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Therapist as client : revisiting the idea of clinicians in therapy

Laura Elisabeth Mowrey
Smith College

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Laura Mowrey

The Therapist as Client:
Revisiting the Idea of
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ABSTRACT

The subject of graduate students undergoing their own therapeutic process in order to become more competent clinicians is a subject of much debate in the literature. There is evidence to suggest both benefits and risks to clinicians undergoing the therapeutic process.

This study was undertaken to further explore how clinicians perceive their own mental health, if they have been in therapy previously, found it to be helpful, or unhelpful, and if they think that personal therapy should be a requirement for graduate students who are studying to be clinicians.

This was a mixed methods study, which was exploratory in nature. The study was an anonymous online survey consisting of 23 questions. Seventy-eight graduate students and mental health professionals from various mental health disciplines completed the survey.

Major findings include 92.22% of participants had engaged in personal therapy previously, 95.8% found it to be helpful, 94.8% thought that personal therapy would be helpful for graduate students in a clinical program, but only 56.4% thought that personal therapy should be a requirement for students. Future studies may focus on specifically seeking out individuals who found their personal therapy to be unhelpful.

THE THERAPIST AS CLIENT: REVISITING THE IDEA OF CLINICIANS

IN PERSONAL THERAPY

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

Laura Mowrey

Smith College School for Social Work
Northampton, MA 01063
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CHAPTER I

INTRODUCTION

A much debated topic among mental health professionals and researchers is the

relevance of clinician graduate students undergoing personal therapy in order to prepare

for careers as mental health professionals (Garfield & Kurtz, 1976; Guy, Stark &

Poelstra, 1988; Macaskill, 1988). Specifically, the debate centers around the utility of

personal therapy aiding the mental health practitioners professionally (Atkinson, 2006;

Norcross, 2005). There is research that evidences both benefits and risks to clinicians

engaging in therapy in order to achieve greater professional competency (Norcross,

2005). Currently, therapy is not required for most clinicians in training. However,

literature has shown that psychotherapy can increase self-awareness using empathy,

heightened understanding of the therapeutic process, and personal and professional

growth (Macaskill & Macaskill, 1992; Mackey & Mackey, 1994). Furthermore, the most

common reasons for seeking therapy were to aid clinicians in personal and professional

growth (Daw & Joseph, 2007).

On the other hand, in a review of the literature, Atkinson (2006) suggests that

there is little empirical evidence to suggest that engaging in therapy facilitates therapists

in their clinical process with clients. He contends that it may not be necessary for those

with healthy psyches to experience therapy. In fact, he argues that there is more

possibility for risk than benefit to a person entering into therapy solely because it is a requirement for a program. Examples of the harm may be confidentiality and boundary violations on the part of the therapist (Pope & Tabachnick, 1994). Therapy may also be a costly endeavor and may not be accessible to clinicians of limited means. In addition, Bellows (2007) identifies possible negative themes to personal therapy: increased distress, issues with the relationship, mistakes in treatment, identifying too much or too little with the therapist, and role confusion due to alternating from therapist to client.

The current study examined student and mental health professionals' attitudes toward their mental health and if they think that undergoing their own therapy can benefit work with clients. The study assessed if clinicians believe therapy can be helpful or unhelpful to graduate students and if it should be a mandatory requirement for students who are in school to be clinicians.

This study is relevant to the field of social work, because it reexamines clinicians' attitudes about whether they believe clinician graduate students in various disciplines should be required to experience their own therapeutic process, a topic which is a subject of debate. The study also examined clinicians' perceptions of undergoing their own therapy, which types of therapy they underwent and how it was beneficial or harmful.

The study utilized a mixed methods design, applying both qualitative and quantitative measures. The format was an online anonymous survey via Survey Monkey based on questions that I designed. The intent of this study was to expand upon and enhance the existing knowledge base of the topic of clinicians undergoing their own psychotherapy.

This thesis was used to fulfill the requirement for the Smith School for Social Work Master's program. The data collected was used in my master's thesis and may also be used in other publications and presentations.

CHAPTER II

LITERATURE REVIEW

Introduction

The importance of clinician graduate students undergoing their own

psychotherapeutic process as they prepare for their careers as counselors has been a much

debated topic in the literature (Atkinson, 2006; Garfield & Kurtz, 1976; Guy, Stark &

Poelstra, 1988; Macaskill, 1988). Freud was the first person to suggest that people

become therapists because they have their own set of personal problems. Freud was also

the original proponent of personal therapy for psychoanalysts (as cited in Pope and

Tabachnick, 1994; Norcross, 2005). The debate around personal therapy for clinicians

centers around its usefulness in aiding mental health practitioners professionally

(Atkinson, 2006; Norcross, 2005). There is evidence that suggests both benefits and risks

to clinicians engaging in therapy in order to achieve greater professional competency

(Norcross, 2005). For example, therapy can be a useful place for addressing and

resolving personal issues which may interfere with a therapist's work with his or her

client. Some examples of these issues may be, the stress that can be created by being a

therapist, personal lack of understanding of one's own problems and feelings and lack of

understanding of countertransference. (Halewood & Tribe, 2003). Since Freud's time,

numerous studies have supported this notion (Buckley, Karasu & Charles, 1981;

Macaskill & Macaskill, 1992; Pope & Tabachnick, 1994). Guy and Liaboe (1986)

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suggest that there should be more focus on individual counseling for trainees in mental health fields in order to reduce the negative effects that therapeutic work with clients can have on them which can lead to burnout. In Britain, in order to receive the first part of a degree in counseling, trainees must complete at least 40 hours of individual counseling. And for the second part, counseling is recommended (as cited in Halewood and Tribe, 2003). Halewood and Tribe (2003) state

> Personal therapy is thought to be important for a number of reasons: to relieve the stress of practicing therapy, to improve the therapist's awareness of their own problems and areas of conflict, and to help recognize and deal with countertransference issues. (p. 93)

Currently, therapy is not required for most masters of social work programs. However, literature has shown that psychotherapy can increase self-awareness. (Macaskill & Macaskill, 1992; Mackey and Mackey, 1994). Increased self-awareness can enhance a therapist's understanding of why his or her countertransference occurs, which can be of greater benefit to the client. Countertransference can increase negative reactions from the therapist and towards him or her. The greater awareness that the therapist has of why she is having negative feelings, the more likely it will be that she will be able to work through them.

This literature review will examine theoretical articles and qualitative and quantitative studies which have addressed the questions of whether it is beneficial for students and clinicians to undergo counseling in order to be more competent practitioners. I explore the various reasons why therapy may benefit one's ability to be a good counselor, such as gaining self-awareness by understanding one's own countertransference and the phenomenon of projective identification.

First, this paper will examine the benefits of therapy for clinicians. For clarification purposes, I will refer to clinician therapy as "personal therapy". For the most part, various therapeutic techniques will not be differentiated and will be simply referred to as therapy. I will then explore alternatives to personal therapy; indeed counseling is not the only method for increasing self-awareness. Next, I will explore negative countertransference and projective identification. I will then focus on empirical studies which have addressed the outcomes of personal therapy. Finally, I will investigate the debate surrounding therapy as a requirement for graduate students and examine the potentially harmful or negative results of clinicians engaging in their own therapy.

<div align="center">Perceived Benefits of Personal Therapy</div>

A clinician's self-awareness is a central component in his or her ability to be a good and effective therapist. Meeks (2005) states, "self-awareness reduces countertransference interference in the practitioner's work with clients…"(p. 34). A mixed methods study by Williams, Judge, Hill and Hoffman (1997) found that some trainees in a graduate doctoral program used self-awareness to guide them in their work with clients. Self-awareness for the trainees included attentiveness to their feelings during a session, noticing how similar clients' problems were to their own personal issues, and awareness of the countertransference that arose during their sessions.

A qualitative study by Mackey & Mackey (1994) found that clinical social workers believed that their personal therapy enhanced their work with clients around measures of self-awareness, using personal therapy as a guide for their sessions with

clients, empathy, heightened understanding of the therapeutic process, and personal and

professional growth. To further support that personal therapy may be beneficial for

clinicians, in a study of 48 therapists, it was found that 2/3 had been in personal therapy.

The most common reasons for seeking therapy were for personal and professional

growth. On a personal level, therapy was seen as being valuable for self-care.

Professionally, the therapist-client was able to learn from his or her therapist and apply

this when engaging with his or her own clients (Daw and Joseph, 2007).

Other issues addressed in personal therapy may relate to the therapist as a person.

Personally, therapist-clients have reported that psychotherapy can facilitate

"improvement in multiple areas: self-esteem, work functioning, social life, emotional

expression, characterological conflicts, and symptom severity" (Norcross, 2005, p. 843).

All of these factors were enhanced if the therapist felt liked by his or her therapist

(Buckley, Karasu & Charles, 1981).

Previous studies show that the most important aspect of treatment was the

relationship between the therapist and the therapist client (Bellows, 2007; Norcross,

2005). The therapist starts to internalize parts of their therapy that contribute to their

professional development. Bellows (2007) states that the internalization of therapy

becomes the ability to self-analyze.

Bellows (2007) examined the potential for the therapists to internalize the work

with their own therapists. The qualitative study, which involved interviews with 20

psychoanalytic therapists found the majority of participants viewed entering into personal

therapy as being beneficial for their professional work. These therapists were referred to

as the high level of influence group. The participants were Midwestern psychiatrists,

social workers and psychologists who had been mental health professionals for at least 5 years. They had terminated their own personal therapy 5-10 years prior. Those who were most influenced by their personal therapy in their own clinical practices had varying positive experiences in therapy. It was found that a small number of people in the lower level of influence group had unresolved issues with the therapist and had not internalized the therapeutic dialogue.

The therapists who were most influenced by their own personal therapy in their clinical work saw personal therapy as producing some sort of change. Therapists who viewed their previous therapist as someone to model their work after were more likely to think it is important to address interpersonal issues between therapist and client with their own clients (Bellows, 2007). The study found positive themes of how personal therapy enhanced work with clients. These are: the clinicians witnessed an experientially different style of conducting therapy, saw variations in handling countertransference, had the opportunity to model their therapy after the therapist's techniques and viewed the therapist as an internalized mentor.

The major findings of the study showed that participants most influenced by their personal therapy said it contributed to their professional identify and enhanced their interpersonal relationships with clients. Being able to successfully navigate interpersonal conflicts with their therapists influenced whether they viewed the therapists as role models for their professional development. The therapists found they were more likely to admit flaws that increased empathy for their own clients for how difficult personal change is. Good terminations influenced whether or not the therapist saw his or her own therapist as a professional role model and contributed to internalization of the work.

