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The dyad of colleagues : transferential experiences of clinical trainees with their personal therapists and its impact on practice

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ABSTRACT

This study was conducted in pursuit of the answer to the following question: what is the experience of transference in the personal therapy of clinicians-in-training and how does this unique therapeutic relationship influence the practice of clinical trainees?

This study utilized exploratory qualitative intensive interviews. Participants included individuals who were enrolled in a masters in social work (MSW), counseling, or clinical psychology program; participant had to have aspirations to be a therapist, voluntarily be in personal therapy, and reside in the United States. Questions were designed to draw from subjects their experiences of transference, specifically those that arose as a result of the participant being a trainee in the same field as their therapist, and how their relationship with their therapist impacted practice.

Findings resulted in three major themes: conceptualizations of transference, experience of transference in personal therapy, and the impacts of being emerging colleagues. Respondents generally agreed on the nature of transference and expressed a variety of transferential experiences, including idealization, admiration of professional skills, and fear of judgement regarding clinical skills. Interviewees reflected on how their relationship with their therapist impacted their practice.

THE DYAD OF COLLEAGUES: TRANSFERENTIAL EXPERIENCES OF CLINICAL TRAINEES WITH THEIR PERSONAL THERAPISTS AND ITS IMPACT ON PRACTICE

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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CHAPTER I

Introduction

It is not uncommon for mental health professionals to be in personal therapy during their graduate studies, in fact, some institutions require or strongly urge their students to enroll in counseling during their schooling (Stozier & Stacey, 2001). However, little is empirically known about the phenomenon of transference that occurs when clinicians-in-training, or clinical trainees, are in personal therapy. Due to the unique dynamic that could arise when a trainee is in personal therapy, I became interested in the possibility that there may be experiences of transference specific to clinical trainees may arise and could either assist or hinder the self-exploration process in therapy. These dynamics may also impact the clinician-in-training's own professional development as a result of how therapy has personally been modeled to/experienced by them.

For the sake of this study, the terms clinician and therapist will be used interchangeably. Graduate students studying to be therapists will be referred to as clinicians-in-training, clinical trainees, or trainees. Though clinicians-in-training may also be considered by some to be graduates who have not yet been license, in this body of work clinicians-in-training are considered to be graduate students. Though there are many types of clinicians-in-training (Ph D students, MFT students, MSW students, MD students, etc.), this study focused on students studying clinical social work, clinical psychology, or counseling graduate students at the masters-level or higher.

Since it is an obligation of the social work field to ensure that all patients receive the quality of care they deserve, including clinicians themselves, it is essential to explore the potential for the specific nature of transference of clinicians-in-training in the clinical setting. The results of this study may lead to further knowledge of the therapeutic relationship in this particular scenario and could result in the development of clinician-in-training specific interventions. This study explores the following research question: W*hat is the experience of transference in the personal therapy of clinicians-in-training and how does this unique therapeutic relationship influence the practice of trainees?*

Much of the literature in this area has focused on MSW students' values and predictors concerning personal therapy (Strozier & Stacey, 2011, Dearing, Maddux, & Tangney, 2005) and the experiences of therapists and personal therapy (Orinksy et al., 2011, Rizq, 2011). However, there is little literature specifically on trainees and their experiences with their personal therapists, especially those who are voluntarily in their own therapy. These topics and others relevant to trainee experiences with therapy and transference, including the conceptualizations of transference and countertransference, and therapists and their relationship with personal therapy will be further explored in the second chapter of the thesis, the literature review.

The Methodology chapter will explain the process of ethically and scientifically sampling participants, collecting data, and deriving findings. The transferential experience of clinical trainees in personal therapy explored through semi-structured qualitative interviews with 12 graduate-level clinicians-in-training voluntarily in their own personal therapy.

The fourth chapter will detail the findings that resulted from the interviews. Many participants agreed that in general, transference manifests in behavior and feelings toward the

clinicians as a result of other relationship patterns. The majority of interviewees reported

idealizing transference toward their therapist while also having a fear of one's clinical abilities or

fit for the field being judged. For how the relationship impacts practice, almost all respondents

reported using their therapist as a model for their own practice.

The discussion chapter (chapter five) reports on the results, suggestions for further study,

and implications for clinical practice. The strengths and limitations of the study are discussed.

CHAPTER II

Literature Review

The following literature review explores theoretical and empirical literature that relates to this researcher's question: what is the experience of transference of clinicians-in-training in personal therapy, particularly to their status as colleagues, and how do this phenomenon impact the clinician-in-training's own ideas about practicing?

The first section covers transference and the second covers countertransference. Because this study is based on these phenomena, it is essential to have an adequate understanding of these concepts and how they apply to the dynamic that can occur when clinicians-in-training are in personal therapy. It is worth noting that both of these phenomena warrant their own body of literature which is out of the scope of this study. The third section explores therapists' and trainees' relationship with personal therapy: how they view it, what brings them into therapy, and so on. The fourth and final section explores the impacts of personal therapy.

Transference

To be able to explore the experience of the client in therapy, it is essential to understand the theory of transference. While the concept of transference began with Sigmund Freud's neurological writings in 1888 (Freud, 1888), it is a theory that has evolved (Freud, 1912) and continued to be relevant over time. Levy and Scala defined the contemporary concept of transference to be "a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships" (as cited in Levy & Scala, p. 392). In the therapeutic relationship it t is described to be an unconscious phenomenon that takes place on the

behalf of the client toward the therapist and may be rooted in either cognitive distortion or reality. Transference can often unconsciously provoke the client to act a certain way toward the therapist and illicit certain thoughts/feelings from the clinician themselves (Levy and Scala, 2012). Because of this pervasive phenomena, interpreting transference is an essential element of psychodynamic interventions (Ulberg, Amlo, Critchfield et al., 2014). Thus it is imperative that a further understanding of the occurrence of transference in clinicians-in-training is developed; this phenomenon may be impact the therapeutic relationship between the individuals and thus influence how the clinician-in-training may experience transference and countertransference with their own clients. For the sake of this study, this researcher will use this definition to define transference and how it arises between clinicians-in-training and therapists in personal therapy.

Marmarosh (2012) concurs with Levy and Scala's definition of transference and highlights the empirically supported importance of the client making use of the interpretation of transference, the accuracy of the interpretation, and the context. If this is the case, transference may happen in other non-dynamic relationships as well, and it may influence people's perceptions of others based on important people from the past. Thus it is an important phenomenon to cue into. In addition, there is qualitative and quantitative evidence that transference does occur in all forms of psychotherapies and other relationships regardless of theoretical orientation/context, though it is reported more in psychoanalytic therapies (as cited in Gelso and Bhatia, 2012; Beach and Power, 1996). This phenomenon indicates the importance of exploring transference, as it happens on a regular basis in many types of relationships and psychotherapy settings.

Countertransference

In their review of the history, definition, and research regarding countertransference, Hayes, Gelso, & Hummel (2011) describe the original definition of countertransference (postulated by Sigmund Freud), which was "the therapist's unconscious, conflict-based reaction to the patient's transference. Unresolved conflicts originating in the therapist's childhood are triggered by the patient's transference and are acted out by the therapist" (as cited in Hayes, Gelso, & Hummel, p. 88). There are also three other conceptions of countertransference beside Freud's. The totalistic conception, which originated in the 1950s, theorizes that countertransference includes all of the therapist's reactions to the client, all of which should can be used clinically. The complementary definition of countertransference, as described by Levenson (1995) and Racker (1957) is the therapist's complementary response to the client's attachment style. Finally, the relational perspective of countertransference, developed by Mitchel (1993) is that transference is constructed by both therapist and client: the history of both parties is brought into the room to create countertransference. All of these definitions are often used interchangeably and inform one another.

