open level of disclosure with family and friends, yet minimal disclosure with colleagues and supervisors. Over the years, one participant has limited his or her level of disclosure due to experiences that proved stressful. She said, "I…was really being treated poorly and I

think a lot of that was this particular boss was very uncomfortable with my mental health history." This experience influenced the level of caution with future disclosure.

Maximum Disclosure

Six participants identified as exercising a maximum level of disclosure about their personal psychiatric experiences in the mental health system. Each participant had expressed full disclosure to those who they reported needed the information. These participants had utilized their information through appropriate levels of disclosure to ensure the best level of professional growth, especially with their supervisors regarding countertransference issues. Each participant ranged from thirteen years to twenty-three years of personal psychotherapy, averaging close to eighteen years. Five participants had two or three providers; one had six.

One participant discussed her level of disclosure with her supervisor. She said

I have very good supervision at my agency. I am really lucky that I am working in a …very theoretically psychodynamic-based agency so the support systems are very good there and I can bring anything into my supervisor.

Later the same participant said

My supervisor at work is partially aware of what my history is. I more often than not in supervision I will talk about what is being induced in my…I will talk about my own transference with clients and will explore that.

Another participant said, "My very close friends and my…mentors in the field…know about my personal history. There's nothing secret about it. I don't much care if people know or not." The same participant went on to describe the geographical location as an extremely small community; therefore, she did limit her disclosed information due to not wanting their clients to feel burdened with their personal histories. She said, "I worry

56

that [my clients] might try to take care of me or they might worry about telling me something for fear it would trigger me."

One participant spent a significant amount of time speaking out politically towards the structure of the mental health system. This participant was actively practicing psychotherapy as well as speaking out about her personal experiences as a consumer of psychotherapy. Another participant spoke about how comfortable she had been with sharing her personal stories with their friends, family, and personal psychotherapists, as well as colleagues. Another remembered entering the field of mental health during a time where personal disclosure with supervisors was expected. It was assumed it would help in sorting out the countertransference experiences. Finally, one participant stated, "I am very open about [my diagnoses] with my closest friends and certainly with [my therapist]."

Fighting the Stigmatization

Three themes emerged among the participants regarding the challenge of fighting the stigmatization and discrimination within the mental health field. Participants indicated that changes are required at a systemic level, a political level, and a personal level in order to fight the various levels of stigmatization.

Systemically

Participants expressed that systemically the medical model approach towards mental health continues to perpetuate stigmatization. Individuals assessed and viewed through the medical model lens are viewed as ill or sick, therefore there is a negative value placed on their specific challenges. In reference to the medical model view one participant said

> A lot of the model of the way the system's even set up is very medical model-based. If you have the flu, you have the flu. There's something wrong with you but if you have depression and you need treatment doesn't mean there's something wrong with you it just means you have an extra challenge.

There is an assumption that individuals who are sick are also blemished or impaired in some way.

One participant said, "I think pathologizing is a real problem because I think the DSM system does that." This participant continued talking about the DSM diagnostic system as a necessity for insurance; however, she felt that if it were eliminated, it would assist in breaking down the stigma. Eliminating the medical model approach and embracing the empowerment model approach allows the individuals' strengths to remain the qualities focused upon, allowing the individual to view themselves as a whole person with a variety of influencing components rather than their illness defining who they are.

Participants identified eliminating labels and generalizations as another systemic approach to breaking the stigma. If labels and diagnoses continue to define consumers they will continue to remain bound by the perceived limitations of their labels or diagnoses. One participant said

> I think the terminology that we use is really important and the words that we use to refer to the people that we work with are important. …because my agency is very psychodynamically, very traditional psychodynamically-oriented, a lot of the people there … through training have done psychoanalytic training, they refer to their clients as patients and I personally… think that stigmatizes, that assumes that someone is sick.

Participants felt that eliminating labels frees the individual to view themselves as an individual with challenges rather than impairments.

Participants also suggested systemically challenging the belief system of us/them. One participant recalled attending professional clinical meetings and experiencing the

clinical staff referring to clients and their diagnoses "and it is all very much them, never a 'we' perspective."