Bellows (2007) reports that the study yielded a number of unexpected findings. For example, if the therapist was more likely to admit flaws and apologize to the therapist-client, then the therapist-client was in turn more likely to admit his or her own imperfections. This can be viewed as a kind of modeling. Through personally experiencing therapy, the therapist-client is more likely to understand that self-change is difficult, which may increase respect for the difficulty his or her clients endure in creating changes in their lives.

The therapist-clients developed a greater understanding of the limitations that therapy imposes. For example, some of the therapist-clients realized that they could not become perfect versions of themselves in therapy, which created greater understanding that they could not make their clients perfect. Having more realistic expectations for themselves would communicate to the clients that they needed to release their own standards of perfectionism. In addition, they had a more realistic view of how much can be accomplished in therapy in general. Good termination led to better internalization of the therapeutic relationship/dialogue. Conflicted terminations led to conflicted feelings about the relationship.

The therapist-clients who conducted the most hours of psychotherapy with their clients had been in personal therapy for the most hours. This suggests that the longer one is engaged in his or her own psychotherapy, there is a reduction in burnout and greater ability to sustain work. Those who engaged in the greatest amount of personal therapy were in the highest level of influence group.

Despite the rich findings, there are many limitations to this study. Therapists may be more biased towards the benefits of individual therapy, because they have chosen to

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make therapy their careers. They may overvalue its benefits. Furthermore, those who agreed to participate in the study may have been proponents of therapy. This supports the notion that there needs to be more studies which specifically seek therapists who viewed their therapy in a negative light or saw the therapy as contributing little to their clinical practice (Bellows, 2007; Norcross, 2005).

In my opinion, the findings in this study in support of personal therapy have implications for people in therapy who may one day become clinicians. If the therapeutic relationship can be modeled and provokes an interest in therapy, budding therapists might treat their clients with respect because they have internalized their work with their own therapists. This has implications for the training of therapists who are interested in social justice and the client as the expert perspectives. However, this does not answer the question of how potential therapists might be influenced or deterred if they have negative experiences in therapy.

A study by Halewood and Tribe (2003) provides further support for clinicians in personal therapy. In a comparative, quantitative study of counseling psychology trainees and post graduate students, it was found that trainees are more susceptible to narcissistic injuries, which can be detrimental personally and to their clinical work. Examples of these narcissistic injuries are, lack of mirroring, difficulty setting boundaries, perfectionist tendencies and limited self-understanding. It is suggested that people drawn to the clinical field may have a high level of narcissistic injuries. They may not have had adequate mirroring by their own parents and as therapists may seek mirroring and validation from their clients. Narcissistic injuries can increase burnout, drop-out rates, and may negatively affect work with clients. (Halewood and Tribe, 2003). The authors

suggest that one way for trainees in mental health fields to address their narcissistic

injuries is to undergo psychotherapy in order to increase self-awareness. The authors

imply that the postgraduate group may have had fewer narcissistic injuries because they

were required to undergo 40 hours of therapy in order to receive their degrees.

Barnett (2007) conducted a qualitative study with 9 therapists who operated from

a psychoanalytic framework to gather their opinions regarding why they had entered the

field. The author found themes of entering into the profession because of childhood loss

or loneliness, a history of depression and attempting to satisfy early, unmet narcissistic

needs through work with clients. The author states that it is difficult for therapists with

narcissistic injuries to handle negative transference, as they are often unwilling to work

through interpersonal problems with clients. In addition, therapists may wish for clients

to idealize them, or see them as the parental figure that they did not have growing up.

The author implies that when therapists reach a point where they can look at the reasons

why they entered the field more objectively, they can begin to assist others in a more

helpful way. The author poignantly states, "Therapists need to be able to acknowledge

the client in themselves" (p. 269).

Barnett (2007) also addresses the issues of narcissistic needs in therapists.

Therapists may be projecting their own needs onto clients. The author suggests that

therapists may also be entering into the profession because of unfilled childhood sadness

or loneliness. They may see the bond with clients as being intimate and may prolong the

work unfairly for the client. These issues can be dealt with in personal therapy and in

supervision. Barnett (2007) states that therapists must address their own narcissism:

Narcissistic needs are always present in infancy and early childhood and may be met through 'good-enough' environment and parenting. If, however, unfavorable circumstances prevent that from happening, the effects may persist, unconsciously into adulthood, resulting in characteristics of intolerance and failure, grandiosity and cravings for love and attention. (p. 267)

Therapists with narcissistic conflicts may have perfectionist tendencies that could interfere with their work. As children, they may have become parentified because of their own parents' narcissism, which caused them to become attuned to the wants and feelings of others. These children may have developed a false sense-of-self that stems around catering to others' needs. (Glickhauf-Hughes & Melhman, 1995). Thus, they may enter into the field to help foster a sense of identity. Barnett (2007) states that many who enter into the profession are wounded healers. People must understand what is behind the wounds, how the wounds motivate them to enter into the work and they can use that knowledge to be of assistance to others.

Schumacher Fineel (1985) suggests that therapists' supervisors can try to point out issues, like narcissism, that clinicians may struggle with and try to work with them around these issues. If this is not effective, the clinicians can enter counseling. If counseling is not effective, it is recommended that perhaps the person not be in the field, because they might not be effective in working with their own clients' issues of narcissism (As cited in Halewood and Tribe, 2003).

Despite promising results, such studies as the above mentioned are extremely challenging to conduct due to numerous confounding factors, such as difficulty in measuring clinician and client attitudes and then correlating the two. Most studies which examine if personal therapy can enhance therapists' work with clients are flawed due to

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small samples, are poorly controlled and use subjective measures of client outcome. (Norcross, 2005).

Alternatives to Therapy

Supervision may be an alternative to personal therapy. An Australian study conducted with 316 psychotherapists showed that 96% of the participants engaged in psychotherapy supervision. The number of times per month that the participants engaged in supervision varied. Interestingly, there are several variables, which correlated with frequency of supervision; these are: clinicians who engaged in more personal therapy, had more client hours, and are female (Grant and Schofield, 2007). The authors state,

> …the fact that the learning is custom made to the individual struggling with a problem, and the notion that supervision can be an anecdote to burnout, staleness and grandiosity are significant reasons to continue to encourage a culture of supervision. (Grant & Schofield, 2007, p. 11)

This study also suggests that personal therapy and supervision are complimentary to each other in terms of aiding the therapist in his or her work. However, in considering supervision over personal therapy, it is important to take Schore's (2003) neurobiological contributions to the field of psychotherapy into account. Schore (2003) suggests that the dyadic relationship of supervisor and clinician may not create the same emotional corrective experiences as in psychotherapy, which can create change in the new clinician.

Traditionally, many clinicians have received psychotherapy in order to analyze their own internal processes, but with increased costs of analysis and limited time, this is not a reality for many mental health care professionals. Meeks (2005) discusses infant observation as an alternative to clinician psychotherapy to facilitate self-awareness.

Infant observation is the process of observing an infant in its natural environment over time. The purpose of this observation is to gain mindfulness skills by being present in the moment. This process helps the clinician to be more focused, attuned, and present during a therapy session and more likely to be able to identify and recognize countertransference. The author states, "This is important for all people working in teaching and caregiving professions, all of whom are taught the importance of self-awareness but given few tools for accomplishing it" (Meeks, 2005, p. 35). She raises an interesting point, as self-awareness is an abstract and subjective concept and therefore, difficult to teach. Meeks also discusses the role that supervisors and cohorts can play in developing a clinician's self-awareness. Although the idea of clinicians participating in observation seminars is intriguing, I can see some inherent problems in the system. If a clinician has little self-awareness of her or his countertransference, what are the chances that she or he would agree to endure such a process? In other words, if one does not believe one has a problem, why would s/he participate in the intervention? This problem would apply to a clinician's decision to enter into personal therapy as well.

Awareness of Countertransference and Projective Identification

Self-awareness and understanding one's countertransference are important for conducting good therapy. An article by Green (2006) discusses the importance of acknowledging hate that therapists sometimes feel for their clients. This article identifies the importance of therapist self-awareness and if the hatred is not confronted, it may conjure feelings of shame, guilt and incompetence in the therapist and will perpetuate an inability to cope with this in the client. Green (2006) also discusses that if the therapist is

able to experience hate, then the client will too. The therapist can model experiencing hate for the client. Clinician therapy can help to facilitate understanding and awareness of such powerful emotions.

Schore (2003) discusses the ways in which transference and countertransference occur on a neurobiological level. Transference and countertransference must be examined from a neurobiological perspective because they are often unconscious processes which affect states of regulation in both the client and the clinician (Schore, 2003). Personal therapy helps to regulate affect, and attunement to client affect happens through clinicians' own emotional attunement. The client often utilizes the transference for unmet self-object needs. Schore (2003) states "…when the self-object seeking dimension is in the foreground, the analyst must *resonate* at the deepest layers of his/her personality to be sufficiently available to the patient's developmental and self-regulatory needs" (p. 50). Schore (2003) suggests that personal therapy can aid in the clinician developing a more robust sense-of-self to become a suitable self-object for the client.

Therapists must also be tuned into projective identification as they could be silently colluding with their clients' negative views of themselves, or procedurally creating enactments of both their and clients' negative life experiences. Schore (2003) states, "Klein's concept of projective identification attempts to model how an unconscious system acts as a 'transmitter' and how these transmissions will then influence the receptive functions of the other unconscious mind." (p. 55).

Because of the intersubjective, unconscious right-brained processes that occur between client and clinician, Schore (2003) argues that a clinician's own psychotherapy is fundamental for heightened attunement to the clinician's clients. In order for a

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clinician to sit with the powerful feelings that arise in clients, a clinician must be able to tolerate and accept these states of affect. Much of this ability stems from past experiences that the clinician has had and his or her own attachment styles. This also involves the unconscious messages that one received in one's own family about the acceptability of emotions. Personal therapy can help to facilitate and strengthen emotional attunement within the clinician and intersubjectively between the clinician and client.

Do Therapists Believe Personal Therapy is Valuable?