Clarkson and Nuttall (2000) discuss the history of the concept of countertransference and its relationship to the Kleinian concept of projective identification and its relationship to the object relations school. The authors also cite the history of Freud being a key developer of the theory of countertransference; they add, however, that Melanie Klien's development of the concept of projective identification, or the projection of unwanted feelings onto another in order to ward them off, was an essential part of understanding counter-transference (Clarkson and

Nuttall, 2000). Klien also emphasized the projection of good and bad parts of the self are projected, which is part of the healthy development of object relations. Paula Heimann used this concept to describe how therapists who are cued into this phenomenon can use it to notice and respond to the client (Clarkson and Nuttal, 2000).

The concept that countertransference must be analyzed developed two conceptualizations of countertransference. The first, the vectors, originally identified by Sigmund Freud, are called proactive countertransference (concerned with the therapist's own history, fears, experiences, and so on) and reactive countertransference (developed by Heimann, which relates to the therapist's response to the client's history, fears, experiences, and so on). These are also called concordant and complementary countertransference (Clarkson and Nuttal, 2000). Concordant transference occurs when the therapist is attuned to the emotions that belong to the client about their past, while complementary countertransference is when the therapist picks up on feelings others (including parents, friends, etc) have about the client. These definitions are more psychoanalysis-specific understandings of countertransference. Both types may have a strong impact on clients if the therapist does not adequately address their countertransference process, and for clients who are clinicians-in-training, may model inappropriate methods of addressing countertransference.

While there are a few different views of countertransference throughout history, one contemporary, general definition of countertransference is postulated by Berzoff (2011) and is described as "thoughts and feelings and reactions to the client rooted in [the therapist's] own history and current world" (p. 28). This general definition incorporates the ideas of the therapist's past playing a role in the relationship between clinician and client, unconscious and conscious feelings stirred in the therapist, and allows for the projection of both good and bad feelings onto

the client. For the sake of this study, this researcher will use Berzoff's definition of countertransference.

Having a broad understanding of countertransference allows clinicians to understand the experiences of the trainee as client; the countertransference on the behalf of their therapist may impact the transference felt by the patient. Clinicians-in-training in personal therapy who do not witness appropriate tracking of countertransference from their clinician may use maladaptive techniques in addressing their own countertransference with their clients.

Clinicians and Personal Therapy

To investigate the importance of personal therapy for clinicians-in-training, specifically MSW students, Strozier & Stacey (2001) surveyed 148 professors who worked at clinical MSW programs in North America and 139 MSW students enrolled in these programs. The researchers used questionnaires with basic demographic questions and asked the student respondents how relevant they believed personal therapy was to education in social work, as well as how beneficial it can be for MSW students. For the faculty, they asked whether or not they thought therapy should be mandated for MSW students, and if their institution did have a policy on the subject, how attitudes have or have not changed over the past ten years.

The hypothesis that students value therapy more than faculty was indicated in their findings. On the Likert scale the researchers used, students rated therapy as essential at a much higher rate than their professors (Strozier & Stacey, 2011). This researcher speculates that this phenomenon may be attributed to many factors, including professors possibly having difficulty recalling the stress of graduate school or the desire to have therapeutic modeling. Professors may also recognize that is may be financially difficult for some graduate students to afford personal

therapy, and thus students who can afford personal therapy enter personal therapy so by their own volition.

There are a few aspects of this study worth critiquing. Students are indicating that they view therapy to be significant to their experience, but this study does not explore why or what aspects of therapy are considered important to students. In addition, it does not address the nature of the therapeutic alliance students may be seeking. It does, however, show that students find therapy important, indicating a need to further understand what happens when clinicians-in-training are in therapy.

Dearing, Maddux, & Tangney (2005) exclusively explore the predictors for clinicians-in-training seeking personal therapy, noting that since both psychotherapists and clinicians-in-training seek personal therapy at high rates, it is essential to understand why or why not these populations seek treatment (Dearing, Maddux, & Tangney, 2005). Data was gathered by the distribution of study materials to 959 psychology graduate student members of the American Psychological Association. Results showed that the three most likely obstacles to getting into therapy for clinicians-in-training are cost, time, and confidentiality concerns. In a 5-point scale ranging from 1 (disagree) to 5 (agree), students indicated favorably to seeking personal therapy. On a similar scale relating to disagreeing with the statement "Personal psychotherapy is a necessary and integral part of the training of a mental health professional" (p. 325), the students indicated that they tend to believe psychotherapy is indeed essential. These results imply that graduate students do find therapy to be important, and that it is a safe place to turn to when in crisis. Thus, it must be further explored what their experiences like once in therapy so this population can be served better.

Norcross, Bike, and Evans (2009) address the process by which clinicians in general select a therapist once they make the choice to see one. Re-creating a study by Norcross, Strausser, & Faultus (as cited in Norcross, Bike, & Evans, 2009) that had a small participant pool, the research team obtained their data by mailing out questionnaires to 2,100 randomly selected US mental healthcare professionals including psychologists, social workers, and counselors. Of the respondents (727 people), 84% shared that they at some point attended personal therapy. The results indicated that the five top qualities in a therapist were competence, warmth and caring, clinical experience, openness, and professional reputation (Nocross, Bike, and Evans, 2009). While it is important to understand why clinicians pick certain therapists for personal therapy, this study leaves out which qualities motivate the clinician/client to stay. It is essential to understand what is happening in the room transference-wise that keeps the therapeutic alliance intact. In addition, this population does not include clinicians-in-training.

Orinsky et al. (2011) expand on the previous research done regarding the utilization of personal therapy by therapists themselves by studying the experiences of clinicians in six different English-speaking countries. The researchers used the psychotherapists common core questionnaire (as cited in Orinsky et al., 2011), which inquires about a broad range of topics including seeking personal therapy. The data showed that 86% of respondents had been to therapy at some point, and 25% were currently in therapy. In addition, 73% of the therapists in their 20s had been or were in therapy (Orinksy et al., 2011). This dataset exemplifies that most therapists tend to be in therapy at some point, indicating that therapists value having a therapeutic experience themselves. However, because the study includes participants from various countries it cannot be generalized to the United States. In addition the participants come

from a range of backgrounds, including psychiatric nursing, clinical psychology, etc. Finally, this data indicates that young therapists/possibly clinicians-in-training are indeed getting personal therapy. Therefore, it is important to explore the experiences of clinicians-in-training in personal therapy and how transference plays a role in their professional development.

Rizq (2011) begins to explore what happens in therapy for clinicians in personal therapy based on their attachment attachment styles. She draws attention to the lack of data around how the characteristics of therapists impacts the experience in psychotherapeutic training (p. 175). To investigate, Rizq colleagues interviewed 12 UK counseling psychologists whose experience ranged from three to seven years' professional experience. The participants were interviewed twice. The first interview was an AAI: an "hour long semi-structured interview designed to elicit a full story of the interviewee's early childhood experiences with primary caregivers and the impact of these on his or her current functioning" (p. 178). After the interview the participants' attachment style was categorized into three classifications: secure/autonomous (F), insecure/ dismissing (Ds) and insecure/preoccupied (E) (p. 178). The second interview focused on the participants' experiences in personal therapy during training.

The results indicated that securely attached clinicians anticipated therapy, found therapy helpful, used their therapy/therapists to make progressions in their lives/own practice (Rizq, 2011). They also felt comfortable confronting their therapists when the therapist did something disappointing (p. 179). The insecurely attached participants were more reluctant to attend therapy, were more cautious/suspicious of their clinicians, and expressed both negative feelings about mandatory therapy and subsequently their relationship with their therapists (Rizq, 2011). This data set illustrates the need to further explore the experiences of therapists in therapy and

possibly the development of new interventions for therapists with insecure attachment. It is limited to post-graduate psychologists and only surveys clinicians in the UK. More must be explored with other types of clinicians, particularly clinicians-in-training in the United States.