Participants suggested psychotherapists should be required to participate in personal psychotherapy prior to entering the training to become a psychotherapist. This would assist in individuals dealing with their own struggles prior to assisting others with theirs. This would limit the levels of intrusive countertransference within future sessions with clients.

Politically

Participants indicated a level of political involvement required to influence the change of stigmatizing views of the mental health field. One participant suggested access to more free clinics as one solution. This would allow more individuals to seek treatment regardless of their socioeconomic status. The participant suggested the more available mental health services are, the less stigmatizing they appear.

Multiple participants suggested various levels of advocating for clients. One suggested speaking out publically regarding the challenges within the existing system. Another suggested empowering clients to speak out for themselves and assisting them in understanding what role they can play in a change movement. Another suggested simply listening to what the clients are asking for and assisting them in attaining their goals.

Personally

Many of the participants indicated a variety of approaches each individual can utilize on a personal level. One of the most common themes was to become more visible as consumer/providers. Many suggested that visibility would assist in normalizing treatment therefore begin breaking the stigmatization barriers. One participant referred to

the value of talking about psychotherapy and what role psychotherapy may have in people's lives. This participant went on to say

> Therapy is about helping people come to terms with life's rewards and disappointments and living more authentically… I think it's being able to talk about it in a much more real way is extremely… valuable.

The participants believed that telling their personal stories, would naturally erode the stigmatizing views. The fear of judgment fueled many to remain silent, perpetuating the internalized views of discrimination.

Participants also suggested that the stigmatization could be fought in the classroom. Normalizing treatment history and normalizing experiences while training would assist in the challenge towards breaking the stigmatization. One suggested professors share their stories and encourage others to explore their personal experiences within the mental health system. Regarding the level of discussion in the classroom, one participant said

> Professors set the tone and if professors made it a part of just the content of classes for people to get used to the idea, all of our histories that they make us who we are, that they make us good clinicians …I think that stuff shows up in people's personal statements, maybe in private, in their papers, in their theses but we're not out fully in the classroom, in the group because there's still this fear that we're not good enough, we're not going to be good clinicians.

Regarding personal experiences within the mental health system, another participant said

> I think it should just be something that gets talked about all the way through your education. … when I look back on my graduate work at [name of school] it was referred to a lot but it wasn't really talked about.

Sharing of the stories would assist in students understanding and anticipating their experiences of transference and countertransference.

Despite the fact that most of the participants reported the mental health system played a role in perpetuating the stigmatization and discrimination of consumers of the mental health system, one maintained another view. She said, "Because the stigma isn't really terribly generated by our profession, it's really by the public in general. At least that's my take on it."

One participant suggested a group therapy model for psychotherapists, allowing for a therapeutic support system that is beyond what peer supervision offers. This participant acknowledged the level of implied fear of lack of confidentiality in this model. She also acknowledged a level of concern with disclosing her experiences with her personal psychotherapist, feeling the psychotherapist would expect her to be "healthier than I am," she felt an expectation that she should be held to high standards of mental health healthiness due to the role she has in helping others. She expressed fears due to living, working, and seeking her own treatment all within a smaller rural area.

CHAPTER V

DISCUSSION

The research questions for this study explored views of psychotherapists who possessed a variety of psychiatric diagnoses found in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000); their transference to clients who possessed similar diagnoses or symptomatology, as well as explored what connections, if any exists, between the psychotherapist's support systems and her professional identity development. This research also questions the validity of the us/them dichotomy.

This chapter reviews the various findings of this study and compares these findings with existing literature. Specifically, the chapter will discuss findings on the psychotherapists' levels of empathic attunement, the professional development of psychotherapist, levels of disclosure of personal psychiatric history by psychotherapists with friends, family, personal treatment provider, and/or colleagues/supervisors, each psychotherapist's views of stigmatization within the mental health system, as well as findings that were not consistent with other participant's answers.