Interestingly, previous studies have shown that most licensed professionals believe therapy to be beneficial. In a recent study conducted by Pope and Tabachnick (1994) of 800 psychologists, 84% of psychologists surveyed had undergone therapy previously, 86% of these found it to be helpful and only 2% found that it was not helpful. The therapists found it to be most helpful for increasing self-awareness and self-knowledge. Despite that most found their therapy to be helpful, 22% of therapists also found their personal therapy to be harmful in certain capacities. Examples of harm are perceived confidentiality violations by their own therapists and therapy being a mandatory requirement for their programs, thus not having had a choice regarding being in personal therapy. Most of these psychologists believed that therapy should be a requirement for graduate programs. Another empirical study of 855 clinical psychologists found that 63% had previously been in therapy (Garfield & Kurtz, 1976). Of the 855 psychologists, 45% believed that therapy should be required for practicing clinicians, 62% thought that therapy was very or moderately important for psychology

students, 15.5% believed therapy would not be helpful and less than 1% thought therapy would be harmful. Not surprisingly those who had been in therapy previously found it to be more relevant than people who had not and were more likely to recommend it. Finally, people who practiced from a psychoanalytic orientation found personal therapy to be more relevant than people who practiced from a learning theory framework (Sol & Richard, 1976). Another study found that psychodynamic, psychoanalytic, person-centered and eclectic therapists are likely to be proponents of personal therapy (Lucock, Hall & Noble, 2006). Therapists who operate from a Cognitive Behavioral framework were least likely to view personal therapy as important.

It is important to note that results have varied among clinicians' feelings about the importance of psychotherapy, depending upon whether the therapist is experienced or relatively inexperienced. For example, the study conducted by Pope and Tabachnick (1994) found that in a survey of 800 psychologists, only one third believed that mandated therapy would be helpful for a clinician after receiving an ethical violation. A survey of psychologists by Guy, Stark and Poelstra (1988) found that 22% of those surveyed had never received individual psychotherapy, which is thought by the authors to be the most relevant modality for resolving personal issues. The authors question why practitioners of therapy are hesitant to enter into the same treatment services that they provide for others. This suggests that there may be a lack of confidence in the techniques that the clinicians are practicing. The study also found that psychodynamically oriented practitioners were more likely to be in psychotherapy, both during training and after beginning their careers. The authors state, "Such individuals may recognize the importance of their own emotional health for the integrity of the treatment they provide"

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(Guy et al., 1988, p. 475). Another finding of the study is that clinicians who practiced

from an eclectic framework were more likely to have been in therapy before entering

their profession. Finally, the study found that clinicians who were in therapy before

graduating were more likely to continue therapy into their careers. The results of this

study suggest that the theoretical orientation from which a clinician operates may

determine how relevant they perceive therapy for themselves and/or others to be.

Another study conducted by Macaskill and Macaskill (1992) with psychotherapy

trainees showed that 87% of participants reported that therapy was moderately to very

helpful in their work as clinicians and in their personal lives. The trainees' most common

goals were personal growth and resolving personal conflicts. This would imply that

trainees seek therapy in order to resolve some personal problems before they begin their

careers, which could ultimately better serve their clients. On the other hand, in a review

of the literature of 30 years of empirical studies, Macaskill (1988) found that 15-40% of

psychotherapist trainees found their own personal therapy to be unsatisfactory in some

respects.

The Ongoing Debate for Students and the Risks of Personal Therapy

Despite the above theoretical arguments for clinicians to seek therapy, most

graduate programs do not make psychotherapy a prerequisite for a degree. Atkinson

(2006) argues that therapy should not be mandatory for training programs and there are

other methods of obtaining some of the above benefits of therapy. In a review of the

literature, Atkinson (2006) suggests that there is little empirical evidence to show that

being in therapy makes therapists more effective. In fact, he argues that there might be

more risk than benefit to a person with a healthy psyche who is entering into therapy solely because it is a requirement for a program. He makes the argument for a requirement such as a therapeutic group as opposed to personal therapy. In my review of the literature, I have noticed that most of the literature places emphasis on being in individual personal therapy. Atkinson (2006) states that personal therapy should be not be mandatory for training programs because of the empirical studies which have found that it can be harmful. Examples of the harm may be confidentiality and boundary violations on the part of the therapist. (Pope & Tabachnick, 1994). In addition, Bellows (2007) identifies several negative themes: increased distress, issues with the relationship, mistakes in treatment, identifying too much or too little with the therapist, and role confusion due to alternating from therapist to client. To further expand upon this, I believe the empirical studies suggest that the skill level of the therapists conducting the personal therapy with therapist's clients is difficult to measure. If the therapist-client is working with an inept clinician, will there be fewer personal and professional benefits?

Norcross (2005) argues for the importance, but not the requirement of personal therapy. He states that in the face of evidence based practice techniques, psychotherapy has lost some of its humanity (Norcross, 2005). The author states that the therapeutic relationship and the psychotherapist as a person may hold as much clout as practicing with evidence based treatments. In Europe, most countries require personal therapy to become a therapist (Norcross, 2005). In a review of the literature of the past 25 years, Norcross (2005) identified several significant findings. First, there are few programs in the US that make therapy a requirement; however, some psychoanalytic institutions do. Research shows that nearly ¾ of all mental health professionals surveyed have been in

their own therapy (Norcross and Guy, 2005). Personal therapy can refer to group, couples therapy, etc. The review also found that therapists have been in therapy three times as much as the general American public (as cited in Norcross, 2005). The author states that few studies have been conducted that examine at which stage(s) in their lives/careers therapists choose to enter into personal therapy.

Interestingly, the author states that qualitative studies provide more support for personal therapy providing change for clients, including increase in empathy and less dislike of clients. To contrast this finding, a separate study found that the amount of time a therapist spends in personal therapy did not correlate with their own clients' personal change over time (Sandell, Carlsson, Schubert, Grant, Lazar and Broberg, 2006).

In a study conducted by Norcross and Guy (2005), 1%-5% of the participants reported that their personal therapy was harmful to some extent. Regardless, this represents a small percentage of mental health professionals. Norcross (2005) continues to provide support that therapists most valued the personal relationship they had with their therapist.

A literature review by Norcross, Strausser-Kirtland & Missar (1988) found six major recurring themes that contribute to professional development. These are: 1) improving one's sense of well-being, self-care 2) increasing awareness of the intersubjective processes between themselves and their therapist which translates to awareness of this in their own work 3) Reducing stress levels 4) internalizing his or her therapist as a role-model 5) understanding the perspective of being the client 6) experientially observing their own therapist's skills (as cited in Norcross, 2005, p. 844).

Conclusion

The above topic regarding clinicians in therapy led to an interest in clinicians'

perceptions of their own mental health, their self-awareness, and whether clinicians

should undergo their own therapeutic process. Further clarification about clinicians'

attitudes towards graduate students working towards becoming clinicians going through

their own therapy is warranted. The current study will examine clinicians' attitudes

toward their mental health, if they think that undergoing their own therapy can benefit or

harm work with clients, and assess if they believe psychotherapy should be a mandatory

requirement for students who are in school to be clinicians. Although obtaining

clinicians' opinions about these subjects will not determine whether therapy should or

should not be a requirement for graduate students, it is important to assess clinicians'

viewpoints.

My study will interview clinicians from multiple disciplines and will make

comparisons based on professions, degrees and various demographics. It is noteworthy

that in my literature, I was only able to locate one study which focused specifically upon

clinical social workers (Mackey and Mackey, 1994). In addition, my will assess the

theoretical framework from which the clinicians operate. It will be interesting to see if

my results parallel those of previous studies (Lucock, Hall & Noble, 2006; Norcross,

2005) that cognitive behavioral therapists believe that personal therapy is less beneficial

than those practitioners who are psychoanalytically oriented. In addition, most of the

studies in this literature review were conducted in the United Kingdom. It will be

interesting to see if my study yields participants from other countries so that their

perceptions may be compared to the perceptions of American practitioners.

Few studies have focused on experienced therapists' perceptions of being in psychotherapy (Bellows, 2007). The majority of studies have focused on how novice therapist students are influenced by personal psychotherapy. For purposes of this study, I will compare experienced versus novice therapists' ideas about being in personal therapy.

I will examine how therapists have found personal therapy to be helpful or harmful based on personal and professional reasons. Professionally, I will examine if clinicians believe personal therapy has contributed to awareness of countertransference and transference as the literature has indicated this knowledge is paramount to being a competent clinician. (Schore, 2003).

This study is relevant to the field of social work, because it further examines attitudes and opinions about whether clinician graduate students in various disciplines should be required to undergo their own therapeutic process. This has been a much debated topic in the past and although individual therapy is not mandatory for most mental health programs in the United States, this policy could easily change.

CHAPTER III

METHODOLOGY

The current study examines clinicians' attitudes toward their mental health and their beliefs about ways undergoing their own therapy can benefit work with clients as well as assesses if they believe psychotherapy should be a mandatory requirement for students who are in school to be clinicians. I hypothesized that most clinicians would have participated in some form of therapy, would believe that personal therapy would be helpful for graduate students, but should not necessarily be a requirement. I also hypothesized that mental health professionals who conduct psychodynamic work with clients would have been more likely to have been in therapy than practitioners of behavioral therapies, policy makers and administrators.

The study used mixed methods employing both qualitative and quantitative measures. The study design was simple: an online anonymous questionnaire via Survey Monkey based on questions I designed informed by findings from previous studies. The survey was distributed to participants after undergoing review and approval by the Human Subjects Review Board at the Smith College School for Social Work.

Sample

The only prerequisite for the study was that the participant be a mental health professional or a graduate level student in a mental health field. There were no specific

study requirements for demographics such as gender, race or ethnicity. All participants were above age 18. The end sample size was an N of 78, and I had originally stipulated in my Human Subjects Review Form that I would obtain at least 60 participants. (Six participants had to be removed from analysis because they began the survey, but did not complete it).

The clinicians were recruited via the method of snowballing. Most graduate students were recruited from the Smith College School for Social Work (SSW). I posted a cover email to my cohort on www.facebook.com containing a link to my survey and, in addition, requesting that they forward the email to any clinician or student contacts they may have. Some clinicians were recruited through my current internship at Wardenburg Health Center's Psychological Health and Psychiatry Services at CU Boulder. I sent an email cover letter with a link to my study to mental health practitioners within the agency. The email cover letter and survey link were sent to the members of the SSW Alumni Students of Color Committee. In addition, the survey was posted on the Psychodynamic Research listserv and the Society for Personality Assessment listserv. Finally, I sent the mental health professional email to friends and other mental health professional contacts that I have, requesting that they forward my email to their contacts. The study did not recruit specifically for clinicians of color or white clinicians, however, attempts were made to solicit a diverse group of people. An email asking for a diverse representation of people was posted to my page on www.facebook.com. I also emailed the listserv moderator for the National Association of Puerto Rican and Hispanic Social Workers; however, I did not receive a response.