The Impacts of Personal Therapy on Clinicians

Gold & Hilsenroth (2009) illustrate that once the clinician-in-training is in therapy, there is an impact on the clinician-in-training's confidence with their own clients. The study had two populations: clinicians-in-training and clients. The client population was 30 participants who were seeing a clinician enrolled in personal therapy, and the other 30 participants were clients seeing clinicians without a personal therapist (Gold & Hilsenroth, 2009). The therapists in training were 25 advanced doctoral students; 18 of these clinicians-in-training were in therapy, the remainder were not. Both groups of clients reported high levels of therapeutic alliance with their clinicians. However, the clinicians-in-training in personal therapy reported feeling more confident, were more likely to feel like they shared their clients' goals, felt more bonded to their clients, and perceived that their clients engaged more. In addition, the clinician-in-training population had clients stay for treatment twice as long as the clients of the trainees who had not received personal therapy. These results indicate that personal therapy impacts not only the clinician-in-training, but also their clients. They do not, however, explore the experiences of the clinicians-in-training with their therapists and what does/does not work in their therapy. Thus it is important to explore further the experience of these clinicians-in-training with their own therapeutic relationship.

The Gold Et al. conducted a similar study, exclusively featuring 14 clinicians (all of whom were advanced doctoral students) with experience with personal therapy who were using

psychodynamic short-term therapy to treat 54 outpatients (Gold et al., 2014). After conducting

semi-structured interviews with about relevant therapeutic topics, results indicated that was a

negative correlation between "degree of perceived helpfulness of their personal therapy and how

[they] rated alliances with their own patients as therapists" (Gold et al., (2-14, p. 8). This

phenomenon could be due to a number of factors, including that the clinicians may have felt that

they aren't as competent as their own therapist or their countertransference with their clients is

different than the transference they experience with their therapists. However, there was also a

positive correlation between the clinicians rating their personal therapy alliance as high and the

rating of the patient's therapeutic alliance. These results, which may seem counter-intuitive, are

evidence that there is a necessity for a further understanding of the transference/

countertransference phenomenon between clinicians-in-training and their own therapists.

Probst (2014) attempts to fill some these gaps by studying what exactly clinicians in

therapy find most useful. Participants were recruited through personal contacts, referrals,

professional organizations, listservs, flyers, etc. and the qualifications were to be a clinical social

worker who received therapy and/or psychiatric diagnosis (p. 4). Probst conducted qualitative

interviews with the 30 people who agreed to participate. A number of themes arose: using the

self skillfully, putting the client first, sharing control, external reflecting the internal, authenticity,

and giving/giving back. The more the therapist emphasized these techniques, the more positively

the clinician-as-client felt. Though this study is helpful in understanding what builds a

therapeutic alliance, it is important that the specific clinical position of being a clinician-in-

training is studied. Being a student and having not only appropriate modeling for good therapy

but also a therapist who understands the unique position of being a future colleague would

expand the field's knowledge on successful interventions related to the nature of this specific therapeutic relationship.

Orinksy (2011) explores the experience of psychoanalytically-oriented therapists in their own therapy and how it relates to professional growth. The researcher used a qualitative dataset of 12,000 therapists in various countries who reported on various experiences in therapy in response to the Development of Psychotherapists Common Core Questionnaire (Orinsky, 2011). Orinsky used this dataset to answer questions inspired by articles written by McWilliams (2013) and Geller (2013): how do psychoanalytically-oriented therapists differ from those who are minimally psychodyamic, how do they compare in regards to their use of personal therapy, and how are the reasons for psychoanalytically-oriented therapists seeking personal therapy related to positive professional development (Orinsky, 2011)?

The results indicated that 73% of psychaoanlytically-oriented practitioners found therapy to be essential or required and 93% of them had history in therapy. Of the minimally psychoanalytically-oriented therapists, 39% felt similarly (however, 56% of these practitioners did believe personal therapy is desirable). Both groups sited primary reasons for going to personal therapy as growth, training, and problems; problems was the highest indicated reason. For professional development, practitioners benefited the least if they only went for problems alone. In general, therapists who only cited one reason for attending therapy benefitted the least (Orinsky, 2011). This study does not explore what made therapy beneficial once they were in it. In addition, it does not explore the transference. This study indicates a need for further exploration of the therapeutic relationship.

Mandated Personal Therapy for Clinicians-in-Training

Some institutions, including universities in the United States and foreign psychological societies, mandate their clinician-in-training students be in personal therapy (Kumari, 2011). It is a practice that, because of the potential of forcing someone who is well to participate in treatment, the cost of personal therapy, the potential for personal therapy to be damaging, and so on, has its ethics challenged (Ivey, 2014).There have been findings indicating that mandatory personal therapy can be a platform for personal and professional growth (Kumari, 2011; Ivey & Waldeck, 2014; Murphy, 2005). In addition it has been found to provide an opportunity to reflect on being in the role of the client, elicit feelings of completing a rite of passage as a future therapist, be a source of support as an emerging processional, and be validating (Grimmer & Tribe, 2001). However it can also contribute to heightened stress levels, financial stress, and complicated relationships. (Kumari, 2011; Ivey & Waldeck, 2014). This topic is a body of research that has been heavily researched in the UK (Kumari, 2011; Ivey, 2014; Ivey & Waldeck, 2014; Murphy, 2005; Grimmer & Tribe, 2011), but there is little literature on this topic in the United States. These findings indicate that while there is a need to further understand the nuances of mandated personal therapy, it is beyond the scope of this study. For this reason, the participants in this study are either clinicians-in-training who are voluntarily in therapy.

Therapists Providing Personal Therapy to Fellow Clinicians

Therapists who see therapists encounter unique and complicated dilemmas when they have therapist-patients (Bridges, 1993). Bridges theoretically proposes several elements that contribute to making this relationship unique and sometimes challenging. One issue that arises is over-identification; the treating therapist may sense what they interpret to be similarities between

themselves and the therapist-patient, which could lead to either a particularly caring or harmful

therapeutic relationship (Bridges, 2011). The therapist may unconsciously focus on their own

struggles, expectations of the patient because of their status as a fellow therapist, and lose sight

of the therapist patient's actual clinical issues. In addition, because of their status as colleagues,

boundaries that may be present with other patients may be more blurred with therapist-patients.

For example, the therapist-patient may know their therapist's colleagues and friends, which could

lead to the therapist feeling concerned about their professional reputation should the therapist-

patient be displeased with their treatment (Bridges, 2011). While Bridges's theories are targeted

specifically at the therapist/therapist-patient relationship, they may also be used to inform ideas

bout the therapist/clinician-in-training relationship.

King (2011) empirically explores these dilemmas therapists navigate when their clients

are clinicians-in-training. By conducting qualitative interviews with seven UK

psychodynamically-oriented therapists who have clients that are clinicians-in-training mandated

to be in treatment, King found that therapists' dilemmas included concerns for reputation,

pressure to model theory in practice, feelings of competition, blurred boundaries, tolerating envy,

neurotic countertransference, excessive use of self, and fears of professional exposure (King,

2011). Clinicians-in-training were experienced as more difficult and critical clients. This study

corroborates that the relationship between therapist and clinician-in-training clients are unique

and require more attention. This study was conducted in the UK and because of cultural

variations may not be generalizable to therapists in the U.S. The clinician-in-training clients the

participants were working with was limited to those required to be in treatment. It is possible that

the results would be different if the clients were there willingly. Thus it is critical to further

explore the relationship between therapists and their clinician-in-training clients; the therapist's countertransference may be impacting the nature of the clinician-in-training's transference.

Summary

The literature gives us a clear understanding of what countertransference (Heyes, Gelso, and Hummel, 2011) and transference (Levy and Scala, 2012) are, but we do not get a clear idea of the types of transference that arises when a clinician-in-training is in personal therapy. We also see why clinicians-in-training seek therapy (Dearing, Maddux, & Tangney, 2005), how their attachment style impacts the therapeutic alliance (Rizq, 2011), and who they want as a therapist. Research shows that personal therapy may lead to improved confidence for the clinician-in-training with their own clients (Gold & Hilsenroth, 2009; Gold et al., 2014). Finally, the literature illustrates what is useful in therapy for clinicians (Probst, 2014). In addition, though there is literature describing the challenges of seeing a clinician-in-training as a client (King, 2011), more must be done to specifically research the countertransference phenomenon and how it impacts the transference of the patient, particularly in the United States and when the trainee client is not mandated to be in therapy. Knowing more about the nature of unconscious processes in this specific, special relationship between future colleagues is essential for providing the best care possible to trainees and influencing their own practice in a positive way. It is essential to ask: what is the experience of transference of clinicians-in-training in personal therapy, particularly to their status as colleagues, and how do this phenomenon impact the clinician-in-training's own ideas about practicing? Current gaps in the literature regarding transference clinicians-in-training have to their personal therapists will be filled in with this study.