Empathic Attunement

Thematically, three different levels of empathic attunement came of the interviews. Participants described circumstances that outlined a high level of empathic attunement, various levels of identifying with clients and their pain, and levels of over identifying with their clients. Psychotherapists with similar life experiences as their

62

clients frequently experienced noticeable internal and physical reactions to their clients

(Holmqvist & Anderson, 2003; Saakvitne, 2002). It is important for the individual

psychotherapist to be aware of these internal reactions. Failure to acknowledge these

internal reactions may result in clinical impasses with clients.

One influencing factor towards levels of empathy is linked to level of support

systems. Lack of support systems may influence professional burnout, consisting of

emotional exhaustion and sense of depersonalization leading to lower levels of empathy

toward others (Bruce et al., 2005). Support systems can be utilized as a forum to process

internal struggles. Supports can assist individuals in coping with stressors as well as

offer structure for internal exploration.

Several participants outlined diverse support systems, however many had not

shared their personal psychiatric experiences with their supports. I measured the quality

of their supports by how open each person was with their individual supports. A

connection between how much participants disclosed with supports and the number of

years the individual had engaged in personal psychotherapy was apparent. Those who

had engaged in more years of personal psychotherapy were more likely to have disclosed

their personal experiences with others.

Another influencing factor regarding empathic understanding is linked to

psychotherapist's level of engagement in personal psychotherapy. According to Strozier

and Stacey (2001), a level of empathic understanding through countertransference is

greater for those who did engage in personal psychotherapy. The more insight

individuals have for their own internal processes the more available and aware they are of

their clients' internal processes. As psychotherapists develop a higher level of awareness

of countertransference the more able they are to recognize it when it occurs and to understand the ramifications it may have if not acknowledged or recognized.

As outlined in the findings chapter, there were various levels of engagement in personal psychotherapy by the participants. The range was between two and twenty-three years of personal psychotherapy. There was a consistency between more years of personal psychotherapy and psychotherapists' level of empathic attunement. The less personal psychotherapy a participant had the higher levels of over identifying with the clients, poorer boundaries with personal self-disclosure with clients, and less in tuned the psychotherapists were to their transference and countertransference experiences.

Professional Development

Professional development was measured by levels of clinical insight. This was divided into two sections, higher levels of clinical insight and lower levels of clinical insight. Participants were separated into each of the categories after analyzing their responses during the interviews. They were divided seven to six, according to how they discussed their role as a psychotherapist, what their level of awareness of this role was, as well as their thoughts around the impact their role has had on their clients.

Seven of the participants were identified as having a higher level of clinical insight. These participants ranged from three to forty-three years of experiences as psychotherapists and had personally engaged in twelve to twenty-three years of personal psychotherapy. These participants maintained high levels of clinical insight evidenced by their ability to engage during the interview regarding their clients' ability to work in psychotherapy and their personal high level of understanding of how their own experiences may influence the work they do with their clients.

Six participants were identified as having a lower level of clinical insight. The experience of these participants as psychotherapists ranged from two to eight years. Their personal psychotherapy ranged from two to twenty years. Five of these participants engaged in personal psychotherapy ranging from two to four years and one engaged sporadically for twenty years. Each participant had a number of personal psychotherapists, suggesting lack of in-depth work with any one psychotherapist. The interviews revealed a lower level of participant's ability to separate their personal issues from their clients. There was a high level of overidentifying with their clients and lower level of insight regarding their influence in their client's lives.

These six participants represent a part of the professional psychotherapy population that should have been required to engage in longer and more intense personal psychotherapy prior to entering into the field as a provider. Some training programs require students to engage in at least one year of personal psychotherapy, others, requires psychotherapy during the entire training program. This result suggests that this amount of psychotherapy may not be enough for many who choose this professional path. It is not suggested that individuals who require personal psychotherapy to not be banned from the profession, I am suggesting that there be a better screening process for those entering into professional training programs, encouraging those in need of more psychotherapy to obtain it prior to entering/completing various training programs. The number of years individuals have engaged in personal psychotherapy has not been focused on in the published literature. These findings suggest an in depth review of this topic would be beneficial for future research.