The method of sampling was purposive- that is looking for highly specific individuals: a clinician population. The cover letter and link to the survey were posted to the above links twice. Originally, I had planned to post on the above websites three times; however, I quickly reached 60 participants and deemed it was not necessary to post three times.

Procedures

The questionnaire, informed consent and cover emails were reviewed and approved by the Human Subjects Review Committee at the Smith College School for Social Work. Once the study was approved, emails were sent to the participants described above.

If a potential participant clicked on the link to the survey, s/he was immediately taken to the informed consent page. Participants did not have the option to continue unless they acknowledged that they had read and understood the terms of the consent page. The consent indicated that participation in the study was voluntary, confidential and anonymous. Participants were given the option to download and print a copy of the consent to keep for their records. The informed consent also explained standard research protocol, such as keeping the data for a minimum of three years in a locked and secure location.

Risks of participating in the study were thought to be minimal. However, the participants were informed that some of the questions may cause mild personal discomfort. A list of resources was not given to the participants given they were a

clinician population and it was deemed that the questions would cause minimal discomfort.

Participation in my study was brief. Subjects completed an online survey consisting of 23 questions, which was estimated to take between 15 to 30 minutes to complete. In order to increase response rates, the survey was short. (Please refer to appendix B for the survey instrument.

The data collection instrument was an online questionnaire on the website: www.surveymonkey.com. The interview questions were designed to assess opinions about psychotherapy being a requirement for graduate students working towards licensure. It also addressed if the clinician has had their own therapy, the importance of self-awareness, and clinicians' opinions regarding if personal therapy impacted their awareness of countertransference and projective identification. Examples of survey questions include, "Do you think personal therapy can be helpful for graduate students entering into a clinical field?" and "Do you think therapy should be required for graduate students entering into a clinical field?"

Some questions were yes/no/don't know questions, some were multiple choice and others operated according to a Likert Scale rating system. While the survey was fixed, I enclosed a dialogue box, so the participants could elaborate on each question if they felt they had more to say. I also assessed for race, ethnicity, gender and geographic region and then broke these demographics down in my analysis to compare these variables to the body of the survey answers. The clinicians were also asked to identify the field in which they work, or if they are a student.

Data Analysis

I gathered narrative data through open-ended dialogue boxes where participants could choose to expand upon any question. My rationale behind this was that I would like to provide a richer narrative of some of the participants' experience, and at the same time, gather quantitative data. Demographic data was collected by asking the participant to self-identify for race and ethnicity and choose from categories from other demographic variables, such as age, sex/gender and geographic region.

Descriptive and inferential statistics were used to analyze the quantitative data. Inferential statistics were used to analyze the demographic data and descriptive statistics to analyze the body of the survey. Content analysis was be used to code the narrative data. The narrative questions are analyzed for themes and coded. Responses of graduate students and working mental health professionals were compared.

CHAPTER IV

FINDINGS

Overview: Major findings

Quantitative results of the study were analyzed in SPSS and yielded descriptive

and inferential statistics. A total of 78 participants completed the survey. (Six

participants had to be removed from the survey because they began the study but did not

complete it). The major findings of the study were that 92.2% of respondents identified

that they had engaged in personal therapy and 7.8% of participants stated they had not

been in therapy previously. Of the therapists who had/have been in personal therapy,

95.8% of the therapists believed that their personal therapy was helpful. The above

results include both working mental health professionals and graduate students. Only 1

respondent said personal therapy was not helpful and 2.8% of participants stated they

were unsure if it was helpful.

Regarding clinicians' opinions about the usefulness of therapy for graduate

students, 94.9% of all participants thought that therapy would be helpful for graduate

students in a clinical program, 3.8% said they were unsure if therapy could be helpful,

56.4% of total respondents thought that therapy should be a requirement for graduate

students, while 30.8% thought that therapy should not be a requirement. More people

appeared to be undecided about this question than other questions on the survey, with

12.8% stating they were unsure if they thought therapy should be a requirement.

Therapists were given the option to expand upon their answers to these questions, which will be discussed in qualitative themes at the end of this chapter.

Demographics: Age, Gender and Race

A total of 78 participants completed the survey. Sixty-five (83.3%) participants indicated their age. Thirteen people, or 16.7%, declined to answer this question. The average age was 37.2 (standard deviation = 12.72). The range of ages was between 23-82 (see Table 1, Graph 1). Fifty-four (67.9%) self-identified as female, 24 (30.8%) identified as male and 1 participant (1.3%) identified as other (see Table 2, Graph 2).

The participants were asked to self-identify their race for purposes of this study. It is important to note that these categories were interpreted and compiled by me for statistical analysis. Thus, the actual breakdown of race is in Table 3 given that some of the category assignments I created were subjective. For example, a person who identified as Indian and Asian and a person who identified as African-American and Caucasian were both assigned to the category of bi-racial. Seventy-five participants (96.2%) indicated their race; 3.8% declined to answer this question. The breakdown of racial categorizations resulted in the following: 80.8% self-identified as Caucasian, 4% of the respondents self-identified as African-American, 3.8% identified as biracial, 3.8% indicated that they self-identified as multi-racial, 2.6% identified as Asian, and 1.3% (n=1) identified as other.

The ethnicity category was not analyzed in the SPSS program. Respondents answered in multiple and diverse ways that were difficult to categorize. In order not to

generalize, the results were not compiled into quantitative categories. Reports of

ethnicity are listed in Table 4.

Geographic Location

Ninety-one percent of participants indicated the geographic region in which they

practiced; 9% did not answer this question. Twenty-seven percent of respondents

indicated they were practicing or were students in the Northeast, 25.6% in the Midwest

5.1% indicated they were practicing in the Northwest, 16.7% practice in the Southwest,

6.4% in the Southeast, 3.8% outside of the country, and 6.4% stated "other," which

thematically indicated either that the participant had moved to different regions

throughout his or her career or that I did not include an option specifically for "the West".

This question became convoluted because there was not a place to indicate if the

participants had practiced in multiple regions throughout their careers, so several of the

participants resulted in indicating this information in the "other category". Therefore, all

these results were compiled into a general "other" category with location not being

specified.

Mental Health Professional or Student

Seventy-three percent (n=57) of the respondents identified that they were

clinicians, and 26.9% (n=21) identified they were students. It is critical to note that these

numbers are approximate and may not be entirely accurate. Some respondents seemed to

be confused about how to categorize themselves. There were eleven respondents who

answered that they were both clinicians and students of social work and psychology in

questions pertaining to their area of focus, e.g. social work or psychology. Therefore, for

purposes of data analysis, respondents who indicated a specific profession were counted

as clinicians and respondents who did not specify a profession were counted as students.

It may be concluded that some participants considered themselves to be both students and

clinicians. Another possibility is that respondents may have been unsure about the survey

design and checked off both categories out of uncertainty. Therefore, it is impossible to

determine with certainty if the participants who answered in both categories were mental

health professionals or students. Please refer to Tables 5-8 for full results of mental

health professionals and students.

Of the clinicians, 34 (59.6%) identified being in psychology, 14 (24.6%)

identified as social workers, 7 (12.3%) identified as being in psychiatry and 2 (3.5%)

identified as other (see Table 5, Graph 3). Of the students, 69.7% (N=23) identified as

being psychology students and 30.3% (N=10) identified as being social work students.

Psychology students and professionals were both masters and PhD level (see table 7). It

is noteworthy that there were no respondents who indicated that they were in the

psychiatric nursing field. In addition, there were no psychiatry students who participated

in the survey.

There was much overlap among answers for work context. Many people

indicated that they worked in multiple areas. Thirty-six percent (n=28) of participants

were in private practice, 33.3% (n=26) were students, 33.3% (n=26) were in teaching,

26.9% (n=21) were in research and 17.9% (n=14) identified as other (refer to Table 8).

Of the clinicians who indicated that they worked in an agency, 50% (n=39) said they

were in clinical practice, 17.9% (n=14) said they were supervisors, 2.6% (n=2) said that

they were policy makers and 2.6% (n=2) said they were program administrators (see

Table 9).

<center>Orientation</center>

Many participants selected multiple options for theoretical orientation as well.

Forty participants (51.3%) indicated they practice psychodynamic/psychoanalytic theory.

Twenty-seven (34.6%) people said they practiced cognitive behavioral psychology (CBT

or DBT), 24 (30.8%) said they have an eclectic orientation, 5 (6.4%) have an

intersubjective orientation, and 4 (5.1%) have a neuroscience orientation. Twenty-seven

(34.6%) practice individual therapy, 14 (17.9%) practice family therapy and 10 (12.8%)

practice group therapy. These are the main orientations that clinicians selected, although

there were other options from which to choose (see Table 10, Graph 5). In addition, I

hypothesized that practitioners of psychotherapy would be more likely to engage in

personal therapy then practitioners of behavioral therapy; however, there were not

enough practitioners of cognitive behavioral therapy, or participants who had not engaged

in therapy previously to run this hypothesis of difference.

<center>Personal Therapy</center>

Ninety-two percent (n=72) of the respondents have engaged in personal therapy;

five (7.8%) have never engaged in therapy. (See Table 11, Graph 4). Of the participants

who had been in therapy, 69 (95.8%) found it to be helpful, 2 (2.8%) were undecided if it

was helpful and 1 (1.4%) found it to be unhelpful. Sixty-eight (94.4%) said that they

entered therapy for personal reasons and fifty-nine (81.9%) for professional reasons.

<center>32</center>

Nineteen (26.4%) entered therapy for family reasons and 16 (22.2%) of respondents

indicated that they entered therapy because of a crisis (see Table 12). Similarly to the

parameters listed above, there was much response overlap with these questions.

Approximately half (44.4%) of participants had engaged in therapy for 1-5 years, 15.3%

for 2-6 months, 13.9% for 5-10 years, 13.9% for 10+ years and 11.1% for 6 months to 1

year. (See graph 6 for a visual representation of these numbers).

Ninety-four percent of participants said therapy was helpful for their personal life;

81.9% indicated it was helpful for professional life (see Table 13). Most (98.6%)

indicated that personal therapy improved their work as a clinician, 82.1% of participants

stated it increased awareness of the clinician's own feelings, 82.1% stated that personal

therapy gave them an increased sense of self-awareness, 67.9% said it helped to give

them an increased self-esteem and integrity, 64% said it helped them to understand

countertransference better, 51.3% said it was helpful in terms of greater awareness of

projective identification and 50% said it helped to decrease their stress levels (see Graph

7).