CHAPTER III

Methodology

The purpose of this study is to answer the following question: what is the nature of transference in the personal therapy of clinicians-in-training in relation to their personal therapist and how does the experience of the therapeutic relationship impact the trainee's own practice? This study utilized exploratory qualitative intensive interviews. Using qualitative exploratory research methods allowed the participants to make meaning of their experiences (Engel & Schutt, 2001). Qualitative methods gave the participant the opportunity to be as specific and detailed as they wished, and in turn the researcher had the opportunity to ask the participant to elaborate or clarify their narrative. Intensive interviews were be semi-structured and open-ended, which the researchers to the voices and detailed experiences of clinicians-in-training in personal therapy (as cited in Engel & Schutt). Through using these methods, study participants were given the opportunity use this platform to articulate to their liking their personal view of their transference.

Sample

The sampling size of the study was determined by theoretical saturation, around 12 participants (Engel and Schutt, 2013). The sampling frame was individuals who were enrolled in a masters in social work (MSW), counseling, or clinical psychology program; participant had to have aspirations to be a therapist, voluntarily be in personal therapy, and reside in the United States. Because of the variety of degrees one can have to become a psychotherapist, including participants from various academic backgrounds allowed for a more holistic body of voices. Participants were required to be in therapy voluntarily— because of the complexities being

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mandated to be in treatment can cause (Ivey, 2014; Kumari, 2011; Ivey & Waldeck, 2014, Murphy, 2005), this study was best suited for trainees who are in personal therapy by choice.

Participants were to be obtained through snowball sampling methods, word-of-mouth, flyers, advertisements posted on my personal Facebook, and by advertisements posted in the CAMFT and California Society for Clinical Social Work websites. In addition I planned on asking professionals I knew in the community if they knew people who would fit the criteria for this study and would be willing to participate. I assured these professionals that our relationship would not be impacted whatsoever by their ability to assist in recruiting.

Once I heard from participants and they answered the screening questions asked in the response e-mail I sent them the consent form and question set. Once they stated that they wanted to participate I will ask them to print, sign, and bring the consent form for the interview. For those who lived out of the area I offered to send them a self-addressed, self-stamped envelope to return the consent form to me by postal service. Many opted to send me their own stamped envelope by postal service.

Ethics and Safeguards

There were some benefits associated with participating in this study. Participating in this study could have lead to further insight into the participants' therapy process. This study may have also given participants an opportunity to explore and better understand their experiences in therapy and as a developing therapist. It could have also lead to self-discovery, as well as an opportunity to talk about something participants may have never felt comfortable discussing before. This research may have also informed the participants' own clinical practice. The risk associated with participating in this study was that some of the questions may be trigger

unpleasant thoughts or feelings.

Participation was kept confidential. Participants were asked to pick a pseudonym to mask their identity; if they did not want to pick one I chose a name for them. All documentation regarding participation matched this pseudonym. Any other identifying information, including geographic location, and program the participants are a part of, were not included in any documentation, including notes, information sheets, transcripts, etc. I will not include any information in any report we may publish that would make it possible to identify participants. To ensure confidentiality I only met with in-person participants in privately reserved locations (such as a reserved library study room). For those who I interviewed on the phone, I spoke to them in the office in my home. All research materials including recordings, transcriptions, analyses and consent/assent documents were stored in a secure locked drawer and will be there for three years in compliance with federal regulations. In the event that materials are needed beyond this period, they will be kept in the locked drawer until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. Once no longer needed the recordings will be deleted and all paper documentation with be destroyed by a cross-cut shredder.

Participating in this study was completely voluntary. Participants could refuse to take part in the study at any time up to March 1st, 2015. A decision to withdraw would not affect participants' relationship with me or Smith College. The decision to withdraw would not result in any loss of benefits (including access to services) to which participants were otherwise entitled. Participants had the right not to answer any single question, as well as to withdraw completely up to the point previously noted. Participants had to notify me of their decision to

withdraw by email or phone by March 1st, 2015. After that date, participant information was to be included in the thesis.

Participants had the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If they had any further questions about the study, they were welcome to e-mail me at transferencestudy@gmail.com or by call me by telephone. If participants wanted a summary of the study results, one was to be sent to them once the study is completed. If participants had any other concerns about their rights as a research participant, or if they had any problems as a result of their participation, they could contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Data Collection

Participants were obtained through snowball sampling methods, word-of-mouth, recruitment posts on social me, and recruiting messages posted on Facebook. I asked professionals I knew in the community to pass along recruitment messages via e-mail to relevant recipients. I assured these professionals that our relationship would not be impacted whatsoever by their ability to assist in recruiting. For contacting and corresponding with potential participants I created an e-mail address for the study: transferencestudy@gmail.com.

I used member checking to ensure that the participants felt accurately represented. To ensure reliability I formulated a set of clear and specific (Steinberg, 2009) questions relating to being a trainee in personal therapy. I used the same questions each time and only deviated when asking the participant to elaborate, asked if there was more to say, or reflected on what they said to ensure that I accurately understood them. The questions were given to the participant ahead of

time so they would have time to consider how they wished to answer them. First I asked the participants to explain their conceptualization of transference. This question illuminated how the participants understood this phenomenon and thus give insight into why they answered the proceeding questions the way they did. In addition, I asked "What has been your overall experience with transference to your therapist?" This question gave me insight into what was happening in the therapeutic relationship on a general level. Later I asked the participants how their identity as future colleagues impacted the transference. The combination of these questions gave my an understanding of how much participants' status as colleagues in the dyad impacts the therapeutic relationship.

The following questions were the official interview guide.

1. How do you conceptualize transference?

2. During your clinical training, what has been your overall experience with transference in your personal therapy?

3. Describe a time when you specifically noticed your transference to your therapist specifically in relation to your status as professionals in the same field.

4. How do you think your identity as a clinician-in-training has impacted your transference to your therapist?

5. When you notice your transference, how do you address it?

6. How do you think your experience with your therapeutic relationship with your personal therapist impacts your own practice?

Participants were additionally asked their age, gender, race/ethnicity, and type of degree they were working on. During the data collection I constantly compared newly collected data to support reliability, validity, and reflexivity.

Data Analysis

After I interviewed the participants, I transcribed the interviews and analyzed them using phenomenological analysis. I analyzed the interviews line-by-line to assess the essence of the interviews. Phenomenological analysis allowed me to look at themes across the summary of participant answers and understand the experience of the individual participant. One detractor of using qualitative methods for for this body of research was that the coding could be subjective, especially since I am a member of the clinician-in-training population and may have a subjective view of the importance of transference.

Findings

The purpose of this study is to explore the experience of transference of clinicians-in-training in personal therapy and how this phenomenon may impact the clinician-in-training's own practice. This chapter contains findings based on 12 interviews with clinical trainees voluntarily in their own personal therapy. In addition participants were required to have aspirations of being psychotherapists. These semi-structured interviews were conducted over the phone, on Skype, in person, and were fully transcribed and coded using phenomenological analysis.

First, demographic information including the race/ethnicity, age, gender identity, and type of degree in progress, were collected from the interviewees. Then six questions were asked regarding how participants conceptualize transference, their general experience of transference in their own therapy, how they they felt their transference to their therapist was impacted by being in the same field, an example of a time when they noticed their transference to their therapist in relation to their status as professionals in the same field, if they address their transference, and how they thought their relationship with their therapist impacted their own practice. Findings resulted in three major themes: conceptualizations of transference, experience of transference in personal therapy, and the impacts of being emerging colleagues. The findings in this chapter will be presented according to these three major themes and their sub-themes.

Demographics

This study included 12 participants, all of whom answered the demographic questions. All participants identified as female (one individual specified being cis-gendered female)

enrolled in Masters in Social Work (MSW) programs. Three individuals (25%) specified that their MSW program had a clinical focus. The respondents' ages ranged between 24 and 40 with a mean age of 31. Six (50%) of participants identified as white or caucasian, three (25%) identified as white and Jewish, one identified as Mexican American, one identified as mixed race/hispanic, and one identified as European American/white.

Though the question was not explicitly asked, many of the participants mentioned how long they had been seeing their personal therapists. Six participants (50%) had been seeing the same therapist since prior to starting graduate school. Two participants (16.7%) had a history of therapy starting prior to graduate school but started working with their current therapist after starting their program, three (25%) started working with their current therapists after starting their programs with their history of therapy being unknown, and the remaining respondent's history with her therapist including when therapy started was unclear. In addition, eleven of the twelve subjects mentioned that their therapist was a women or referred to their therapist with feminine gender pronouns and one mentioned that her therapist was a male. All respondents were given a pseudonym, which is used throughout the study to protect confidentiality.

Conceptualizations of Transference

In order to understand how participants may experience transference, it was first essential to know their general understanding and response to the phenomenon. Subjects were asked questions to draw out their definition of transference and how they viewed its relationship to treatment.

All interviewees stated that transference manifested in feeling and behavior patterns, and the vast majority (n=11) stated that it develops from previous or current relationships with others.

Most participants (n=8) noted that transference was specifically directed toward therapists, while the remaining participants (n=4) stated that transference occurs with all types of relationships. A little less then half (n=4) noted that transference is a tool in treatment, while one person expressed that she felt it interferes with treatment. A respondent referred to as Joan illustrated the general definition of transference that arose from the dataset with the following statement:

> [Transference is] any reaction that a client has to a therapist. So that can be just any reaction, positive or or negative…transference refers to the reactions that a client will have that are, I don't want to say negative, but maybe the therapist will remind them of someone in their life…

In terms of subjects' responses to their transference to their personal therapists, four specifically noted that transference is a helpful tool in their treatment with their therapist, while one stated that it interferes with treatment. A participant called Louisa illustrated her view of transference being a tool in treatment when she shared the following:

> something I say to my patients when I'm explaining how therapy works, I feel like transference makes therapy kind of work like a laboratory in which feelings and dynamics that happen in the patients life can be worked on in the moment from a certain degree of intentionality.

The majority of participants (n=9) stated that when they were aware of the phenomenon occurring or it seemed particularly relevant they brought it into treatment. A participant referred to as Rebecca shared that "I address it pretty directly now but there's also probably a lot of times that I don't notice it because that's part of the nature of transference" while another interviewee called Sylvia stated that "It's usually something that gets addressed. But it's not like, ok, so every

session I talk about my transference. But, every once in a while it's sort of the kind of thing that gets brought up." Two subjects shared that transference was something they brought up on occasion. A participant called Morgan was one of these two people, and in addition she was one of one of two people who shared that sometimes she consulted her peers before discussing her transference to her therapist.

> I just kind of sit on [my transference] but that's when I usually kind of discuss what's going on in therapy with some of my classmates from [school] (…) But I think that having that conversation with other clinicians allows me to figure out "is this something that I need to bring up in therapy and talk about or is it just something I can like work through in these kinds of conversations and get feedback?"

One interviewee shared that she did not address her transference to her therapist, but that her therapist brought it up instead. Two participants shared that they liked the feeling of their transference and did not want to address it. A participant called Penny revealed that "I do not address [my transference] (…) at all…I've thought of it, I like it, so I don't…I really haven't dealt with it."

Manifestations of Transference

 The following section reports the themes that arose when participants shared their experiences with transference.

The transference reported by participants fell into three categories: general transference, positive transference related to being future colleagues, and challenging transference related to being future colleagues. General transference, for the purpose of this study, was operationalized as transference reported by participants that may be experienced regardless of the whether or not

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the patient was an emerging colleague in the field of psychotherapy. Positive transference related to colleague status was conceptualized to be the transference experienced by trainees to their therapist that may be pleasurable in nature. Challenging transference related to colleague status referred to the transference experienced by trainees that is specific to being in the same field as their therapist that may be uncomfortable or cause distress.

General Transference

Most participants were able to identify a root of their transference. The majority of subjects (n=9) mentioned their mothers as being an origin of their transferential responses or their therapists serving as mother figures. Sylvia shared that "I very much feel like my therapist is kind of like my mom." One respondent generalized their experience of transference with her experiences during childhood and another mentioned that her transference was both maternal in nature and related to sibling dynamics. Two people did not explicitly share the root of their transference.

For general experiences of transference, most of the themes that arose were positive in nature. First, the majority of interviewees (n=8) described having their therapist work as a good mother figure. A participant called Jane illustrated this phenomenon by reflecting on the following:

> With my personal therapist, I definitely think there's times where the transference manifests…not that I'm seeking approval but I need those validating feelings similar to what I seek with my biological mother. I like the feeling of being comforted by my therapist the way that I would want my mother to comfort me when I'm going through situations."

An additional notable theme was idealization. Half of the participants either explicitly shared that they idealize their therapist or used idealizing language to describe how they feel about their therapist. A participant called Molly captured idealized feelings toward her therapist by sharing that "I think she's really wonderful, and I really respect her. She's like a good enough mother and we have a pretty honest relationship…overall my transference is really positive and respectful and I guess maybe sometimes idealizing." In addition, a little less then half of the participants characterized their relationship with positive words including warmth and nurturance. Morgan shared the following regarding when she was looking for a therapist and then met hers: "then meeting with her I wanted, I knew that I wanted to feel very nurtured and taken care of." One of these people used the word "love" to characterize her relationship with her therapist, while another shared that a client of hers expressing love and need for her as a therapist helped validate her own sense of love and need toward her personal therapist.

Themes of more uncomfortable general transference arose, but these themes were less salient than those that were positive or pleasurable. Two respondents shared that they had concerns that they were not pleasurable to work with. An interviewee called Dawn stated that "… there'll be times where I'll feel like I'm boring or…my therapist doesn't really want to be talking to me, that I keep talking about the same thing over and over again and she's tired of hearing it." Two participants also reported a desire to feel special to their therapist. Finally, a small amount of participants (n=2) overtly reported that they were curious about their therapist's countertransference.

Transference Related to Colleague Status

In terms of transference that appeared to arise because the patient was a clinical trainee, there were more instances of challenging transference reported (n=27) than positive or pleasurable transference (n=17). This phenomenon will be explored in this section.

In terms of positive/pleasurable transference, half of the respondents reported that they felt admiration for how their therapist professionally conducts themselves, and 25% reported that they aspire to be like their therapist. A participant called Molly captured both of these phenomenon by sharing that "…I also find myself admiring how she's always on time….always…she's just like incredibly reliable and incredibly empathic. And so I find myself finding myself wanting to be, I guess, as wise about humanity as she is." About 25% of respondents shared that they feel validated by the feedback they receive about their field work when it comes up in treatment. Almost half (n=5) participants noted that a positive outcome of their transference is that they had deeper empathy for how their own clients must feel in treatment. A participant called Joan shared how she felt about her own transference in relation to her patients:

> "[Transference in my personal therapy] is good because it…gives you the point of view from being a client *and* a being a therapist so…you kind of are able to see what it feels like to be the client. So that kind of helps you when you're in session to realize that sometimes it's hard for [patients] to disclose things and you can understand and empathize with them a little bit more…because I know how it feels to be in that situation."

There were a number of instances in which participants indicated that their transference to their therapist in relation to their status as emerging colleagues in the same field was uncomfortable in nature. Over half of participants (n=7) indicated that they had fears or concerns that their therapists were judging whether or not they belong in the field or judging their clinical skills. A participant called Jessica captured this experience by mentioning the following:

> I've definitely transferred a lot of…being in training myself makes me feel…more nervous about being judged by my therapist…I think a lot of that is just based…on the reality of [what] I think a lot of people go through when they become therapists, all those feelings of like "oh, am I too fucked up to do the work? (…) or am I just fucked up enough to understand other people…?" all those thoughts.

Four participants shared that their feelings of transference changed or intensified because they were training to be therapists themselves. Louisa, a participant who had been in therapy with the same therapist since before starting her program shared that "this transference feeling I have about her being an adult and me being a child in…this way that feels quite solid for me right now, I don't think that existed before I was trying to learn to be the thing that she does."A little less than half (n=4) of the students brought up the theme of critique— three shared that they had critiques of their therapist while one participant's (recently) former therapist told her that she felt intimidated by the participant. A participant called Anna stated that "there are better ways to do that [intervention] but that's kind of my own transference and feelings. So I think [being a trainee in therapy] makes me a tough critic."

Three respondents expressed discomfort with their status as colleagues in the same field as their therapist. Rebecca, who started treatment with her therapist prior to graduate school, said the following on the subject:

I think I had a fear of the way [me being a trainee] would change our dynamic…instead of me being the one who didn't know anything and she was the expert, which was of course my own transference [and] not something she was trying to set up, but that being able to kind of claim that role as being a peer felt, I don't know, I guess a little scarier and dangerous…"

A small number of participants (n=2) indicated evolving views regarding their therapist's treatment modality and how it intersects with their own practice style. Dawn noted that "I have more respect for the work that [my therapist] does and I definitely view her differently. I view her with more respect but not as *the* authority on things the way I used to" while Rebecca reflected that "I didn't know how to share this common identity with [my clinician] of therapist but potentially develop an identity as a different kind of therapist than she is. It's almost a separation/individuation feeling." Additionally, two respondents stated that at times their therapists offered clinical advice and the respondents sometimes felt it was obtrusive. Morgan reported that "It's almost like [therapy] takes on a supervisory role. I have to bring myself back to 'I'm not here for that, I'm here for me'" and Molly shared "one thing that comes up is that [my therapist] will start trying to act like my supervisor and give me her clinical advice. So I've had to kind of be like 'I just want to tell you this as my therapist, not as a colleague.'" Finally, one participant reported feeling uncomfortable with their therapist's clinical knowledge.

Impacts of Colleague Status

Respondents were specifically asked how they felt their relationship with their therapist impacted their practice. When themes began to emerge it appeared as though there were a number of ways their relationship with their personal therapists impacted practice. It was also revealed that aside from transference, there were a number of ways the participant's status as an emerging member of the field the therapist practiced in impacted their relationship. These two themes are detailed in this section.

Impacts on the therapeutic Relationship

The two most pervasive themes for the impact of being emerging colleagues were attention to skill and the feeling of being colleagues. The majority of respondents (n=8) expressed gaining an understanding of their therapist's interventions and general attentiveness to their clinical techniques. Anna reflected that "[in therapy] sometimes I think to myself, like "I see what you're doing there" and Jane, who had started working with her therapist prior to graduate school, shared shared that "I have a better clinical view of where [my therapist is] coming from whereas before it was like ok, she's just helping me out."

Half of the interviewees mentioned the awareness of being or having fantasies of being colleagues with their therapist. Sylvia commented that "I feel like we're like more in this… colleague realm where she recognizes me as doing the same kind of work that she does and I tell her about clients." Joan shared a somewhat contrasting awareness when she stated the following:

> It's kind of strange to be speaking with someone whose also in the helping profession, so
>
> I think a lot of [my transference]…gets in the way of what I'm comfortable disclosing or

maybe the way I'm comfortable presenting myself to my therapist because sometimes I

see her almost as a colleague because we both do therapy."

In addition, four of the twelve participants shared that their relationship with their

therapist overlapped into their professional life. An interviewee called Mary stated the following:

There's been a couple moments where I'll be thinking about her as a clinician and that

[she] could be my colleague…within the therapists in the community, she knows people

and she knows my own boss" and Louisa shared that "my therapist…teaches at the social

work school that I go to.

Twenty five percent of respondents noted that their dialogue in therapy involved high

amounts of clinical jargon. Jessica illustrated this phenomenon when she shared the following:

I was telling [my therapist] about a guy that I've been dating, and she said 'I think it

would be very useful for you and I to think about so-and-so in terms him being a psychic

object of your creation, obviously a co-creation of who he actually is in reality

objectively but also, if we think playfully and imaginatively in terms of your psychic

objects.' And…I thought to myself, 'I wonder if she talks to non-therapists like that?'"

In addition, 25% of participants expressed that being in graduate school gave them a more

humanized perspective of their therapist. Dawn reflected that "I understand her process better

[now] so I…view her more as someone who's been educated to apply tools and theory in a way

that I would like to one day and less as what she says is the word of god." All three of the

respondents who expressed having a view of their therapist humanized started therapy before

entering graduate school.

A small number of interviewees (n=2) mentioned that their differing theoretical orientations from their therapist impacted their treatment. Jessica shared that with a former therapist, "…I think there was more work we could have done but I relayed that maybe I was wanting more to work relationally with her and that wasn't what she did." Two participants indicated that they do not bring their clinical identity into treatment. Mary shared that "I feel like I really sink into the role as client when I'm [in therapy]." In addition, one respondent mentioned that her therapist normalized the experience of being a trainee.

Impacts on Practice

Participants clearly indicated that their relationship with their therapist had a strong impact on their practice. When asked how the participant felt their relationship with their personal therapist impacted their practice, Jessica replied with, "in every way. I think in absolutely every single way, completely" and Mary shared that "I think it's really important…I think that just being part of therapy myself just allows me to really internalize the process." Nearly all respondents (n=11) stated that their therapist worked as a model for their own practice. Louisa illustrated this phenomenon when she shared that "there's a way in which I'm often… imitating [my therapist], or saying things in a way that are similar to a way that she may say things, or giving myself permission to do something because she has done it." Molly captured the passion many participants expressed while describing how their therapist was a model when she stated the following:

it's both she stands behind me and is kind of my foundation, and she's also (…) inside me

in the sense that her kind of loving acceptance is there with me, and I also feel like she's

in my horizon in the sense that I can look to how she does things to see how I want to do things.

Similarly, the vast majority of interviewees (n=8) indicated that their therapist helped them develop their professionalism in some way. Penny stated that therapy "has made me a better clinician" and Dawn shared that "I think if you have really good therapists, and you're a clinician-in-training, they will help you become more *you*, and your, as a clinician…they'll help you develop your own style based on who you are." In contrast, while reflecting on a moment in which Morgan had an unfavorable experience with her therapist, she shared the following in regards to her own professionalism:

> I remember making a mental not at the time being like 'if a client ever tells me something difficult, for them to share about how they responded to something I said, I need to make sure that I don't make them feel like they need to take care of me…because that's what I felt like I had to do because [my therapist] kept apologizing.

In addition, over half of participants (n=7) shared that their therapist sometimes served as a supervisor. When reflecting on her treatment, Sylvia shared that "I don't use [therapy] entirely supervision but I use [it] like supervision because I haven't gotten great supervision this year. So we're talked about…my casework and stuff with [my therapist]." Jane reported that "sometimes I come to her about things I'm learning in school or things that I'm learning at internship…I go to her for advice because I think she's such a great example…"

Almost half of respondents (n=5) expressed that therapy was a source of empowerment and confidence. Anna shared that being in therapy has "broken down some stigma for me and I

try to bring that across to my clients and my colleagues." In addition, Morgan reflected her own

experiences of having her work empowered by her therapist:

I think of [my therapist] as being a very accomplished child and family therapist, so when

I have received feedback from her that the work that I'm doing with kids is really

wonderful and great, that gives me confidence in doing that work.

A little less than half of interviewees (n=5) reported that they use their personal therapy

to explore their own countertransference to their clients. Jessica stated that "I talk about my

countertransference in therapy all the time. And really find that it's so helpful to work through

my own countertransference in my own therapy." Joan reflected on an instance in which her

therapist helped her navigate her countertransference:

I work at a high school, and so I've had some students who will kind of remind me of

myself when I was in high school….I get a lot of countertransference when they tell me

something, maybe a situation I experienced when I was in high school and I maybe didn't

know how to work through it at that age so I kind of feel like I don't know what to tell

the client. And so there are times when I'll address that in my therapy.

Four respondents indicated that they thought being in personal therapy is a highly

important part of developing as a clinician. Dawn reflected on the complex nature of therapy

being an important tool for clinical development and its intersection with financial privilege

when she shared that "I just don't know how you could do this work without having been in

therapy yourself. but I'm also…aware of the fact that it's costly… it's a privilege, and that a lot

of people don't have access to that…" When discussing therapy as a tool in training, Sylvia

divulged that "I feel like I've learned more about therapy and doing therapy from being in

therapy than I have from any of my coursework….to me being in therapy has really been the best training."

Similarly, three participants shared that being in therapy gave them confidence in the efficacy of the therapeutic relationship. Rebecca stated that because of her own therapy, "[I can] believe in the work even when the patient doesn't yet. [I know] that a relationship with another person can change your life…in particular a therapeutic relationship can change your life in a really particular kind of way." Similarly, Anna reported that "I know what happens in the therapy room from the other side of the table so I know what I hope to bring about from the [therapist] side. I see changes that can occur in myself and have occurred." Finally, two interviewees revealed that their relationship with their therapist influenced them to join the field of therapy. Molly shared that "…my my relationship with her probably effected my choice to apply to clinical social work graduate school and then knowing her really effected how I perceived her once I was in school."

Summary

This chapter reports the themes that resulted from interviews 12 clinical trainees in their own voluntary, personal therapy. Interviewees responded to a set of six questions designed to illicit information about their transference to their to their personal therapist and how their relationship with their therapist influences their own practice. A rich dataset was developed that resulted in three major themes: conceptualizations of transference, experience of transference, and the impacts of therapist and patient being emerging colleagues. The following chapter will discuss these themes and their implications.

CHAPTER V

Discussion

This study was conducted in pursuit of the answer to the following question: what is the experience of transference in the personal therapy of clinicians-in-training and how does this unique therapeutic relationship influence the practice of clinical trainees? In order to answer this question, 12 clinical trainees, all of whom were in MSW programs and voluntarily in their own personal therapy, were interviewed. Participants were asked a series of questions designed to capture the essence of the experience of transference between trainee and their own clinician and how this relationship influences practice. The findings of this study provide new data to the field of social work regarding how trainees conceptualize, respond to, and experience their own transference and how they connect their therapeutic relationship to practice.

The discussion will go over the key three themes, which will be broken into the following sections: conceptualizations of transference, manifestations of transference, and impacts on practice. The findings related to each theme will be compared and contrasted with the content of the literature review. This chapter will also include the strengths and limitations of this study and its implications for the social work field.

Conceptualizations of Transference

All 12 interviewees reported that transference manifested in feeling and behavior patterns, and the vast majority stated that it develops as a result previous or current relationship patterns with others. Most participants noted that transference was specifically directed toward therapists, while the remaining participants (n=4) stated that transference occurs with all types of relationships. The respondents' conceptualizations of the meaning of transference was mostly

aligned with the definition formulated by Levy & Scala (2012), who proposed that the contemporary definition of transference is "a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships" (as cited in Levy & Scala, p. 392).

I anticipated the consistency of these results with the literature. The concept of transference is a signature piece of clinical work that arises in various modalities of psychotherapy (as cited in Gelso and Bhatia, 2012; Beach and Power, 1996) and would thus be taught to trainees in most clinical education settings. In addition, the finding that most participants mentioned their mothers as being the cause of their transferential responses or their therapists serving as mother figures is aligned with the contemporary definition of transference created by Levy & Scala, as mothers are often formative figures in the emotional development of their children.

Manifestations of Transference

Some of the findings derived from the data indicate experiences of transference that are also experienced by patients who are not in the field, including idealization of the clinician or the use of idealizing language to describe the clinician (n=6). This finding was intuitive; trainees are in most ways akin to patients who do not have clinical training in the sense that they have varied psychosocial stressors and relational histories that impact the nature of transference.

In terms of transference that appeared to arise because the patient was a clinical trainee, half of the respondents reported that they felt admiration for how their therapist professionally conducted themselves, and 25% reported that they aspired to be like their therapist. This finding

is somewhat present in the literature, as Rizq (2011) found that therapists in their own therapy develop both personally and professionally from their own treatment. Almost half (n=5) participants noted that a positive outcome of their transference is that they had deeper empathy for how their own clients must feel in treatment. This finding is evidenced in the literature; Gold & Hilsenroth (2009) found that as a result of personal therapy, clinical trainees felt more bonded with their clients.

Over half of participants (n=7) indicated that they had fears or concerns that their therapists were judging whether or not they belong in the field, judging their clinical skills, or a combination thereof. There is little literature on this aspect of trainees' experiences in therapy. The lack of research on such an important phenomenon is indicative of a need for further study. A little less than half of the students brought up the theme of critique— three shared that they had critiques of their therapist while one participant's (recently) former therapist told her that she felt intimidated by the participant. Participants either feeling more critical or their therapists reporting that they feel criticized is indicated in research regarding the countertransference of therapists who see trainees (King, 2011), who reported that they felt their clinical trainee clients were more critical and challenging to work with.

The two most notable themes of the impact of being emerging colleagues were attention to skill and the feeling of being colleagues. The majority of respondents (n=8) expressed gaining an understanding of their therapist's interventions and general attentiveness to their clinical techniques. This finding is similar literature developed by Rizq (2011), who fount that therapists use therapy for professional development. However, Rizq focused on therapists, not clinical

trainees, so this finding is only partially related. More must be known about the experience of the trainee using their therapy for professional development.

Half of the interviewees mentioned the awareness of being or having fantasies of being colleagues with their therapist. In addition, four of the twelve participants shared that their relationship with their therapist overlapped into their professional life. This finding exemplifies the theory developed by Bridges (2011), who postulated that overlap may be common and could create unique considerations. Twenty five percent of respondents noted that their dialogue in therapy involved high clinical jargon. In addition, 25% of participants expressed that being in graduate school gave them a more humanized perspective of their therapist.

Impacts on Practice

Nearly all respondents (n=11) stated that their therapist worked as a model for their own practice. Similarly, the vast majority of interviewees (n=8) indicated that their therapist helped them develop their professionalism in some way. This result is indicated in the literature, as there has been evidence that therapists in therapy used their therapy/therapists to make progressions in their lives and in their own practices (Rizq, 2011). In addition, over half of participants (n=7) shared that their therapist sometimes served as a supervisor. Almost half of respondents (n=5) expressed that therapy was a source of empowerment and confidence. This finding is contrary to the literature developed by Strozier & Stacey (2011), who found that 85% of the student respondents in their study found therapy to be an essential or important part of their social work education. However, discrepancy between these numbers may be due to the fact that participants were not explicitly asked if they felt therapy was an important part of their social work education.

About 25% of respondents shared that they feel validated by the feedback they receive about their field work when it comes up in treatment. This result was also a finding in Stozier & Stacey's work; research indicated that trainees in personal therapy reported generally feeling more confident.

Limitations

There are some aspects of this study that keep it from being generalizable to the United States population of therapists. The participants in this study were exclusively individuals who identify as female, which is not an accurate representation of the variation of gender identities among therapists. In addition, the results of this study are not generalizable due to the fact that 83% of the respondents identify as white or caucasian.

Participants for this study were required to be in personal therapy voluntarily. However, there are programs throughout the country who are required to be in therapy while they are in graduate school (Kumari, 2011). Though the experience of being in mandated personal therapy is likely different from voluntary personal therapy, the lack of these trainees' perspective in this study keeps the results from being generalizable.