Disclosure of Mental Health History

Each participant identified a variety of levels of disclosure regarding their personal experiences as consumers in the mental health field. The levels of disclosure were identified by whom each individual had shared his or her personal psychiatric experiences. The individuals identified friends, family, personal therapist, and colleagues/supervisors, as recipients of their information. Three categories surfaced including minimal disclosure/indiscriminate disclosure, limited disclosure, and maximum disclosure.

Those who had reported minimal personal therapy were more likely not to disclose or to disclose indiscriminately. Those who have worked in personal psychotherapy for a moderate amount of years or those who have worked for many years were more likely to share their personal struggles with a limited or maximum number of supports.

There was a difference between those who indiscriminately disclosed and those who disclosed to all supports. Those who fully disclosed to their supports expressed a higher level of understanding of what their disclosure represented. They reported their awareness of the consequences surrounding their disclosure and expressed minimal concern with backlash. One participant reported a history of speaking out politically on behalf of consumers of the mental health profession, utilizing her own experiences as her political platform. Those who indiscriminately disclosed presented with emotions as the motivation behind their choice of disclosure, appearing to have given little thought as to what consequences their disclosure may bring.

66

As outlined earlier, there is a connection between how much personal psychotherapy the participants had engaged in and their level of disclosure of their psychiatric history with friends, family, personal therapists, and/or colleagues/supervisors. This connection may suggest that the individuals have processed their own psychiatric challenges, the more comfortable they are with the challenges, and therefore, the more likely they will share their experiences due to limited fear of stigmatization or discrimination. This has not been directly researched in previous literature. It would be beneficial for future research to explore the connection between level of disclosure and number of years engaged in personal psychotherapy.

<center>Fighting the Stigmatization</center>

When discussing the level of change regarding the fight against the stigmatization placed on the mental health profession, the participants outlined several options. Three different categories were identified where change was suggested.   The participants identified the fight against stigmatization needs to occur at three different levels. These levels were identified as systemic, political, and personal.

The systemic level was identified as the mental health profession in need as a system restructure away from the medical model. Politically, the mental health system is underfunded and difficult for many populations to access, therefore stigmatizing those who are in need and appear not worthy of care. Personally, each provider in the mental health system can add positive change by fighting at an individual level against stigmatization. Providers frequently utilize stigmatizing and discriminating language that can be alters to allow for individual psychiatric differences to co-exist without shame accompanying the differences.   Many of the participants suggest a higher level of

<center>67</center>

exposure in order to fight the stigmatization, yet many of the same participants were

unable to identify a high level of personal disclosure. Fear was identified as the

motivating factor for silence.

It is apparent that there is little, if any difference between consumers and

providers within the mental health system, indicated by the large number of responses for

the request for participants. It is obvious that many individuals successfully carry a dual

identity of provider and consumer. The large number of responses for this study suggests

many successful psychotherapists managing their personal psychiatric symptoms.

This does not suggest that there are not individuals who experience a level of

symptomology that would interfere with their level of functioning, therefore limit their

ability to maintain mainstream employment. It does suggest however that systemically

the mental health profession should not limit individuals' access to enter the mental

health profession solely based on a history of personal experience as a consumer.

Other Findings

Although most of the participants' answers were consistent with each other, there

were ideas that surfaced during the interviews that were notably different independent of

the other participants' answers. One participant reported her belief that stigmatization

and discrimination of consumers of the mental health system are not perpetuated by the

mental health system. This is not consistent with the literature (Anonymous, 1981; Bar-

Levav, 1976; Bassman, 1997; Frese & Davis, 1997; Jamison, 1995, 1998, 2006; Olson,

2002). The literature supports the idea that the mental health system by design

structurally and in professional interactions assists in the perpetuation of stigmatization

and discrimination. The mental health system is based on a medical model suggesting

psychiatric challenges are illnesses, therefore need to be addressed accordingly and cured. Many professionals in the mental health field support this theory and treat clients accordingly, therefore continuing the legacy of discrimination.