How Clinicians Rate their Practices

Forty-seven (60.3%) clinicians rated their work as highly successful, 30 (38.5%)

rated their work as somewhat successful, and 1 (1.3%) rated their work as neutral. It is

noteworthy that there were no clinicians who rated their work as being unsuccessful.

Types of Therapy in which the Clinicians Engaged

The main types of therapy in which the clinicians engaged were eclectic (n=24;

30.8%), psychoanalysis (n=21, 26.9%) and Cognitive Behavioral Therapy (n=15, 19.2%).

This first result is difficult to interpret because the therapy may have been eclectic due to the fact that the therapy itself was eclectic or the clinicians saw a number of therapists, all who engaged in different techniques. Some of the lesser percentages that participants engaged in were marital counseling (n=6, 7.7%), family counseling (n=5, 6.4%), and supportive counseling (n=18, 23.1%). It is noteworthy that none of the therapists had engaged in DBT (see Table 16 for full results).

Do Clinicians' Contacts also Engage in Personal Therapy?

Most (n=76, 97.4%) said that their colleagues/friends/other contacts had engaged in some sort of therapy. Forty-eight (61.5%) respondents said they believed that this was helpful for their colleagues' work, 29 (37.2%) stated that they did not know if this could be helpful and 1 (1.3%) said that they did not believe it was helpful (see Table 13).

The following section addressed how the participants saw personal therapy as being helpful or unhelpful for their colleagues. I wanted to investigate if the therapists found personal therapy to be helpful to their colleagues for the same reasons that they found their own therapy to be successful. The major findings of this section were that 86.5% (n=67) of participants thought that therapy was beneficial for their colleagues in that it contributed to increased self-awareness, 67.3% (n=35) thought it contributed to increased integrity and self-esteem, 59.6% (n=31) believed it contributed to decreased stress levels. These percentages are consistent with those regarding how therapists found therapy to be personally helpful (see Graph 7).

Training with Students

Approximately 1/3 of clinicians (n= 26, 33.8%) conduct training with clinicians in training and 20.5% (n=16) conduct therapy with clinicians in training. In order to compare answers between students and mental health professionals, cross tabulations were performed. Of the participants who found therapy to be helpful (n=21), 100% of the students said that they found their own personal therapy to be helpful, and 73% of professionals said that they found therapy to be helpful. Three professionals indicated that they either did not know or did not think therapy is helpful. Six people did not answer this question. There were no major differences in the way that mental health professionals and students responded to questions.

Comparisons were made between graduate students and mental health professionals on various study questions. A significant difference was found in the mean age of professionals and students ($t(52.59)$= -7.0502, p=.000 two-tailed). The professional group had a mean age of 41.43 and the student group had a mean age of 26.68. A significant difference was found among the gender of participants by whether they were a student or a professional (chi square $(1,77)$= 11.54, p= .001 [continuity corrected]). One-hundred percent of the students were female compared to 57.1% of the mental health professionals. A chi square could not be run to determine if there were significant differences among race because the group categorizations were too small. (Race results are listed in table 3).

A chi square test could only be run to look at difference among graduate students and professionals in terms of therapy being required for graduate students. No significant

difference was found on this measure between the two groups. There were no significant differences found in how students and clinicians responded to questions.

<div align="center">Qualitative Themes</div>

Following is a list of qualitative themes that emerged from the open dialogue boxes.

What Therapists Gain from Personal Therapy

Most people chose not to elaborate upon their responses and most of the quotes were brief. However, several qualitative themes emerged from the open dialogue boxes, which were not included in the original multiple-choice questions. These new themes involved elaborating on therapy as enhancing professional work. There were not enough responses from student and clinician answers to divide them in to separate categories and compare results, therefore the themes were analyzed generally combining student and clinician responses.

The following themes are based on the responses of mental health professionals and students. Seven people indicated that they found personal therapy to be helpful because they were able to see how it felt to be a client, which in turn, gave them a better sense of what their clients' perspectives might be.   Following is a quote from a participant that exemplifies this point:

"Being in my own tx helped me not only empathize with the experience of the clients, but find new methods and approaches in my work with clients. It gave me a better

understanding of what it's like to be in a room and share with someone your stories, allow yourself to be vulnerable, and the challenge and rewards of making changes in your life."

The second theme was that several therapists were able to view their own therapist as a role model and model aspects of their own work after their therapist's style. Following is a quote from a respondent that demonstrates this theme:

"My therapist was a great model--she helped me see what a good therapist looks like".

Opinions Regarding Graduate Students in Personal Therapy

The theme that was most prevalent around therapy being helpful for graduate students is having the experience of knowing what it feels like to be a client. This theme was similar to the one above found for clinicians in their own therapy:

"I think it's important to have the experience of being a client - and the vulnerability and power dynamics inherent in the role of a client - before being in the role of therapist."

Therapy as a Requirement for Training

In general, people seemed unsure about whether therapy should be a requirement for graduate students. This seemed to stem from a number of different reasons. Below are several quotes that exemplify this point. A participant who had not previously engaged in therapy stated:

I have a highly supportive family/social network, and therefore did not reach the crisis level that would lead me to seek therapy. If someone does not

have material to work with, that they are not addressing elsewhere in their life, then therapy should not be forced upon them

Other participants stated: "Cost is a major issue for graduate students and psychotherapy is expensive so requiring psychotherapy doesn't really seem like a viable option unless the program plans to pay for it."

"While in general I think that this is a good idea for clinicians, I would not want it to become mandated. I would be concerned how this information might be used by programs e.g., limits of confidentiality".

CHAPTER V

DISCUSSION

Introduction

The main purpose of the study was to reexamine the idea of therapists undergoing their own therapeutic process. In addition, further clarification about clinicians' attitudes towards graduate students working towards becoming clinicians going through their own therapy was warranted. The study is relevant to the field of social work, because it reexamines clinicians' attitudes about whether they believe clinician graduate students in various disciplines should or should not be required to experience their own therapeutic process. This idea is a topic of debate and this policy varies and changes based on graduate program and country. In addition, I hypothesized that practitioners of psychotherapy would be more likely to engage in personal therapy then practitioners of behavioral therapy, however, there were not enough practitioners of cognitive behavioral therapy, or participants who had not engaged in therapy previously to run this hypothesis of difference. This was a mixed methods study design, utilizing both quantitative and qualitative data. The study was exploratory in nature and obtained clinicians' viewpoints on a variety of subtopics within the overarching topic of therapists in personal therapy. The main study questions were: do therapists think that personal therapy is helpful or unhelpful and in what ways? Do therapists think that undergoing their own therapy can benefit or harm work with clients? Regarding graduate students in therapy, the main

questions were: how do clinicians perceive the utility of personal therapy for graduate students in mental health programs and do they believe that therapy should or should not be a requirement for graduate students? Based on the findings obtained in the literature review, the main hypotheses were that the majority of clinicians would have engaged in personal therapy and that they would have found it to be a helpful experience for both personal and professional reasons. The study was primarily exploratory in nature and did not specify any hypotheses of difference.

Summary of Findings

The main findings of the study were that the majority of participants had both engaged in personal therapy and found it to be helpful. These results are consistent with many of the findings in the literature review, which were that therapists found personal therapy to be a positive experience, both in terms of personal and professional reasons. Most therapists thought that therapy could be helpful for graduate students, however only 50% of respondents thought that therapy should be a requirement. However, clinicians are somewhat divided if they think that therapy should be required for students entering into the field. Qualitative themes emerged from the open-dialogue box in response to this question. Of the clinicians who did not think personal therapy should be required, they thought so because of the coercive nature of a requirement. However, most respondents thought that therapy should be encouraged and strongly recommended. Several participants discouraged mandatory therapy because of the financial constraints for students and how this may be difficult for some students to finance. Of those who

thought it should be a requirement, they strongly felt that part of being a competent therapist is having had the experience of being a client.

Another interesting finding is that one hundred percent of the graduate students were females as opposed to 57.1% of the mental health professionals. A future study might specifically recruit men or women to study the same measures and then compare results among genders. Given that most people who enter into the social work profession identify as female (Schilling, Morrish & Liu, 2008), it would be interesting to obtain data on males who work in the field and their opinions about engaging in the therapeutic process.

It is interesting that not as many clinicians indicated if their colleagues had engaged in personal therapy and the ways in which they found it helpful and unhelpful as they indicated for themselves. One interpretation of this is that clinicians may not discus the details of personal therapy with other clinicians. They simply may not know about their colleagues' experiences in personal therapy. The subject may be too personal or even stigmatized among clinicians. Corrigan (2004) discusses how mental health care is associated with stigma and the implications for who seeks and does not seek mental health services. Also personal therapy may be more common among certain populations of clinicians. It would be worthwhile to conduct a study surveying how clinicians from various racial and ethnic groups perceive personal therapy and how much they disclose their personal therapy experiences to colleagues.

About half of the clinicians identified that they were in clinical practice exclusively. The results may have differed if they focused on various aspects of being a mental health professional, such as being an administrator or policy maker. An

interesting finding is that there were no clinicians who indicated that they had engaged n therapy for Dialectical Behavioral Therapy, yet 15 participants or 19.2% indicated that they practice behavioral therapy. This begs the question, does the type of therapy that one engages in need to be consistent with the modality that one practices?

Many of the participants seemed to be eclectic in their practices indicated by the fact that such a large number or respondents answered that they drew from various theoretical frameworks.

Many of the respondents were practicing in the Midwest and stated that they were psychologists. Most likely, they were recruited from the psychology listservs on which the study was posted. This may indicate a biased sample, as many of these participants indicated that they practice from a psychodynamic orientation and are at least PhD level clinicians. In addition, many of the students were recruited from the Smith College School for social work, which is psychodynamic in nature. The finding from the literature review that imply that psychodynamic practitioners are more likely to be proponents of personal therapy (Lucock, Hall & Noble, 2006) may be indicative of this result. It is noteworthy that most of the participants indicated that their orientation was psychodynamic, although there was only one practitioner of CBT who indicated that he or she had not previously engaged in personal therapy. It would be interesting to specifically seek out practitioners of behavioral therapists and then compare these results.

Many people indicated that they are supervisors for clinicians in training. As supported in the literature review, the supervisory relationship may be viewed as an alternative to personal therapy in order to gain greater self-awareness, better understanding of countertransference and one's internal process. (Meeks, 2005).

Strengths

The main strength of the study is that it produced results that are consistent with major findings reported in the literature review. In addition, the study received a large number of respondents (n=78), which provided multiple viewpoints and voices. Furthermore, the study obtained both quantitative and qualitative data, which produced both statistical and descriptive results. This enabled the respondent's opinions to be summarized statistically, but also gave voice to their stories.

Limitations

It is important to note that there were eleven respondents that were difficult to determine if they were clinicians or students. In retrospect, some questions on the survey may have been somewhat ambiguous, and respondents may have been unsure how to answer. On the other hand, some students may also define themselves as clinicians, if they have previous experience or practice therapy during internship. Please refer to the survey (which is in Appendix B) for examples. The instrument could have been constructed in a way that made this question clearer. For example, surveys on the Survey Monkey website can be designed to automatically skip to a different section if the question is not applicable to a particular respondent. The question of clinicians' history in therapy does not address multiple episodes of therapy, and having various therapists; this question inherently assumes that the clinicians were in one episode of therapy. In

hindsight, I would have specified that this question pertain to the clinician's most impactful episode in therapy.

It would appear that most of the people thought that the reasons proposed in the survey were beneficial to their work as clinicians, however people who thought therapy was helpful may have chosen to fill out this survey and people who did not find it to be helpful may have chosen not to participate in the study or may have declined to answer the survey questions.

The results of the study may not have high validity because of the way the participants were sampled. The method of snowballing did not ensure a random sample of clinicians. A great majority of the clinicians appeared to practice from a psychodynamic theoretical orientation. For example, the results may have differed if more clinicians had operated from a behavioral perspective. In addition, clinicians who endorse personal therapy may have been interested in this topic, and therefore chose to take the survey. Clinicians who had not engaged or who did not find personal therapy helpful may not be representative in this sample.

In addition, although efforts were made to recruit for diversity, this study does not have a diverse representation of people in terms of race. Most of the clinicians in this study self-identify as Caucasian. Different results may have been obtained with a more diverse sample of people. In addition, the validity may be low, because some of the survey questions seemed to be ambiguous to people.

Many people indicated that they gained greater awareness of their feelings, greater self-awareness and a better understanding of projective identification from engaging in personal therapy, however the fact that set answers were there for the

clinicians to choose from may have influenced how they answered this question. This

may be a limitation of the study. The ideas discussed in the dialogue boxes may have

been influenced by the set answer choices in some questions.

There were few clinicians who answered negatively about their experiences in

therapy. It would be interesting to further investigate some of the negative themes that

emerge in the therapist-clinician client dyad. Furthermore, it is important to note my own

biases in conducting this research topic. As a proponent of personal therapy, I may have

influenced the set answer questions with my bent. Similarly to the limitation listed

above, people who are proponents of therapy may have chosen to take this survey. A

future study might advertise for clinicians who have not engaged in therapy previously,

or who have had negative experiences in therapy.

The findings of this study are consistent with those in the literature. A more

controlled sample will help to further support or examine alternative viewpoints to

personal therapy being a useful tool for being a clinician. Future studies might focus on

comparing how often novice and experienced clinicians engage in therapy, given that this

question was not addressed in the scope of this study and there were no significant

differences among student and mental health professional responses.

Conclusions

Personal therapy can be useful to a clinician for a number of reasons including,

increased self-awareness, better understanding one's own feelings and the client's

feelings, increased self-esteem and overall well-being. In addition, personal therapy can

have negative consequences such as confidentiality violations, violations of boundaries

and can be costly. While only some clinicians believe that personal therapy should be a

requirement for graduate students in a mental health field, most agree that it can be

helpful for a graduate student as a means to becoming a more effective and competent

clinician.

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APPENDIX A

List of Tables

Table 1

<u>Age of Participants</u>

Age	Frequency N= 65	Valid Percent	Percent
23	4	6.2	5.1
24	1	1.5	1.3
25	1	1.5	1.3
26	2	3.1	2.6
27	4	6.2	5.1
28	7	10.8	9
29	6	9.2	7.7
30	5	7.7	6.4
31	3	4.6	3.8
32	2	3.1	2.6
34	1	1.5	1.3
35	2	3.1	2.6
36	3	4.6	3.8
40	4	6.2	5.1
41	2	3.1	2.6
44	2	3.1	2.6
45	1	1.5	1.3
46	1	1.5	1.3
47	1	1.5	1.3
48	1	1.5	1.3
49	1	1.5	1.3
50	1	1.5	1.3
52	1	1.5	1.3
53	1	1.5	1.3
54	1	1.5	1.3
56	1	1.5	1.3
58	2	3.1	2.6
62	1	1.5	1.3
66	1	1.5	1.3
67	1	1.5	1.3
82	1	1.5	1.3

Table 2

Participant gender

Gender	Frequency N=78	Percent	Valid Percent	Cumulative Percent
Female	53	67.9	67.9	67.9
Male	24	30.8	30.8	98.7
Other	1	1.3	1.3	100
Total	78	100	100	

Table 3

Self-Reported Racial Identity

Racial Identity	Number of participants N=78
African American	1
Anglo	1
Asian	1
Asian American	1
Asian Indian	1
Black	2
Caucasian	34
Caucasian and American Indian	2
Caucasian/ "although recently found I am mixed race"	1
Multi-racial (American)	1
Multiracial Black American	1
White	29
Missing	3

Table 4

Self-Reported Ethnicity

Ethnicity	Number of Participants N=78
African American	1
African, Swedish, Irish, Native American	1
American	2
Anglo	1
Anglo-American	1
Asian Indian	1
Caucasian	9
Caucasian American, Jewish	1
Danish-Italian	1
English/Scottish	1
Euro-American	1
European	2
European American	5
German American	2
German, Romanian	1
Hispanic	1
Irish	1
Italian and Irish and French Canadian	1
Jewish	6
Korean	1
Mixed/English-German (Cree-Creole)	1
Multi-ethnic (American)	1
Non-Hispanic	1
Northern European	2
Other	1
Pakistani	1
Polish American	1
Polish/Croatian	1
Scotch-Irish, Polish	1
Scottish-Irish	2
White	3
White, Non-Hispanic	2
Yankee	1
Missing	20

Table 5

Profession

Profession	Frequency N=78	Percent	Valid Percent	Cumulative Percent
Social Work	14	17.9	24.6	24.6
Psychology	34	43.6	59.6	84.2
Psychiatry	7	9	12.3	96.5
Psychiatric Nursing	0	0	0	0
Other	2	2.6	3.5	100
Total	57	73.1	100	
Missing	21	26.9		
Total	78	100		

Table 6

Self-Reported Professional Degree

Degree	Frequency N=57	Percent	Valid Percent	Cumulative Percent
MSW	13	16.7	22.8	22.8
MA Psychology	4	5.1	7	29.8
PhD Psychology	10	12.8	17.5	47.4
MD	5	6.4	8.8	56.1
PsyD	1	1.3	1.8	57.9
MA Counseling Psychology	2	2.6	3.5	61.4
PhD Clinical Psychology	9	11.5	15.8	77.2
PsyD Clinical Psychology	2	2.6	3.5	80.7
Other	4	5.1	7	87.7
PhD	6	7.7	10.5	98.2
MA	1	1.3	1.8	100
Total	57	73.1	1.8	100
Missing	21	26.9		
Total	78	100		

Table 7

Student Profession

Student Profession	Frequency N=33	Percent	Valid Percent	Cumulative Percent
Social Work	10	12.8	30.3	30.3
Psychology	23	29.5	69.7	100
Psychiatry	0	0	0	0
Psychiatric Nursing	0	0	0	0
Total	33	42.3	100	
Missing	45	57.7		
Total	78	100		

Table 8

Work Context (Check all that apply)

Work Context	Number of participants	Percent
Private Practice	28	35.9
Research	21	26.9
Student	26	33.3
Teaching	26	33.3
Other	14	17.9

Table 9

Agency Work Context (Check all that apply)

Agency Context	Number of Participants	Percent
Clinical	39	50
Policy Maker	2	2.6
Program administer	2	2.6
Supervisor	14	17.9

Table 10

Type of Therapy Practiced (Check all that Apply)

Type of Therapy Practiced	Number of Participants	Percent
Eclectic	27	34.6
Family	14	17.9
Group	10	12.8
Individual	27	34.6
Intersubjective	5	6.4
Neuroscience	4	5.1
Psychodynamic Psychoanalytic	40	51.3
Relational	25	32.1
Don't Know	1	1.3
Don't Have One	2	2.6
Existential humanism	4	5.1
Other	11	14.1
Behavioral CBT DBT	27	34.6

Table 11

Ever Been in Therapy

Personal Therapy	Number of Participants N=78	Percent
Yes	71	91
No	6	7.7
Missing	1	1.3
Total	78	100

Table 12

Reasons Why Participants Entered Therapy (Check all that Apply)

Reasons	Number of Participants	Percent
Crisis	16	20.5
Family Reasons	19	24.4
Personal Reasons	60	76.9
Professional Reasons	35	44.9
Requirement	2	2.6
Other	1	1.3

Table 13

How therapists found therapy to be helpful (Check all that Apply)

Reasons	Number or participants	Percent
Personal Life	68	87.2
Professional	59	75.6
Other	2	2.6

Table 14

Helpful to graduate students

Helpful	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	74	94.9	96.1	96.1
Don't know	3	3.8	3.8	100
No	0	0	0	0
Missing	1	2.3		
Total	78	100		

Table 15

Should therapy be required for graduate students?

Require	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	44	56.4	56.4	56.4
No	24	30.8	30.8	87.2
Don't know	10	12.8	12.8	100
Total	78	100	100	

Table 16

Types of therapy in which clinicians engaged

Type of Therapy	Frequency	Percent
Brief Dynamic	15	19.2
Cognitive	7	9
Cognitive Behavioral Therapy	15	19.2
Dialectical Behavioral Therapy	0	0
Eclectic	24	30.8
Family	5	6.4
Grief Counseling	2	2.6
Group	5	6.4
Hypnotherapy	1	1.3
Marital Counseling	6	7.7
Psychoanalysis	21	26.9
Supportive	18	23.1
Other	11	14.1

List of Figures

Graph 1

Age

Graph 2

<u>Gender</u>

Gender (N=78)

Other

Male
31%

Female
68%

Graph 3

Type of Work

Type of Work

Social Work 18%

Missing 27%

Other 3%

Psychiatry 9%

Psychology 43%
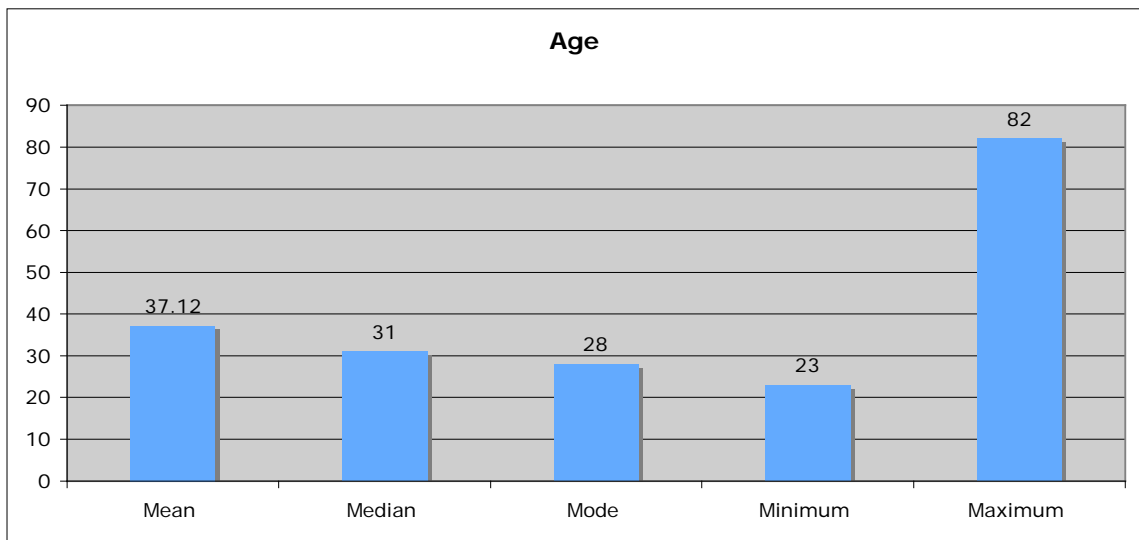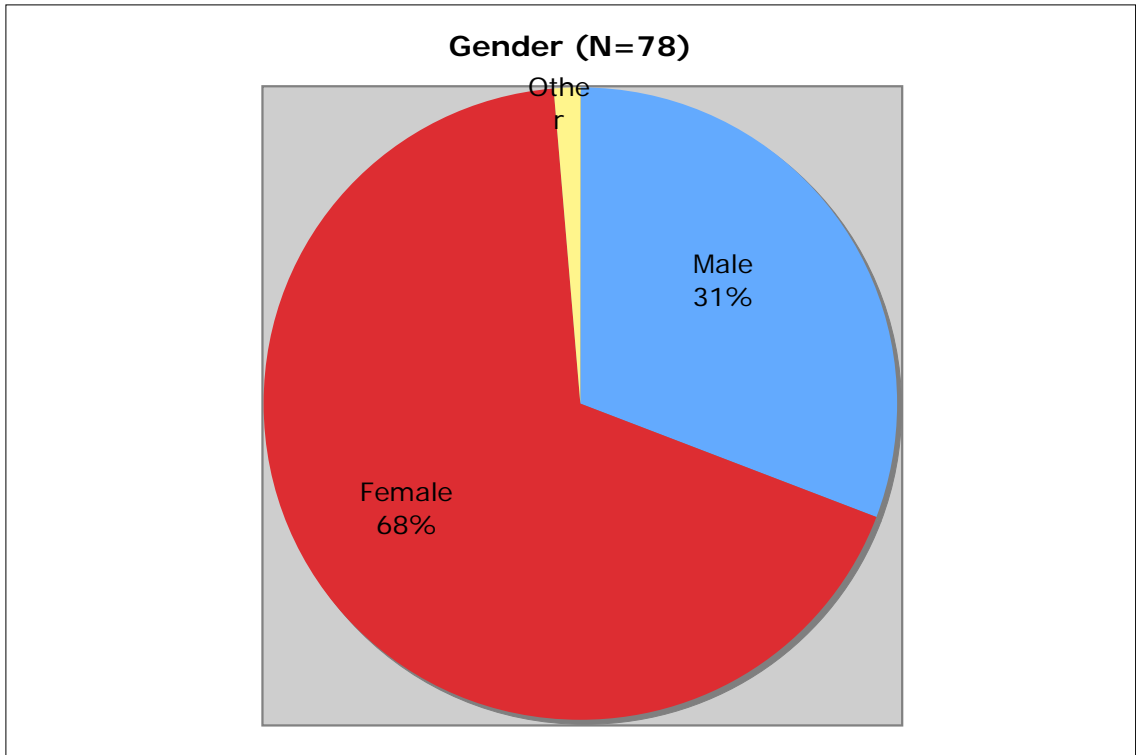
Graph 4

Ever Been in Therapy

Ever Been to Therapy

No
8%

Yes
92%
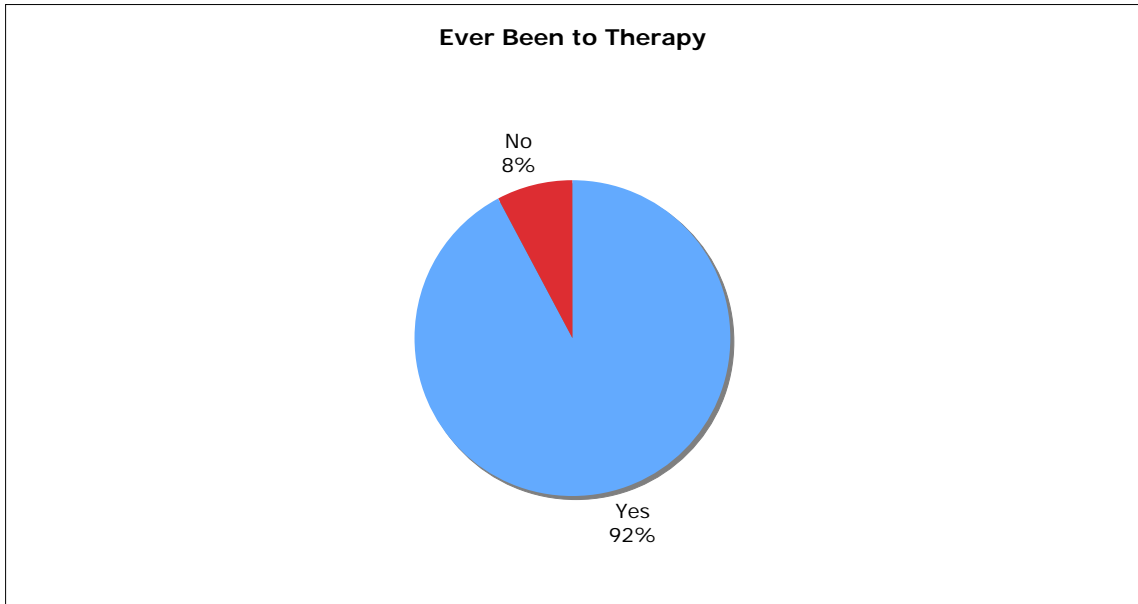
Graph 5

Types of Therapy Practiced

Type of Therapy Practiced

Category	Percent
Behavioral CBT DBT	34.6
Other	14.1
HUMEXI	5.1
Don't Have One	2.6
Don't Know	1.3
Relational	32.1
Psychodynamic Psychoanalytic	51.3
Neuroscience	5.1
Intersubjective	6.4
Individual	34.6
Group	12.8
Family	17.9
Eclectic	34.6

Percent Practicing
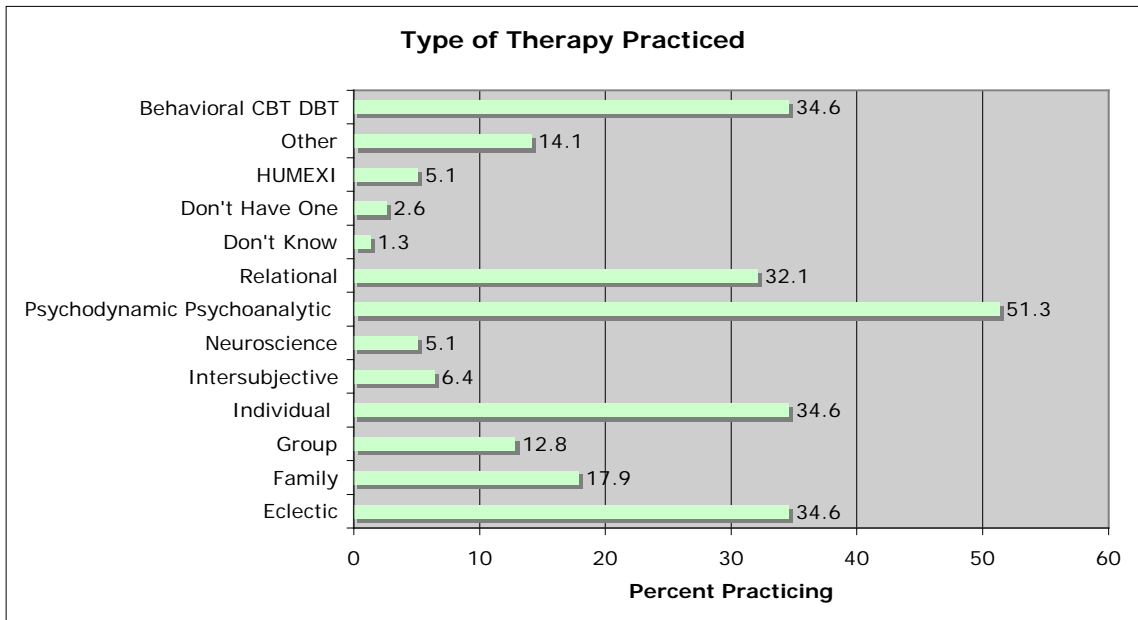
Graph 6

How Long Have you Been in Therapy

How Long in Therapy

Category	Percent
less than 2 months	1.3%
2-6 months	14.1%
6 months to 1 year	10.3%
1-5 years	41%
5-10 years	12.8%
10+ years	12.8%
Missing	7.7%
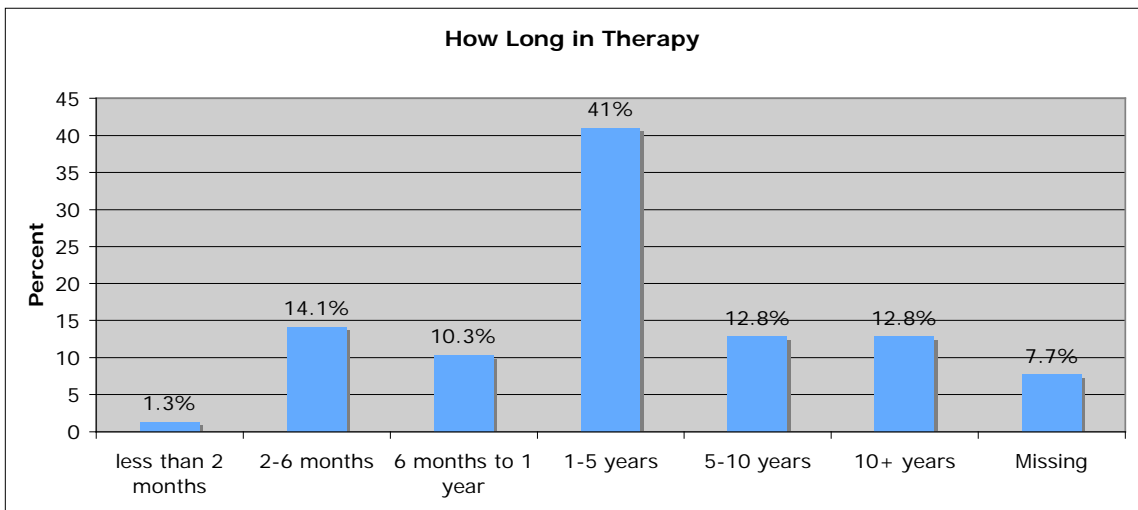
Graph 7

How was Therapy Helpful?

How Therapy Helpful

Category	Percent
Other	~13%
Reduced stress levels	~50%
Increased self-awareness	~82%
Increased integrity, self-esteem, self-efficacy	~68%
Greater awareness of Transference countertransference issues	~64%
Greater awareness of projective identification of client's own feelings	~51%
Greater awareness of own feelings	~82%

Percent checking yes
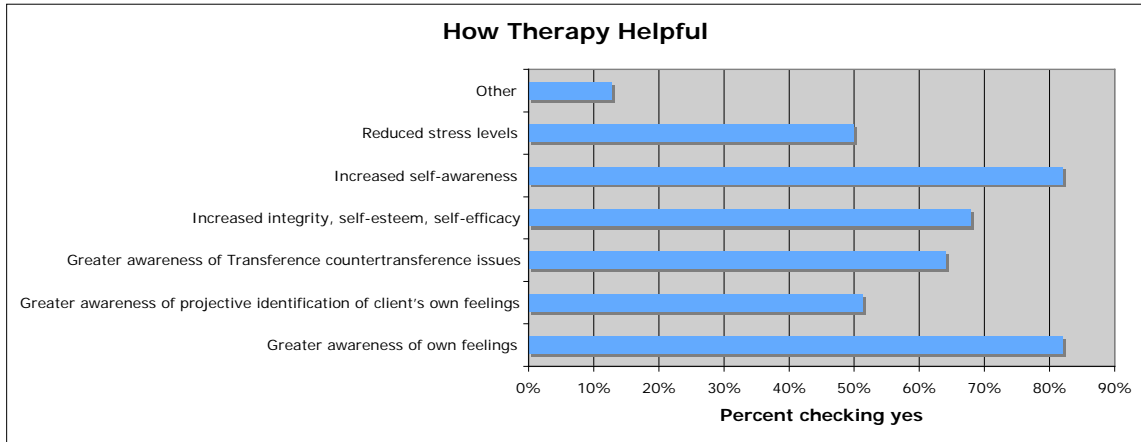
APPENDIX C

Informed Consent

Dear Participant:

My name is Laura Mowrey and I am a master's degree candidate at the Smith College School for Social Work. I am completing an independent research project as part of the requirements for my degree, and I would like to invite you to participate. My study will explore clinicians' perceptions of having benefited from a personal therapy experience either in training or otherwise, and will ask their opinions about whether they believe individual psychotherapy should be mandatory or beneficial for trainees and/or seasoned clinicians. The data collected will be used in my master's thesis and may also be used in other publications and presentations.

In order to qualify, you must be a professional in a mental health field or a graduate student in a mental health profession. Your participation in the study will consist of completing an online survey including 23 brief questions and will take between 15-30 minutes, however you may take as little or as much time as you need.

There are no known risks of participating in this study, although you will be asked to answer some slightly personal questions, which could make some individuals uncomfortable. You may choose, however, not to answer any question at any time. Your participation in this study is voluntary, anonymous, and confidential.

Benefits of this study may include a greater understanding of the psychological processes that clinicians undergo, which may in turn benefit and enhance services provided to clients. Financial compensation will *not* be provided for your participation.

Your involvement in this study will remain anonymous, and confidentiality guidelines will be followed at all times. You will not be asked to identify yourself. All data (notes, flash drives and questionnaires) will be kept in a secure location for a period of three years as required by federal guidelines and the data stored electronically will be protected. Should this researcher need the materials beyond the

three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed. The preliminary data will be shared with my thesis research advisors at the Smith College of School for Social Work. In presentations, the data will be presented as a whole and when brief illustrated vignettes or quotes are used, they will be carefully disguised.

Participation in this study is completely voluntary. There is no penalty for refusing to answer any or all questions. Because the data is anonymous, it is not possible to withdraw from the study after the data has been collected. So please be aware that once you submit your responses, they become a part of a larger pool of data and cannot be reliably retrieved. **You may download a copy of this consent form if you wish to keep a copy for your records.** If you wish to contact me for any further questions, I can be reached at (617) 921-1090. Should you have any concerns about your rights or about any aspect of the study, please do not hesitate to call me at the above number or you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY CHECKING "I AGREE", YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

☐ **I AGREE**

APPENDIX D

Human Subjects Review Letter of Approval

March 7, 2009

Laura Mowrey

Dear Laura,

Your revisions have been reviewed and all is now fine. We are glad to give final approval to your study. You did a particularly good job in grounding your study in a very even handed presentation of the literature. You also have planned extensive and I hope effective recruitment strategies.

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.

Good luck with your project.

Sincerely,

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

CC: Jill Clemence, Research Advisor

Survey Instrument

A. Demographic Information:

1. Age:

2. Profession: (If a student, please skip to 2b.)

        a) Social work
        b) Psychology
        c) Psychiatry
        d) Psychiatric Nursing
        e) Other

2a. Please self-identify your degree: _____

2b. Student of:

        a) Social work
        b) Psychology
        c) Psychiatry
        d) Psychiatric Nursing
        e) Other

2c. Please self-identify your anticipated degree:_____

3. Region working/studying in:

Country:

If USA:
        a) Northeast
        b) Northwest
        c) Southwest
        d) Midwest
        e) Southeast
        f) Other: Specify

4. Sex/gender:

        a) F
        b) M
        c) Other

5. Race: Please self-identify

6. Ethnicity: Please self-identify

B. Survey

7. In what context do you work? (Check all that apply)

        a) Agency:
        -Clinical, Policy maker, Program administrator, Supervisor
        b) Private practice
        c) Research
        d) Student
        e) Teaching
        f) Other: Option to specify

8. What is your primary theoretical orientation? (Check all that apply)

        a) Behavioral (CBT, DBT)
        b) Eclectic
        c) Family
        d) Group
        e) Individual
        f) Intersubjective
        g) Neuroscience
        h) Psychodynamic/Psychoanalytic
        i) Relational
        j) Don't know
        k) Don't have one
        l) Other: write in

9. Have you ever been in therapy? (If no, please skip to question #15)

        a) Yes
        b) No

10. If yes, what prompted you to enter into therapy? (Check all that apply)

        a) Crisis
        b) Family reasons
        c) Personal reasons
        d) Professional reasons
        e) Other:

(Box to elaborate)

11. How long were you/have you been in therapy?

        a) less than 2 months
        b) 2-6 months
        c) 6 months-1 year
        c) 1-5 years
        d) 5-10 years
        e) 10 + years

12. Did you/do you find it helpful?

        a) Yes
        b) No
        c) Don't know

12a. If you engaged in personal therapy, for what reasons (check all that apply)?

        a) Personal life
        b) Professional
        c) Other:

(Box to elaborate)

12b. If no (#12), please elaborate.

13. Did personal therapy improve your own work as a clinician?

        a) Yes
        b) No
        c) Don't know
        d) Other: specify

14. If yes, how so (Please check all that apply)?

a) Greater awareness of own feelings
b) Greater awareness of projective identification/ client's own

feelings

c) Greater awareness of Transference, countertransference issues
d) Increased integrity, self-esteem, self-efficacy
e) Increased self-awareness
f) Reduced stress levels
g) Other: (Please elaborate if desired)

15. How successful do you think your professional work is? If you are a student, please indicate your level of success in the work completed thus far?

a) Highly successful
b) Somewhat Successful
c) Neutral
d) Somewhat unsuccessful
e) Not at all successful

16. What type was your personal therapy? (check all that apply)

a) Brief Dynamic
b) Cognitive
c) Cognitive Behavioral Therapy (CBT)
d) Dialectical Behavioral Therapy (DBT)
e) Eclectic
f) Family
g) Grief Counseling
h) Group
i) Hypnotherapy
j) Marital Counseling
k) Psychoanalysis
l) Supportive
m) Other

16. Have some of your colleagues/friends/acquaintances in your field/relevant fields been in therapy?

a) Yes
b) No
c) Don't know

17. How many?

        a) Few
        b) Some
        c) Most

18. Do you think this has helped their work?

        a) Yes
        b) No
        c) Don't know

19. If yes, how so?

        a) Greater awareness of own feelings
        b) Greater awareness of projective identification/ client's own

feelings
        c) Greater awareness of Transference, countertransference issues
        d) Increased integrity, self-esteem, self-efficacy
        e) Increased self-awareness
        f) Reduced stress levels
        g) Other: (Please elaborate if desired)

(Box to elaborate)

20. Do you think personal therapy can be helpful for graduate students entering into a clinical field?

        a) Yes
        b) No
        c) Don't know

21. Do you think therapy should be required for graduate students entering into a clinical field?

        a) Yes
        b) No
        c) Don't know

(Box to elaborate)

22. Do you conduct training for graduate students entering into a clinical field?

          a) Yes
          b) No
          c) N/A

(Box to elaborate)

23. Do you conduct psychotherapy with clinicians in training?
          a) Yes
          b) No
          c) N/A