This study is limited to individuals earning their MSW. It would have been more holistic if therapists-in-training from other backgrounds had been successfully recruited. In the sixth question, "how do you think your experience of your therapeutic relationship with your personal therapist impacts your own practice,"it would have been better to replace "therapeutic relationship" with "transference." This change would have made the results of the study more consistent and succinct.

It is worth noting that this study was approved by the human subjects review board to research the transference clinical trainees had to their personal therapists and the countertransference therapists have to their clinician-in-training patients. I had intended to interview both groups. However, when I started interviewing clinical trainees I realized that both populations warrant their own body of research. A protocol change was submitted and approved to limit the participant pool exclusively to trainees. This document is available in the appendices.

Implications

The strong response of respondents regarding using their therapist as a model is indicative of a need for further inquiry. I was unable to find any research regarding this topic. If trainees are modeling their therapists' interventions, as a field it is important to learn more about this process so that there may be safeguards for what trainees are bringing to their own practice. The evidence of this phenomenon indicates a that clinicians who treat clinical trainees have a possibly inadvertent dual role of not only providing psychotherapy but additionally shaping the professional identity of these patients.

In addition, the indication that at times the therapist takes on a supervisory role to thee trainee client warrants further investigation. At what point does clinical consultation in personal therapy go from being helpful for professional development to a deviation from treatment? When is it clinically appropriate for therapists to re-direct their trainee patients to their clinical supervisor, if at all? Further research to discover the best practices for therapists treating their future colleagues and how to shape boundaries for these specialized patients would increase the quality of care of these individuals.

Similarly, the fact that idealization of the therapist was present in the experiences reported by 50% of the respondents is indicative of a need to further understand the phenomenon. In the existing literature, the terminology of idealization is varied, with interpretations including being a defense used to keep unacceptable feelings from the conscious and, in self psychology, the idealization of objects is an essential part of the development of the complete self (Melano Flanagan, 2011). It may be fruitful for idealization as a phenomena to be further researched so there can be a cohesive use or categorization of the term. In addition, it may be interesting to survey clinicians on how they do or do not use the idealization of their patients as a tool in treatment.

The large percentage of participants who report a concern that they are being judged by their therapist relating to whether or not they should be in the field because of the material they discuss in therapy may be addressed both at a practice and educational level. In terms of practice, more research must be done in order to develop interventions that may address the specific anxious transference that arises in clinicians-in-training around concerns that their therapist may be judging their ability to be in to therapeutic field. On both a practice and educational level, it appears as though more work could be done to diminish the stigma of being in treatment. I believe humanizing therapists and the fact that at times therapists need treatment could be a fruitful part of the curriculum in psychotherapy programs.

The field of social work has an obligation to provide the best treatment possible to all populations served by social workers, including clinical trainees. This study evidenced that the therapeutic relationship between therapists and their clinical trainee patients is unique and delicate; it provokes transferential feelings in clinical trainee patients that range from idealization

to concerns of being judged regarding clinical abilities. It gives trainees a model for what it means to be a therapist, both good and bad, and provides a space for personal and professional development. This findings of this study indicate a need for further knowledge on topics relating the relationship between trainees and their personal therapists, including countertransference of therapists to these patients, interventions used by therapists that are particular to the trainee client, and how clinical trainees can best be supported as they navigate developing a professional identity in the complex and transformational world of psychotherapy.

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APPENDIX A

HSR Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

November 25, 2014

Aubrey Koch

Dear Aubrey,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

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

Maintaining Data: You must retain all data and other 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.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee
CC: Cara Segal, Research Advisor

APPENDIX B

HSR Amendment Approval Letter

SMITH COLLEGE

School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950   F (413) 585-7994

February 21, 2015

Aubrey Koch

Dear Aubrey,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Cara Segal, Research Advisor

APPENDIX C

Informed Consent Form

The Dyad of Colleagues: Experiences of Transference and Countertransference in the Personal Therapy of Clinicians-in-Training
Aubrey Koch, Smith College School for Social Work

Dear potential research participant,

My name is Aubrey Koch and I am a second year MSW student at the Smith College School for Social Work. I am conducting research on the experience of transference occurring in clinicians-in-training to their personal therapists and the countertransference of therapists to their clinician-in-training clients. This research is being conducted for my thesis.

I am requesting your participation if you are either a clinician-in-training enrolled in a graduate-level counseling, psychology, or social work program with the aspiration to be a therapist and are currently in your own, voluntary personal therapy or you a therapist with a masters-level or higher degree in psychology, counseling, or social work who is either currently seeing a clinician-in-training as a voluntary client or has seen a clinician-in-training as a voluntary client in the past. All participants must be residing in the United States and must believe in the transference/countertransference phenomena. Should you choose to participate I will interview you once either in-person, on the phone, or on Skype regarding your experience with either transference or countertransference depending on your professional status. The interview will be recorded, transcribed, and included in my thesis. After the interview I may contact you via e-mail should I need to clarify something you stated.

The risk associated with participating in this study is that some of the questions may be trigger unpleasant thoughts or feelings.

There are some benefits associated with participating in this study. Participating in this study could lead to further insight into your therapy process. This study may give you an opportunity to explore and better understand your experiences either in therapy or as a therapist. It may also lead to self-discovery, as well as an opportunity to talk about something you may have never felt comfortable talking about. This research may also inform your own clinical practice.

Your participation will be kept confidential. You may pick a pseudonym to mask your identity, or I can pick one for you. All documentation regarding your participation will match this pseudonym. Any other identifying information, including geographic location, and program you are a part of, will not be included in *any* documentation, including notes, information sheets, transcripts, etc. ensure your confidentiality we will only meet in privately reserved locations (such as a reserved library study room). All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure locked drawer for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept in the locked drawer until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. Once no longer needed the recordings will be deleted and all paper documentation with be destroyed by a cross-cut shredder. I will not include any information in any report we may publish that would make it possible to identify you.

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* up to March 1st, 2015 without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any

of your information collected for this study and any recording will be promptly deleted and consent destroyed in a cross-cut shredder. You must notify me of your decision to withdraw by email or phone by March 1st, 2015. After that date, your information will be included in the thesis.

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Aubrey Koch at _____ or by telephone at _____. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

APPENDIX D

Recruitment E-mail

Hello (_____),
Greetings! My name is Aubrey Koch and I am a masters in social work graduate student at the Smith College School for Social Work. I am contacting you because of a referral I received from (referral person), who said that you may be interested in participating in a study I am conducting. I am researching the experience of transference in the relationship between clinicians-in-training and their therapists and how it impacts practice for my masters in social work thesis. The nature of the study is qualitative; should you choose to participate I will be asking you a set of five questions either in-person, on the phone, or on Skype about your experience as a clinician-in-training in therapy. Though the interview time may vary depending on your responses, I am suggesting participants set aside an hour of their time to complete the interview.

I have a couple of questions to ask you before we proceed. First, are you currently in a masters-level or higher program for counseling or clinical social work? Second, are you currently in your own personal talk therapy, or have you been in personal therapy since starting your program? Please note that students who are mandated to be in personal therapy by their institution are not part of the participant pool.

If so, I will forward you a consent form, the set of questions I will be asking, and the definitions of transference I will be using. We can correspond either via e-mail (_____) or by phone about logistics and any questions or concerns you may have.
Thank you for taking the time to read this e-mail; I am looking forward to corresponding with you.
Warmly,
Aubrey Koch
Master of Social Work Candidate A15
Smith College School of Social Work

APPENDIX E

Interview Guide

Transference: "a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships" (Levy & Scala, 2012, p. 392).

Age:
Gender:
Race/ethnicity:
Type of degree:

1. How do you conceptualize transference?

2. During your clinical training, what has been your overall experience with transference in your

    personal therapy?

3. How do you think your identity as a clinician-in-training has impacted your transference to

    your therapist?

4. Give an example a time when you specifically noticed your transference to your therapist in

    relation to your status as professionals in the same field.

5. When you notice your transference, do you address it, and if so how?

6. How do you think your experience of your therapeutic relationship with your personal

    therapist impacts your own practice?