This participant continued to outline her belief that there is stigmatization and discrimination of consumers of the mental health system; she believes the psychotherapists in the system are not at fault for perpetuating it. However, she did say that the professionals in the system are limited in their motivation to fight against stigmatization and discrimination. She did report the beginning of an important change over the years away from a medical model structure towards an empowerment model structure. Little connection was made between whom or how this change has become a reality, nor what is required to continue to fight the stigmatization and discrimination of consumers of the mental health system.

Another area introduced during an interview was the idea of group therapy for psychotherapists. One participant discussed the idea of psychotherapists engaging in group therapy aside from peer supervision. She reported the limitations of fear of lack of confidentiality. Another possible barrier for group therapy would be individuals concerned with others passing judgment due to various levels of personal insight.

As evidenced by several of the interviews conducted for this study, each psychotherapist has a variable level of personal therapeutic work they have done, coupled with their own level of clinical insight. Although some psychotherapists have mastered the skill of being non-judgmental, some have not. This could influence the level of disclosure during a group therapy setting. Another influence may be the size of the geographical area included in the groups. The possibility of broken confidentiality or

69

experiencing judgmental participants possibly multiplies in a smaller, rural setting. Although the mental health profession has strict rules regarding confidentiality, smaller settings challenge the confidentiality on many different levels. Small communities frequently have fewer options of social choices as well as daily activities such as grocery shopping. When faced with less options, there is much more likelihood of overlap between personal and professional world, therefore more challenging to maintain confidentiality.

Limitations

Social workers, psychologists, psychiatric nurses, and psychiatrists were the primary focus. Of those who participated, there was limited diversity in discipline. Twelve participants were social workers either at Ph.D. or MSW levels and one was a psychiatrist who possessed an MD.

This sample is not considered representative nor can it be generalized to all psychotherapists; therefore, there is no external validity. This is due to the use of snowball sampling and the self-selection of School for Social Work alumni or individuals known by alumni. As stated earlier, there were twelve participants with social work training and one who was a trained psychiatrist. This limited diversity of disciplines will challenge any external validity. Other demographic information was also limited. There were nine Caucasian identified, one African American identified, one Latino/a and Jewish identified, and two Caucasian and Jewish identified participants. Many ethnic identities were not represented nor were there enough in this sample to generalize to any population.

Ideas for Future Research

The findings of this study suggest a strong connection between years of personal psychotherapy and level of clinical insight. Most of the participants who had many years of personal psychotherapy also had worked in the professional realm of mental health for several years, this allowed for difficulty in separating which was influencing the level of clinical insight more. It would be beneficial for future research to separate out the two and measure independently. I believe that isolating the two will support existing research that outlines personal therapy as an important tool for professional development. Utilizing these two specific topics with a large sample size, controlling for variables will outline if there is a correlation between personal psychotherapy and level of clinical insight.

Another area for future research is a deeper exploration of the interaction with specific personal diagnoses and professional identity development. Although all psychiatric challenges influence individual's lives, it would be interesting to interview psychotherapists who have experiences with diagnoses that traditionally have difficult symptoms to manage, such as schizophrenia and other psychotic disorders and bipolar disorder. It would be interesting to interview individuals who have managed to maintain symptom control while continuing to develop as a psychotherapist. This would further support the idea of not limiting individuals from entering in the mental health field as providers.

Recommendations

I would suggest that limited motivation and lack of action to change a system that is occupied with stigmatization and discrimination is passively responsible for the

perpetuation of the negative views. Some psychotherapists may not personally engage in stigmatizing or discriminating language yet if not actively fighting against, it can be viewed as a level of colluding with it. The medical model is designed to treat individuals who are sick and require curing. Psychotherapists can play an active role in the fight against discrimination and stigmatization of individuals who receive services within the mental health system.

The mental health profession exists to assist individuals in leading fulfilling lives. Many mental health challenges are limited by utilizing a variety of tools, such as talk therapy, medication therapy, as well as other forms of treatment. Much of the time, it is symptom management as well as learning ways of coping with various challenges. Mental health challenges are not deficits. Mental health challenges are alternative ways individuals process their surroundings. Psychotherapists can work as advocates to fight against the stigmatizing and discriminating behaviors of many who work within the mental health and medical profession.

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Appendix A

Recruitment Flyer

Looking for Psychotherapists with a DSM-IV Diagnosis

- Do you have personal experience as a consumer of mental health services?
- Do you carry a DSM-IV diagnosis?
- Have you earned a Masters degree or higher in social work, psychology, nursing, or psychiatry?
- Have you worked as a psychotherapist within the past year?
- Have you worked with clients with similar symptomology/diagnoses?
- Are you a fluent English speaker?

Purpose of the Research

I am interested in the professional identity development of psychotherapists who possess a *DSM-IV-TR* diagnosis, what role their support system plays in their development and how this may or may not affect their work with clients.

Nature of the Participation in the Research

- Sixty-minute interview over the phone or in person interview.

- Participants may withdraw from the study at any time prior to April 15, 2007.

- Participants may choose not to answer any question.

- Every effort will be made to preserve confidentiality.

Setting Up Contact

If interested in helping a Masters graduate student with research for her thesis, please contact:

Lisa at 413-320-2416 or lfavorit@email.smith.edu

(Any future phone contact will be at no charge for the participant.)

Please pass this on to psychotherapists you may believe to fit the above criteria.

Appendix B

Recruitment Request through Smith College School for Social Work Alumni via Email

Subject Line: **Looking for Psychotherapists with a DSM-IV Diagnosis**

Dear Smith College School for Social Work Alumni:

I am conducting interviews for my Masters thesis. I am requesting your assistance if you

meet the following six criteria:

- Do you have personal experience as a consumer of mental health services?
- Do you carry a DSM-IV diagnosis?
- Have you earned a Masters degree or higher in social work, psychology, nursing, or psychiatry?
- Have you worked as a psychotherapist within the past year?
- Have you worked with clients with similar symptomology/diagnoses?
- Are you a fluent English speaker?

Purpose of the Research

I am interested in the professional identity development of psychotherapists who

possess a *DSM-IV-TR* diagnosis, what role their support system plays in their

development and how this may or may not affect their work with clients.

Nature of the Participation in the Research

- Sixty-minute interview over the phone or in person interview.
- Participants may withdraw from the study at any time prior to April 15, 2007.
- Participants may choose not to answer any question.
- Every effort will be made to preserve confidentiality.

Setting Up Contact

If interested in helping me out, please contact:
                      Lisa at 413-320-2416 or lfavorit@email.smith.edu
                      (Any future phone contact will be at no charge to you.)

Please pass this on to psychotherapists you may believe to fit the above criteria.

Appendix C

Screening Guide

(This will begin with the narrative as follows, preparing the potential participant as to what to expect. The screenings were performed on the phone.)

"It is important for me to review with you some of the topics that we will potentially discuss. I intend on asking questions regarding your personal experiences within the mental health system as a consumer. These questions will explore some of your thoughts feelings and experiences you may have had. We will also explore some of your direct personal reactions to various clients, especially those who possess similar diagnoses or symptomology. I will begin by asking a couple of specific screening questions that will establish eligibility of participation in this study."

I let the potential participant know that at any point during the questioning they have the power to either take a break, postpone, or quit the questioning process. I also let them know that at any point they can ask for clarification if there is some confusion as to what I am asking about.

1. Have you been, or are you currently a consumer within the mental health profession?

2. Have you in the past, or do you currently possess one or more DSM-IV diagnoses?

3. Could you please give my a brief overview as to what diagnoses you have carried?

a. I will be looking specifically one or more of the following: Schizophrenia and other Psychotic Disorders, (excluding psychotic disorders due to general medical condition and substance-induced psychotic disorders); Mood Disorders (excluding Dysthymia and mood disorders due to a general medical condition); Anxiety Disorders (excluding anxiety disorders due to a general medical condition and substance induced anxiety disorders); Eating Disorders; and Borderline Personality Disorder

4. Do you have a Masters degree or higher in social work, psychology, nursing or psychiatry?

5. Have you worked as a psychotherapist within the past year?

6. Do you work, or have you worked with clients who possess similar diagnoses or symptomology?

If the potential participant meets all the above criteria, an interview time will be established.

Appendix D

Letter of Invitation

Dear _____,

        I am a student at Smith College School for Social Work. As part of the professional development of a graduate student at Smith College School for Social Work research is a requirement of the Master's program. I am interested in the professional identity development of psychotherapists who possess a *DSM-IV-TR* diagnosis, what role their support system plays in their development and how this may or may not affect their work with clients.

        I would like to interview you regarding your personal experiences of the mental health system from the consumer role. I am also interested in exploring any influences your diagnosis has had on your professional identity development. This includes discussions regarding your personal and professional support system and possible reactions to various clients.

        If interested in participating, please sign and date one of the Informed Consent Forms enclosed, the other is for you to keep for your records. Please return the signed Informed Consent Form in the envelope provided. Your time and participation is appreciated.

Sincerely,

Lisa Favorite

Contact information:
325 Main Street
Easthampton, MA 01027
lfavorit@email.smith.edu
413-320-2416

Appendix E

Informed Consent Form

Date _____

Dear Participant:

My name is Lisa Favorite. I am a Masters in Social Work candidate at Smith

College School for Social Work. I am conducting a research for my thesis and for other

possible publications and presentations. I am interested in the professional identity

development of psychotherapists who possess a *DSM-IV-TR* diagnosis, what role their

support system plays in their development and how this may or may not affect their work

with clients.

The requirements for participation are:

- to have personal experience as a consumer of mental health services
- to carry a DSM-IV diagnosis
- to have earned a Masters degree or higher in social work, psychology, nursing, or psychiatry and
- to have worked as a psychotherapist within the past year
- to have worked with clients with similar symptomology/diagnoses
- to be a fluent English speaker

You will participate for approximately 60 minutes. Each participant will

complete a brief demographic survey, which includes preliminary questions. Each

participant will engage with me in a verbal interview. Interviews will be conducted

either in-person or on the phone. All interviews will be digitally audio recorded. All

transcriptions of the recorded interview will be held in great confidence by both the

transcriber and me.

The only foreseeable possible risk with participation in this project is the potential

for emotional discomfort that may arise with questions regarding personal experiences.

You will be asked how you handle situations in which your clients carry similar diagnoses or symptoms. Remember, you can end the interview at any time or decline to answer any question.

One potential benefit of participation is having the opportunity to talk about personal experiences within the mental health system as a consumer. Having this opportunity may offer a place to gain a new perspective on your experiences. Another benefit with participating is assisting me in breaking down the barrier between the idea of us and them, of mental health professionals and consumers. There will be no compensation for your time other than knowing your participation is greatly appreciated as well as possibly assist others with similar situations, understanding they are not alone.

Every effort will be made to preserve confidentiality. To ensure the confidentiality of all participants, the digitally recorded interviews, transcription, and demographic surveys will have numbers assigned to each participant with the list of numbers kept in a separate location; all of which will remain under lock and key for a period of three years, per Federal regulations, then all data will be destroyed. My school advisor and transcriber will have access to the data after all identifying information has been removed. I am the only person who will have access to the raw data. In the publication of my thesis all data will be presented as a whole and that when brief illustrative quotes or vignettes are used, they will be carefully disguised.

If you agree to participate in my study, please note that your participation is voluntary. You may revoke your consent and pull out of the study at any time prior to April 15, 2007 when the report will be written. I can be reached at lfavorit@email.smith.edu or 413-320-2416 if you have any questions or concerns.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Thank you for your consideration of participating in this research project.

_____	Signature of Participant
_____	Printed Name of Participant
_____	Date
_____	Signature of Interviewer
_____	Printed Name of Interviewer
_____	Date

Please keep the second enclosed copy for your records.

Appendix F

Demographic and Preliminary Questionnaire

Code Number:_____

1. Age:

2. Race and Ethnicity:

3. Education (Degrees, Licenses, and Certificates):

4. Theoretical Orientation:

5. How long have you practiced psychotherapy? (settings and population served)

6. Diagnoses you have carried:

7. Personal psychotherapy history and/or hospitalizations if any (Please state length
   of time and age of treatment):

*I will remind the participants that if they choose to discuss any of their professional case
material, they are advised to leave out any client identifying information.

Appendix G

Interview Guide

1. I am interested in how psychotherapists respond to clients with similar symptomology or diagnosis as the psychotherapist. What has your transference or countertransference been regarding clients with similar symptomology or diagnosis?

   a. How do you think you approach psychotherapy and interventions different with clients that carry the same or similar diagnosis or possess the same or similar symptoms as you?

2. I am interested in your support systems.

   a. Who is in your support system if you think you have one?

   b. Are these supports aware of your specific diagnosis?

   c. Whom do you talk to if a client experiences trigger an emotion or other internal reaction due to similar personal experiences?

3. I am interested in how your personal experience with your own mental health system may or may not have informed your decision to become a psychotherapist. If so, please talk about it.

   a. How has this influenced what populations you will and will not work with?

   b. How does your personal experience with your own mental health influenced your professional growth?

4. I am interested in hearing about your experiences navigating the mental health system as a consumer. Could you please tell me a little about this?

5. What are your thoughts regarding how we, as psychotherapists, may change the current stigmatization and discrimination of individuals with psychiatric diagnosis?

Appendix H

Volunteer or Professional Transcriber's Assurance of Research Confidentiality

STATEMENT OF POLICY:

This thesis project is firmly committed to the principle that research confidentiality must be protected. This principal holds whether or not any specific guarantee of confidentiality was given by respondents at the time of the interview. When guarantees have been given, they may impose additional requirements which are to be adhered to strictly.

PROCEDURES FOR MAINTAINING CONFIDENTIALITY:

1. All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.

2. A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. Depending on the study, the organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested may also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.

It is incumbent on volunteers and professional transcribers to treat information from and about research as privileged information, to be aware of what is confidential in regard to specific studies on which they work or about which they have knowledge, and to preserve the confidentiality of this information. Types of situations where confidentiality can often be compromised include conversations with friends and relatives, conversations with professional colleagues outside the project team, conversations with reporters and the media, and in the use of consultants for computer programs and data analysis.

3. Unless specifically instructed otherwise, a volunteer or professional transcriber upon encountering a respondent or information pertaining to a respondent that s/he knows personally, shall not disclose any knowledge of the respondent or any information pertaining to the respondent's testimony or his participation in this thesis project. In other words, volunteer and professional transcribers should not reveal any information or knowledge about or pertaining to a respondent's participation in this project.

4. Data containing personal identifiers shall be kept in a locked container or a locked room when not being used each working day in routine activities. Reasonable caution shall be exercised in limiting access to data to only those persons who are

working on this thesis project and who have been instructed in the applicable confidentiality requirements for the project.

5. The researcher for this project, Lisa L. Favorite shall be responsible for ensuring that all volunteer and professional transcribers involved in handling data are instructed in these procedures, have signed this pledge, and comply with these procedures throughout the duration of the project. At the end of the project, Lisa L. Favorite - shall arrange for proper storage or disposition of data, in accordance with federal guidelines and Human Subjects Review Committee policies at the Smith College School for Social Work.

7. Lisa L. Favorite must ensure that procedures are established in this study to inform each respondent of the authority for the study, the purpose and use of the study, the voluntary nature of the study (where applicable), and the effects on the respondents, if any, of not responding.

PLEDGE

I hereby certify that I have carefully read and will cooperate fully with the above procedures. I will maintain the confidentiality of confidential information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Lisa L. Favorite for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

_____	Signature of Transcriber
_____	Date
_____	Lisa L. Favorite
_____	Date

Appendix I

Human Subjects Review Approval Letter

January 15, 2007

Lisa Favorite
325 Main Street, 2nd floor
Easthampton, MA 01027

Dear Lisa,

Your final revisions have been reviewed and all is now in order. We are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor