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Leanne Marie Lemire
The Undercover Wounded Healer:
The Role of Personal Therapy in
Being a Clinical Social Worker

ABSTRACT

This study explored therapists' perceptions of how their experiences in their own personal therapy related to their practice as a clinician. Utilizing interviews with 10 therapists who have prior experienced or who are currently engaged in their own personal therapy, this exploratory study examined clinicians' experiences ways in which their personal therapy affected their clinical practice. Specifically, the study also explored clinicians' reflections, while practicing, of their abilities to identify with their clients, their personal therapists, and their overall understanding of the therapeutic process between therapist and client, due to their participation in their own personal therapy.

The study found a unanimous emphasis on the importance of personal therapy as vital tools for self care and professional care in the practices of clinical social workers. The data indicated that participants found themselves identifying with their clients and/or client-role, by means of vulnerabilities, empathy, boundaries, assumptions, termination, and overall perceptions of therapists, due to their participation in their own therapy. In addition, participants found themselves identifying with their personal therapists in their own practice by either modeling after their therapists or by distancing themselves from their therapists while working. Lastly, the data showed several clinicians found themselves, while working, able to embrace their countertransference and acknowledge

the unspoken love between the therapist and the client, due to their experiences in their own personal therapies. Though this study proved to be both informative and helpful to the field of social work, further research in regards to how clinical practices are affected by therapists' personal therapies would further benefit the field.

THE UNDERCOVER WOUNDED HEALER: THE ROLE OF PERSONAL THERAPY
IN BEING A CLINICAL SOCIAL WORKER

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

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2007

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CHAPTER I

INTRODUCTION

“The therapist is effective only when he himself is affected. Only the wounded therapist heals. But when the therapist wears his personality like a coat of armor, he has no effect.” (Dunn 2001, p.134)

Clinical social workers, by theory, devote their life’s work to bettering and enhancing the lives of their clients through means of listening, understanding, and many times, providing them with a once in a lifetime unique experience of feeling supported enough to feel empowered to help one’s self heal. This phenomenon of client transformation only takes place if both the client and therapist meet in the middle emotionally and delicately unpack the client’s struggles and innermost feelings while in a sturdy holding environment. Though this process is unique in its focus being only on the clients, the therapists too, can allow themselves to be transformed by their experiences with their clients. At times, clients bring forth the therapists’ own hidden pains and struggles which can be unavoidable. Consequently, it could be those very pains and struggles in the therapist that brought him or her to this passionate field of clinical social work.

Being that the profession of clinical social work calls for therapists to use their entire self emotionally, physically, and mentally, within the session, the work can be both rewarding yet taxing for the therapist. As a result, countless therapists have been

known to participate in their own personal therapy to both practice self care and to “tune up” their most valuable tools; themselves (Yalom, 2002, p.40).

The purpose of this study is to explore how a clinical social worker’s personal therapy affects his or her clinical practice. Specifically, this study examines the ways in which therapists, who have experienced their own therapy, identify with their clients, ways in which they identify with their personal therapists, and lastly their overall reflections of how their own therapy influenced their clinical practice.

CHAPTER II

LITERATURE REVIEW

This chapter provides a review of literature on the practice of clinical social workers, their use of personal therapy or the lack of, to practice self care, and the ways in which their practice may be affected by their participation in their own treatment. Beginning with a brief review of clinical social workers' commitment to bettering the lives of their clientele, most of the chapter focuses on studies and literature pertaining to social worker's possible benefits of and/or incentives to participate in their own personal therapy as discussed by various clinicians and theorists.

THE CALLING

What brings one into the field of clinical social work varies extensively among such a community of professionals. Regardless of their reasons to enter the field, they have all committed to "enhancing human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty." (National Association for Social Workers, 2007) Consequently, clinical social workers "seek to enhance the capacity of people to address their own needs." (National Association for Social Workers, 2007) Whether or not the social workers themselves, decide to apply their mission of betterment as professionals towards themselves, occurs so only out of personal choice.

According to Irvin Yalom, “It is the person who has gone through suffering, sometimes great, and as a result of that process has become a therapist with a source of great wisdom, healing power, and inspiration for others” (Yalom, 2002, p23). People may come to the profession of clinical social work because of conscious and unconscious motivations to “give back” and help those in need for they too once were in need (Dunn, 2001, p. 132). However, once a member of the clinical social work profession, many therapists see an “importance of continuous reflection for professional growth, and a life-long personal/profession integration process”. (Ronnestad & Skovholt, 2003) Therefore, many therapists enter their own therapy to continue their life long process of growing both professionally and personally.

THE THERAPIST IN THERAPY

Previous research demonstrates that many therapists at some point in their life may have experienced being a client in their own therapy. Findings indicate that therapists sought therapy for personal growth while others did not seek therapy because they felt no need for it at that particular point in their lives (Holzman, 1996). While this is helpful knowledge, this particular study does not indicate if and how therapy was helpful or, if and how the lack of therapy was satisfactory or not. Studies also show that few therapist trainee programs have integrated as part of their curriculum, a requirement for all students to experience so many sessions of individual therapy (Holzman, 1996). While this proves to be helpful in aiding student’s professional development, it does not indicate in what ways. However, personal therapy is not required for students to experience in order to graduate from in all clinical social work programs. Therefore, if

they, as trainees or as licensed clinical social workers, decide to undergo their own therapy it is out of personal choice.

Further research indicates a correlation between personal therapy and the reduction of harmful portrayals on the therapist's account of countertransference between the therapist and client (Gillman, 2003). Again, the research proves to be helpful but does not indicate exactly how being a therapist-in-therapy affects various issues in the therapist-client dyad.

Various surveys administrated in both the United States and the United Kingdom, indicate that "between two-thirds and three-fourths of therapists have participated in their own psychotherapy". (Macran, Smith & Stiles, 1999, p. 419) Of those clinicians that took it upon themselves to enter into their own personal treatment, "a not insignificant minority" had negative therapy experiences (Macran, Smith & Stiles, 1999, p. 420). Unfortunately, the survey does not define what a negative experience entails nor does it signify how therapy affected the clinicians negatively.

Research also demonstrates that not all therapists seem to feel that their own personal therapy is necessary in the development of their professional self. Laura A. Holzman conducted a large-scale quantitative survey of personal psychotherapy use among clinical graduate students (Holzman, 1996). Of the 1,018 surveys sent out, 50% responded. Nearly 75% of the respondents reported receiving personal therapy at some point in their lives. Personal growth was the most frequently cited reason for seeking therapy while the 25% of students who had not been in therapy reported a lack of need and financing as reasons for not seeking treatment (Holzman, 1996).

EARLY THEORISTS IN TREATMENT

The idea that a therapist's personal therapy is a pivotal ingredient in helping him or her to become and continue growing into competent clinician was strongly recommended by theorist Carl Jung. He stressed that in addition to personal therapy, close supervision and rigorous academics allows for, "a psychoanalyst to be born". (Sinason, 1999; Kirsch, 2000) However, according to Macran & Shapiro, within the culture among therapists, whether or not they should experience their own personal therapy is extremely controversial and varies "according to personal belief and theoretical orientation." (Macran & Shapiro, 1998, p.13)

Freud firmly believed in the obligation to enter personal analysis, for those "who want to apply psychoanalytic technique." (Freud cf. Benedek, 1969, p. 437) While Jung was a Freudian psychoanalyst, he implemented the idea of "training analysis" (Freud, 1912). According to Beiser, Jung became enthralled in training analysis in hopes of developing an in-depth ability to analyze oneself (Beiser, 1984). Later, however, Freud became less convinced about an analyst's ability to analyze one's self effectively. He recommended periodic formal re-analysis by other professionals for psychoanalysts every five years, to ensure that services they delivered were in fact the very best possible (Chessick, 1990, p. 312).

PRESERVING THE TOOLS OF A THERAPIST

According to psychotherapist Irving Yalom, the most valuable instrument the therapist uses is the therapist's own self (Yalom 2002, p. 40). He stresses that the therapist must be familiar with their own dark side and be able to empathize with all human wishes and impulses. This can be accomplished through the process of personal

psychotherapy which Yalom feels should be conducted either during or prior to psychotherapy training (Yalom 2002, p. 41). Freud proposed that personal therapy was the “deepest and most rigorous part of one’s clinical education”. (Norcross, 2005) Theoretically, it has been assumed that trainees benefit from therapy through enhanced self-awareness and empathy which may further result in reductions in potentially harmful counter transference (Prochaska & Norcross, 1983). Countertransference is the term used to describe a psychoanalyst's displacement of emotion onto the patient or more generally the psychoanalyst's emotional involvement in the therapeutic interaction (Prochaska & Norcross, 1983). This not only aides the therapist in understanding his or her own human experience but it also invites the therapist to experience therapy through the eyes of the client (Stringer-Seibold, 1999). However, if the therapist is not aware of such countertransference or reactions to the client, he or she may respond in a non-therapeutic manner which ultimately may hinder the relationship between the therapist and client.

Yalom further suggests that the therapist must “demonstrate a willingness to enter a deep intimacy with the client, which is a process that requires the therapist to be adept at mining the best source of reliable data about the client- the therapist’s feelings.” (Yalom, 2002, p. 40) Self exploration is a life long process in which both the therapist and client can relate in terms of focusing primarily on the client (Kotter, 1993, p. 23). Yalom stresses that therapy for the therapist too, should be as deep and prolonged as possible and most importantly, that the therapist enters therapy at many different stages of life as did he (Yalom, 2002, p. 41).

Clinical social worker Babette Rothschild stressed the importance of self care among therapists within the context of burnout due to the impact of countertransference

(Rothschild, 2006). She also stresses, like Yalom, that therapists too, need concrete strategies for maintaining their own mental health and overall well-being while maximizing their competency with clients. Rothschild argues that therapists who are in their own personal therapy are able assist their clients in a less taxing manner in their minds while managing their exposure to burnout and stress (Rothschild, 2006).

BRINGING PERSONAL THERAPY INTO CLINICAL PRACTICE

Further qualitative studies demonstrate the experience of therapeutic interventions in personal therapy affects the use of therapeutic interventions with clients (Gillman, 2003). Interviews of one participant were conducted six times over a seven week period to explore the relationship of the roles of the therapist-as-patient and the therapist-with-client. Findings suggested that the psychological issues raised in the therapist's personal therapy had an effect on her countertransference with her clients as the therapist seemed to be more aware of her own issues which decreased her actions based on countertransference (Gillman, 2003).

According to psychologist Beate Friedeberg, a therapist uses disturbing thoughts and feelings toward his or her client to better understand the client within his or her own countertransference context (Friedeberg, 2002). She conducted a qualitative study of four experienced psychotherapists to further understand the process of their countertransference feelings within the therapeutic relationship by entering into their own psychotherapy. Results showed that empathic understanding based on such a self-reflective awareness of the therapist's own thoughts and feelings may decrease emotional and judgmental reactivity. This may deepen and enlarge the therapist's perspectives on

the patient's problems if they have dealt with or continue to deal with their own personal issues (Friedeberg, 2002).

According to Freud, “the most direct route to the analyst’s subjective apprehension of psychoanalytic phenomena”, particularly unconscious processes and countertransference is through personal therapy (Meisels, 1990, p. 112). Personal therapy is also said to enlighten therapists with their own “unconscious and neurotic propensities; their unresolved anxieties and defenses”, which further helps them to cope with their reactions in such a way that does not harm their clients (Chessick, 1990). Therefore, these goals of personal therapy for therapists have also become part of the desire for clinicians to enter into their own personal therapy.

Freud further noted that therapists who may be self-reliant and do not partake in their own therapy may run the risk of acting out their own unmet needs countertransferentially (Freud, 1912, p. 116). Consequently, the therapists’ personal therapy may make them aware of the “existence and nature of their own unresolved and disavowed issues” which may prevent the harmful effects of unconscious countertransference reactions (Zeddies, 1999, p. 232). However, despite these goals for clinicians, there is limited research on how a therapist’s personal therapy aids their clinical practice with their clients.

CHAPTER III

METHODOLOGY

The purpose of this study was to examine how a clinical social worker's personal therapy influences their clinical practice in addition to their development as a professional. My research question focused on gaining knowledge from practicing clinicians' who participated in their own treatment in the past or who currently are engaged in their own treatment while practicing clinical social work. Specifically I focused on drawing upon clinicians' reflections, while practicing, of their abilities to identify with their clients, their personal therapists, and their overall understanding of the therapeutic process between therapist and client, due to their participation in their own personal therapy.

Since these questions have not been directly investigated before, an exploratory study using qualitative methods was chosen. In-depth, semi-structured interviews were conducted with 10 clinicians who self-identified as having formerly experienced or are currently engaged in their own treatment while practicing clinical social work. Findings were then analyzed qualitatively.

OBTAINING A SAMPLE

The target size for this sample was 10. To qualify, participants had to be currently practicing clinical social workers (at the Masters level or above) who had previously participated in or were currently engaged in their own personal therapy. To initially recruit participants, a general email was sent to various clinical social workers

within the Smith College School for Social Work community requesting their willingness to participate in this study. Emails briefly explained the purpose, requirements, and expectations for participation. Participants then responded to initial emails, providing the research with names and telephone numbers in which to be contacted, implying a desire to participate.

Potential participants were screened by phone to ensure they met the study's criteria and to schedule interviews. The small sample size of 10 participants meant it was not possible to ensure diversity among the participants regarding gender, age, race/ethnicity, or religious affiliation. In addition, due to the predominantly white population of graduated clinical social workers from the Smith College School for Social Work population, data is somewhat limited and the overall findings of this study is not an adequate representation of clinical social workers of all diverse backgrounds.

A total of 14 clinicians were contacted regarding participation in this study. Of those, 2 did not return my calls, and 2 did not meet selection criteria. The final sample was 10 clinicians.

PARTICIPANTS

This study was composed of 10 participants all of which are women. All participants identified as white and obtained their masters of social work degree from Smith College School for Social Work. The number of years clinicians have been practicing clinical social work ranged from 3-20. Four participants reported to be currently engaged in their own treatment for total of 1- 3 years. The remaining six participants reported to previously partaking in their own treatment anywhere from 3-12 years ago. Of the six, two reported being in therapy for the duration of at least 1 year and

four reported being in treatment anywhere from 2 to 7 years total. Of the 10 participants, two of them sought therapy at least 3 separate times within their lives, three sought therapy twice within their lives, and five sought treatment only once.

DATA COLLECTION

The design of this study was approved by the Human Subjects Review Board of the Smith College School for Social Work (see Appendix A). Informed consent letters were sent to all potential participants (see Appendix B) in advance of interviews; the letter described the study and defined the selection criteria for participants; it also outlined the risks and benefits of participating in the study. Informed consent was obtained before the interviews began.

The method for data collection was a semi-structured interview composed of both closed and opened ended questions that focused on the areas described above. All interviews were conducted face-to-face in the location most convenient for the participants, usually their office. Each interview ranged from 50 to 90 minutes, depending on the length of responses from participants. A pre-defined list of questions was used to guide the interviews (see Appendix C), however depending on responses, further probing questions were asked to allow participants to gain a better understanding of specific questions as well as to add more information to their responses. Interviews were recorded on audiocassettes, notes were taken, and all information was analyzed at a later date. All identifying information was deleted or disguised.

DATA ANALYSIS

Responses were reviewed to identify data relevant to the specific research areas specified, regarding the effects of personal therapy on the clinician's practice. Data were

also analyzed for significant reemerging themes which were raised by various participants during the interviews, in addition to extraneous findings which did not fit into any of the observed emerged themes.

Responses were categorized into appropriate groups thereby providing a visual representation of the data which allowed for easier identification of themes and patterns. Quotes from participants' responses were used to represent the various reemerging themes or patterns. Data was also compared to determine similarities and differences with respect to the literature review.

Due to the small sample size and the limitations to diversity among the interviewed Smith College School for Social Work graduates generalizations of all clinical social workers, who have experienced or who are currently engaged in their own treatment, cannot be made from the results of this study. Instead the findings provide an in-depth understanding of some of the experiences of clinicians who have experienced or are currently partaking in their own treatment while practicing professionally. It is hoped the data gathered through this study and presented here will inspire and inform future research.

CHAPTER IV

FINDINGS

This chapter contains the findings from interviews conducted with 10 clinical social workers who previously participated in or are now currently engaged in their own personal therapy. As a framework for the interviews, participants were asked open ended questions specifically drawing upon their reflections of how their own treatment influences or affects their clinical practice. It was explained that their responses were not limited to only positive ways in which their practice was affected by their engagements in personal therapies, but also the limitations or drawbacks to being a clinician in therapy while practicing professionally. The interview questions were structured to elicit information specifically regarding clinicians' reflections of their abilities to identify with their clients and personal therapists while in the therapist-role with their own clients as well as any other knowledge or influences they utilized in their clinical practice, as a direct result of participating in their own therapy. Participants were also asked to discuss any other relevant aspects of their experience of being clinicians involved in their own therapy that was not addressed by the interview questions asked.

The data retrieved from these interviews are presented in the following order: demographic data of participants, ways in which participants identify with their clients, ways in which participants identify with their personal therapists, and lastly participants' overall reflections of how their own therapy influenced their clinical practice.

DEMOGRAPHIC DATA

As stated in the chapter of methodology, this study was composed of 10 participants in total. All participants identified themselves as white women who obtained their master's of social work from the Smith College School for Social Work. The number of years clinicians have been practicing clinical social work ranged from 3-20. Of the 10, four participants were currently engaged in their own therapy for a total of 1-3 years. The remaining six participants included two who reported being in therapy for at least 1 year and four who were in therapy from 2 to 7 years total. The six also reported to previously partaking in their own treatment anywhere from 3-12 years ago. Of the 10 participants, two of them sought therapy at least 3 times on separate occasions, three sought therapy 2 times, and five sought therapy only once.

IDENTIFYING WITH THE CLIENT-ROLE

Participants were asked several questions regarding their abilities to identify with their clients and/or the client-role as a result of their experience in their own therapy. First, how would you describe your experience as being the client? Second, while working, do you ever find yourself relating to the client-role as you have/are experiencing it in your own treatment? Third, is there anything that you experienced in your own treatment that you find yourself wanting to allow your clients to experience? Fourth, is there anything you experienced in your own therapy that you would not want your clients to experience?

This section contains participants' reports of the ways in which clinicians' found themselves identifying with their clients and/or client-role, due to their participation in

their own therapy. The data are presented in the following sub-sections: vulnerabilities, empathy, boundaries, assumptions, termination, and perceptions of therapists.

Vulnerabilities

In discussing the questions listed above, three participants indicated that their experiences of being the “client” allowed them to better appreciate the vulnerability of their own clients. One participant reported becoming more aware of “the resistance to, the difficulty of, and the eager to let go and succumb to the role of being a client”. Another participant stated that prior to experiencing her own therapy, she was unaware that she actually had less empathy for those of her clients that displayed a desire to change but were for some reason classified as “resistant or reluctant clients”. After experiencing her own process of “push and pull” with her therapist did she “truly understand” where her client’s were coming from. Another clinician reported experiencing being a client as a difficult process, yet looks back on her process of letting go as being a positive yet crucial turning point in her own therapy. She also stated that this awareness has allowed her to be more sensitive to her clients’ vulnerabilities and the comfort they must have with her in order to let go of their defenses and show their “true selves”. Another participant commented on her hesitance to reveal certain thoughts she had as she silently wondered to herself, “Sure, they are not supposed to judge me, but what is this therapist really going to think of me?” It was not until then did she become aware of the hesitations, worries, and all together “humanness” of the client-experience.

Empathy

Each clinician reported feeling more empathy for their clients since they themselves experienced being in the client-role. One participant stated, “We cannot take

our clients where we ourselves have not been. I am not saying that if your client is an architect who has just been divorced, to understand or have true empathy for him you have to be an architect who was divorced as well, no. But it is the therapist who has herself entered this grueling process of bearing all your wounds that can truly have empathy for her clients who are in the process as well.” Another participant reported that being a client herself, gave her a new appreciation for empathy. She further commented that being a client has allowed her to not just intellectually understand what her clients grapple with, but has also added a new dimension in her work of “empathically knowing” their pain and their struggle for hope. Another clinician revealed that she was treating a woman who was struggling with the very same issues which she was discussing in her own treatment simultaneously. She further indicated that the entire process of being in treatment while treating this particular client was something that she does not recommend for others, however, her client had been in her care for approximately two years when she remembered repressed memories of childhood sexual abuse. She used her own therapy to continue her own process of healing and to help deal with her countertransference issues, in addition to utilizing supportive supervision. In retrospect, she feels that her experience in therapy allowed her to keep herself healthy, and effectively treat her client as she stated, “It was truly amazing the empathy I was able to feel for my client. It was as if I knew what she was thinking and when. I had to be mindful to not assume her feelings or fall into the pitfall of expecting or assuming that she would have the same process as me, but in actuality, we are all people and we have different experiences. But walking that path of hell in my own therapy allowed me to reach my hand over that ledge and convince her that if she grabbed it, she would make it and live.” Another participant

revealed that her struggles in therapy allowed her to have more empathy for her clients' frustrations and anger with the therapeutic process and at times, with her. She stated that she struggled with her therapist's inability to "fix" her, even though she intellectually knew that this was not possible. She commented, "I can sense when a client is in such deep pain that he or she cannot even bear to do any more work with me. The clients often end up projecting their anger towards me for not taking their pain away and at the therapeutic process in general for not reciprocating the hope they put into it." Because she is able to sense this resistance with her clients, she feels that it better enables her to help them move out of this stage.

Boundaries

Two participants commented that being a client really gave both of them insight to their clients' understanding of and desire to test the boundaries between the therapist and client. One participant revealed that at first, in her own therapy process, she was extremely cautious of the firm boundary between her therapist and her. However, she was surprised to feel herself wanting more from her therapist as their therapeutic bond grew closer. She stated, "I found myself thinking of her in my personal life throughout my day and also in my work with my own clients. I remember thinking that I wish she was my friend, or my mother, and then I thought my goodness; this is how some of my clients feel with me when they ask me questions about my personal life!" She was then able to better relate to her clients when they displayed behaviors that indicated their need for more of her. Another participant reported that she realized the amount of responsibility clients in general have in order to understand and respect the boundaries the therapist defines. In her personal therapy sessions, she could have easily manipulated

the time limit of fifty minutes by continuing to talk, however, out of respect for her therapist and her profession, she also kept track of the time and ended the sessions herself to avoid having her therapist stop her. She also stated that towards the end of her treatment, she became more interested in knowing more about her therapist personally in an “unconscious effort to keep something sacred to hold inside” as an internal representation of her therapist and/or their work together.

Assumptions

Three participants reported that being in one’s own therapy could lead to therapists making assumptions regarding their clientele. For instance, one participant, who revealed that her own therapy focused mainly on her struggles with her sexuality and the process of accepting and embracing her decision to come out to her family, shared her experience of having a client about three years later that presented with the same issues. She reported that she immediately empathized with her client and assumed that she had a very similar experience of rejection with sharing her homosexuality with friends first. However, to her surprise, after three sessions of discussing possible rejections and how her friends may react, her client stated that her friends were in fact very supportive of her but her family was a different story. Through her client’s redirection of the subject material discussed, the therapist was able to start where the client was in her own process and stop assuming that her client would feel the same way or have the same experience she had. The other two participants commented that they too, struggled internally with assuming their clients felt a certain way due to their own previous or current process with similar material. However, they were able to bring their countertransference issues to supervision and not act on them.

Termination

Five participants reported that they gained a new appreciation for the feelings that arise during the process of termination from the clients' perspective. One participant shared that she and her therapist formed such a close therapeutic bond which touched feelings in her that she never thought would be touched upon due to her intellectual understanding of the limits and time constraint of the relationship. She commented, "I've always been the therapist, who of course felt so much for my clients, but being the client brought about a whole new set of feelings for me. It was a different sadness and gratefulness, being the one helped and not the helper. I wanted her to know how much I appreciated her help, and really her genuine caring." Another participant commented on the use of transitional objects during the process of termination. She reported that for her, it was important to give her therapist a transitional object to show her appreciation for the healing she had experienced throughout their work together.

Perceptions of Therapists

One participant indicated that she was able to identify with her clients' perceptions that therapists in general are perfect, healthy, and have no problems. She participated in her own therapy three years prior to entering graduate school and had not practiced social work yet in her life. She recalls thinking that her therapist was "so put together and so calm" that she actually questioned whether or not she would ever attain such a disposition in life. She further stated that it became empowering for her to accept that being "perfectly fine" was a "journey and not a destination".

IDENTIFYING WITH THE PERSONAL THERAPIST

Participants were asked several questions pertaining to the ways in which they identify with their personal therapists while practicing social work with their own clients. First, while a client, do you ever find yourself recalling aspects of your own therapy? Possibly some conversations with your own therapist? Second, in what ways, if any, do you find yourself evoking your therapist as you work? Third, in what ways, if any, do you distance yourself from your therapist while working?

This section contains participants' reports of the ways in which clinicians' found themselves identifying with their personal therapists while working, as therapists, with their own clients. The data are presented in the following sub-sections: using the therapist as a model and distancing oneself from the therapist.

Using the Therapist as a Model

Eight of the ten participants revealed that they have used their own therapists to model themselves after in various ways. Three clinicians indicated that they find themselves imitating their therapists in their work by responding in the same manner they witness their therapist responding to them. One participant stated, "I began to idealize my therapist and imitate her in my own work. I think, what would my therapist have said here, or I just felt that feeling in my stomach, call it projective identification, but I felt what my client felt and I recall this feeling and instantly I find myself saying exactly what my therapist said to me in that moment. It happens so fast that I have come to realize that I have internalized parts of her that have now become parts of me." Another clinician indicated that she modeled her personal style of using analogies to assist her clients in better understanding their issues, and ways to cope with them, just as her therapist had

done with her. She revealed that her therapist used an analogy of “befriending the scary spider” to help her overcome her struggles with intimacy due to her childhood sexual abuse. When working with one of her clients who dealt with the same struggle, she immediately used the same spider analogy to instill small attainable goals for her client, which focused on slowly exposing herself to the “spider” or feeling of intimacy. She stated that she specifically used this analogy to instill hope as she shared, just as her therapist had with her, that it would be most important for her to select a special “spider” that would help her befriend him, thereby achieving intimacy.

Two other participants commented on their “way of being” with a client that reflected their therapists’ “way of being” with them as clients. One clinician modeled her therapist’s calmness and “warm loving approach” towards her clients. Another clinician commented that if an intervention or statement worked for her and made sense, she passed it along to her clients. She further stated, “When I was at my worst, I know what helped me the most. I know what my therapist said and how she said it.”

One participant reported that in the very beginning of her work, she found herself unconsciously decorating her office with items that reminded her of her therapist. She strategically placed her clocks around the room to allow one to be viewed by the client and one on the side of the client to give herself an easy view, just as her therapist did. Another participant stated that throughout her graduate school experience, she learned all the skills and theories necessary to analyze clients, however, it was her personal therapist who influenced her most with how to best use herself as a tool while with a client. She, like her therapist, used humor to relate to her clients, became creative in her approaches with various clients, and attempted to convey her “humanness” as much as possible.

Because her therapist self disclosed that she was in her own therapy, she realized that everyone has their own problems, even those who are classified in society as “the helpers”. In her own work, she does not disclose to all her clients that she herself has once been a client, however, she aims to normalize being a client and the overall process of therapy, just as her therapist made her feel.

Distancing Oneself from the Therapist

Two participants reported that they distanced themselves from their therapists in various ways while working with their own clients. One participant stated that she did not integrate anything from her first therapist in her work. She described their relationship as having a “lack of connection” which she feels, severely impeded her progress as client. Her therapist presented with a flat affect in each session, according to this participant, and barely gave her any “indication of even being human”. She indicated that she looks back on her experience with this particular therapist and feels grateful to have experienced how “not to be” as a therapist. In her work, she aims to be “compassionate, warm, understanding, and above all, human!”

Another participant reported that she and her therapist had a close therapeutic bond which ended up becoming “too close for comfort”. She recalled a session about eight months into their work together, where she began to reveal various problems with her current husband. To her surprise, her therapist self disclosed that she was also having issues with her husband and that he currently was not speaking to her. In that moment, she thought to herself, “Why did she reveal this to me? How is this helpful for me? I’m the client here.” When she went on to further discuss her feelings regarding her husband, her therapist interjected several times to add that she too felt what her client felt, in

regards to her own marital issues. At one point, her therapist even became tearful and this particular participant felt the gradual power shift within the session as she felt as if she was her therapist's therapist. Upon reflecting this experience, she commented that it enlightened her to the "slippery slope" of self disclosing for one's own benefit and not that of the clients. She further stated, "I really felt close to my therapist up until that point. I knew she cared about me and I in some way care for her too. But the fact is that I was the one paying for her services and I was the client."

EFFECTS ON CLINICAL PRACTICE

Participants were asked several questions pertaining to the ways in which their experience in their own therapy affected their overall clinical practice. First, Can you give some general information of how your own treatment affected or affects your practice? Second, upon reflecting on your own life, how do you think your practice and personal life would have been affected if you had not participated in your own personal treatment?

This section contains participants' reflections of the ways in which their practice was affected by their participation in their own therapy. The data are presented in the following sub-sections: embracing countertransference and acknowledging the unspoken love.

Embracing Countertransference

Seven participants commented on their improved awareness of and use of countertransference in their practice. One participant stated that since her own therapy she has become much more self aware and in tune with her own feelings toward certain subject matter, client personalities, and other external influences in which she

experiences internally while with a client. Another participant revealed that she is more aware of her own vulnerabilities within sessions with her clients and that her experience in therapy has helped her to become more tolerant and more self reflective before speaking. One participant described her perception of her countertransference as “a gift to truly have empathy for the person bearing their soul right in front of you.” She uses her internal reactions to her clients to further gain an understanding of their world. Another participant commented that prior to treatment, she was under the impression that she would never be able to treat individuals who had the same issue in treatment that she had. It was through therapy that she realized that she is no different from her clients as she has “wounds and hang-ups” just as they do, however, she has the awareness of triggers and what to do with such feelings when they arise in the room with her client. She simply stated that to “work with clients that bring forth in us, our own wounds, we just have to be one step ahead of them and know what to do when our wounds get triggered.” For instance, she revealed that she consults with various colleagues, utilizes her supervision to the fullest, and if needed, will seek personal therapy again in order to manage her countertransference triggers.

One participant commented that her experience of being in therapy while being a therapist reminded her that “one can never be truly absolved from all of one’s issues”. She accepted her countertransference as being a “wonderful part of the work that reminds us that we all share this vulnerable experience of being human.”

Another therapist recalled aspects of her work prior to experiencing her own therapy. She stressed that a therapist who does not, at some point in their life, work on their own issues in therapy must be extremely conscious of and careful of their

unresolved issues. She also emphasized the importance of good supervision for therapists who have not been in their own therapy. She said that a therapist who does not experience therapy is like a “dentist who does not get his own teeth cleaned by another dentist. He clearly cannot properly analyze, clean, and repair his every tooth in the proper way by himself. In order to keep his own teeth healthy, he needs the help of another well qualified licensed dentist, just as a therapist needs the help of another therapist.”

Acknowledging the Unspoken Love

Six participants indicated that they have been positively affected by experiencing both roles of being the therapist and the client within the context of the therapeutic relationship. One participant commented that while being a therapist, she deeply cared for her clients and often even felt a sense of non-sexual love for them. However, when a client in her own therapy, during the intense and painful areas of the process, it became clear to her that her therapist did indeed love her. She always remembered their rituals and “little intimacies” that they shared. Many years after their termination, she experienced a client of hers that, upon their last session, stated with tears in her eyes, “I will always hold you in my heart and I will take you everywhere with me.” At that moment, she knew that there was something “magical” to the relationships therapists and clients form. She further stated that she feels, “love” is the most important ingredient to allowing for such a transformation to occur. Another participant commented that in her experience, “The strong force of the therapeutic relationship, at best, transforms both the therapist and client.”

One participant stated that the “love” within the therapeutic relationship cannot be taught in school or learned from a text book; instead it must be a gradual process which is developed throughout the process of therapy for both client and therapist. She further stated that therapists “certainly do not like” all of their clients, however, it is what they do with their countertransference reactions which makes the difference, in her opinion. She described these clients as being “family members who we do not necessarily like, but love because they are family. In the same respect, I think for our clients, we become their temporary family in a respected limited manner to show them they are worthy of being loved and supported and to also help them to see what they can accomplish for themselves when they truly feel loved and supported.”

Another participant related the therapeutic relationship to a “gift” that is given and received between the therapist and client. She describes this often times unspoken point in therapy when both she and her client are in the “zone”. She further describes this as a phenomenon of the therapist “holding and loving the client’s inner spirit with the client unconsciously or consciously experiencing feeling the feelings of being safe, held, and loved.” This participant stated that she has achieved this “zone” many times throughout her work, however, when she did not truly realize its power until she was one the receiving end with her own therapist. The “zone” is what has given her hope in helping those of her clients whom feel that hope is unattainable.

SUMMARY

The data presented in this chapter reflect the participating clinicians’ experiences of how engaging in their own therapy affects or affected their clinical practice. The participants interviewed were consistent in reporting that their experiences in personal

therapy influenced their clinical practice in various ways. Specifically, all participants indicated in some way that their experience of being in their own therapy allowed them to identify with the client-role, their personal therapists, and utilize other knowledge and influences which results directly from experiencing their own personal therapy.

Within their identifications with the client-role, participants indicated that they identified with their clients in a combination of various ways: three clinicians felt they were able to better appreciate the vulnerability of their clients through their experiences of being vulnerable themselves in their own therapy; all ten clinicians reported that they felt more empathy overall for their clientele; two clinicians felt that they gained a better understand of the boundaries of the therapeutic relationship through the eyes of the client; three clinicians felt they over identified with their clients and made assumptions that their client's experienced the same processes as they had; five clinicians felt that they gained a new level of understanding of the termination process through the eyes of the client; and lastly, one clinician felt that she gained an insight into how clients perceive therapists to be all knowing. In addition, eight participants indicated that they found themselves identifying with their personal therapists while working by using their therapist as a model. In contrast, two participants found themselves identifying with their therapists by distancing themselves from their therapists, thereby using them as models of how they did not want to conduct themselves as therapists. Lastly, participants reflected in a combination of two ways in which they felt their overall practice was affected or influenced by their participation in their own treatment. Seven clinicians felt a transformation to embrace their countertransference and six clinicians acknowledged and

became aware of the unspoken love that occurs within the therapeutic relationship between therapists and clients.

In analyzing the data, this researcher noted that all participants reflected upon their experiences in personal therapy as a positive and beneficial experience which has assisted them in some ways in practicing clinical social work with their own clients. Interestingly, even the two clinicians who used their personal therapists as examples of how they did not want to portray themselves, they still seemed to portray an overall positive view of their experience in therapy. Participants also noted that while personal therapy has been beneficial to their practices, consultations with colleagues and utilizing supportive yet effective supervision are also important aspects of their clinical practices.

CHAPTER V

DISCUSSION

The objective of this study was to explore clinicians' experiences of practicing social work while currently partaking in or previously participating in their own personal therapy and to identify specific ways in which they better identified with the client-role, their own therapists, and the ways in which their personal therapy affected or affects their clinical practice. This chapter discusses the findings in the following order: participant demographics, ways in which participants identify with their clients, ways in which participants identify with their personal therapists, and lastly participants' overall reflections of how their own therapy influenced their clinical practice, in respect with the literature previously reviewed. The chapter closes with a discussion of implications for clinical practice and opportunities for future research.

PARTICIPANT DEMOGRAPHICS

There are two key points to note regarding the participants interviewed for this study. One is their collective experience of being practicing therapists who have experienced, at one time or another, being a client in their own therapy; the other is the overall limitation within the participants of the study.

A total of 10 clinicians participated in this study. These therapists had been practicing clinical social work anywhere from 3 to 20 years total and have experienced their own personal therapy anywhere from 1-3 times (ranging from 1-7 years at any one given time) throughout their life. All of the participants reported having overall positive

experiences of being clients in their own therapy. In addition, all participants strongly reflected on their experience of being in their own therapy as a vital component of their current clinical practice as they noted their improved and enhanced ways of being able to identify with their clients, their prior therapists, in addition to utilizing their own therapy during their work with clients. However, it is possible for clinicians, who have not experienced their own therapy, to equally be able to identify with their clients, therapists in general, as well as understanding the therapeutic process on a deeper level, without having ever experienced being clients themselves.

All of the participants, although fulfilled the qualifying criteria of the study, provided certain limitations to the overall research findings. Because all ten of the participants were graduates of the Smith College School for Social Work master's program, findings were somewhat skewed to the experiences and opinions of only Smith College graduates who participated in their own therapy. If the sample size had been larger and thereby composed of graduates of various clinical social work programs, findings would have indicated a much more accurate representation of the experiences of clinical social workers who participate in their own therapies. In addition, all participants were composed of white women, which again, limits the overall findings and conclusions of this study due to the lack of diversity. Further research including both men and women of various races in addition to being graduates of various colleges, would prove to be both useful and informative to the profession of social work.

IDENTIFYING WITH THE CLIENT

Having outlined the primary contextual factors in client and clinician demographics, the primary area of inquiry for this study was clinicians' experiences of

practicing social work while either currently participating in their own therapy or prior doing so. For the purpose of this study, findings were presented in the following themes: ways in which participants identify with their clients, ways in which participants identify with their personal therapists, and lastly participants' overall reflections of how their own therapy influenced their clinical practice.

The findings of this study proved to be congruent with the general literature on therapists' who experienced being clients in their own therapy. As Stringer-Seibold stated, being a client, allows the therapist to understand therapy through the experience of the client (Stringer-Seibold, 1999). Specifically, participants indicated that their own therapies allowed them to identify with the client-role in various ways. Participants reported becoming more aware of their clients' overall vulnerabilities while being in the client-role. Irving Yalom suggested that the personal therapy of the therapist should be as "deep and prolonged" to that of their clients (Yalom, 2002, p.41). Consequently, participants indicated that they found themselves feeling more genuine empathy for their clients as they too had experienced the intense emotions of embarking on the journey of therapy themselves.

Findings indicated that various participants, from the perspective of the client-role, gained a greater sense of boundaries in the therapeutic relationship, became aware of possible therapist assumptions of clients, and realized the possible inaccurate perceptions clients may have of their therapists, due to their own experiences in therapy. However, the literature reviewed regarding therapists-in-therapy, did not particularly touch upon those of who gained a deeper understanding of the boundaries between the therapist and client nor did it shed light on the possible assumptions therapists sometimes

make of their clients because of their own experiences in their personal therapy. The literature reviewed also did not discuss whether or not therapists were able to better relate to their clients' emotions and reactions during the process of termination or their clients' perceptions of therapists overall, because of their enlightening experiences as clients. This may indicate that prior research may not be available regarding these areas in the therapeutic process between clients and their therapists. Further research regarding how therapists-in-therapy are able to identify and further understand the client-role would be helpful in ultimately giving therapists more insight in working with their clients.

IDENTIFYING WITH THE THERAPIST

The literature reviewed indicates that therapists, who have experienced their own therapy, are able to identify with their own personal therapists while working with clients. Specifically, participants indicated that their own experiences in therapy, allowed them to identify with their personal therapists, by either utilizing their therapist as a model or distancing themselves from their therapists, while they work. Gillman's qualitative study revealed that the therapeutic interventions in a therapist's personal therapy, influences his or her interventions with his or her own clients (Gillman, 2003). Participants reported that they at times, found themselves modeling after their own therapists by imitating their personal styles, reusing interventions, and creating a similar therapeutic atmosphere to their therapists' offices.

Other participants indicated that they distanced themselves from their therapists in their own work with clients as their therapists displayed personal styles or used techniques which they feel was either uncomfortable or ineffective for them. However, the reviewed literature did not indicate if and/or how therapists identify with their own

therapists in ways which cause them to be different than their therapists. Although, surveys administered both in the United States and the United Kingdom indicated that of those therapists who participated in their own therapy, a “not insignificant minority” indicated that they had negative experiences in therapy (Macran, Smith & Stiles, 1999, p.420). However, the survey did not define what the “negative experiences” were nor did it discuss how clinicians were affected due to their negative experiences. Further research regarding how negative experiences in therapy affect the ways in which therapists practice therapy with their clients would be extremely helpful in understanding what experiences are viewed as negative within the therapist community. Understanding and becoming aware of these negative experiences would also assist social workers in gaining a deeper insight regarding how to best serve their clients.

EFFECTS ON CLINICAL PRACTICE

Both the literature reviewed and the findings in this study suggest that therapists who have participated in their own therapy have utilized their therapy experiences regarding the relationship between the therapist and client, while working in their own practices. Specifically, participants indicated that their experiences in therapy allowed them to embrace their countertransference reactions with their own clients as well as acknowledge and become aware of the unspoken love between both therapist and client. Chessick states that for therapists, personal therapy allows them to not only become aware of their countertransference reactions but to also further assist them in coping with their inner reactions in such a way that does not harm their clients (Chessick, 1990). Participants indicated that their own personal therapy experience allowed them to view their countertransference reactions as positive attributes in their social work profession

which allows them to both gain a further insight into themselves therapeutically and to gain a deeper understanding of their clients; both of which participants indicated, to be ultimately extremely helpful in better treating their clients. Friedeberg also states that therapists who have dealt with or continue to deal with their own personal issues in therapy may have a deeper understanding and perspective on their client's problems (Friedeberg, 2002). Freud further noted that therapists who do not engage themselves in their own personal therapy may run the risk of acting out their own needs through potentially harmful countertransference reactions (Freud, 1912, p.116). Consequently, participants indicated that their own therapy allowed them to further process their own challenging issues which ultimately allowed them to work effectively with clients who struggled with the very same issues they overcame in therapy themselves. Findings also indicated that various participants viewed their countertransference reactions as extremely valuable humanizing feelings which often times, brought them back into their own therapy. Several participants, however, reported that while personal therapy is helpful for clinicians, they strongly emphasized the necessity of having supportive supervision and a team of colleagues as a support system for each therapist, in addition to his or her own personal therapist while practicing clinical social work.

Participants also indicated that their own therapy experience allowed them to gain a new sense of acknowledgement for the unspoken love that may occur between the therapist and client as each embark on the intimate journey of therapy together. However, the literature reviewed did not touch upon the feelings of love that may occur between the therapist and client from either the therapist's or the client's perspectives. Further research regarding the intense emotions of love that may be present within the

therapeutic relationship would be helpful in further understanding the phenomenon which occurs between both therapist and client during the therapy process. Several participants indicated that they both felt love for their therapists and they in return could feel the unspoken love flooding from their therapists towards them. In addition, these participants also indicated that in their own practice, they experienced feelings of love towards their clients and often felt as if their clients loved them as well.

IMPLICATIONS FOR FURTHER RESEARCH

As noted above, this study allows for various opportunities for further research which would greatly benefit the profession of clinical social work. Specifically, further research could include experiences of therapists-in-therapy who graduated from various clinical social work programs and who are of various races and ethnic backgrounds. This would provide a broader yet more accurate representation of therapists-in-therapy overall. In addition, additional research pertaining to the phenomenon of intense emotion, at times love, that may occur between client and therapist which allows both to be transformed, would be beneficial to gain further insight to achieving such a space therapeutically from the perspective of the therapist-in-therapy. Ultimately, any further research regarding therapists-in-therapy would be beneficial to the field of social work as the topic appears to be limited in studies, yet, as seen in this study, proves to be beneficial for therapists and the clients they serve.

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Appendix A

Human Subjects Review Approval Letter

April 30, 2007

Leanne M. Lemire
511 Rock Valley Road
Holyoke, MA 01040

Dear Leanne,

Your revised materials have been reviewed and all is now in order. We are therefore glad to give final approval to your study. We have one small suggestion. Your language at the end of the Consent when you say that they can choose to “not answer” is rather awkward. Perhaps it would be better to say that “may refuse to answer any question” or that they may “choose not to answer any question”. Please read that over and clarify. Just send the corrected piece to Laurie Wyman.

Please note the following requirements:

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

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

In addition, these requirements may also be applicable:

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

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

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

Good luck with your project.

Sincerely,

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

CC: Roger Miller, Research Advisor

Appendix B

Informed Consent

Dear Participant,

As part of the graduate program of Smith College School for Social Work, I am conducting a research project about the impact of clinical social workers' own personal therapies on their work. This thesis aims to explore how therapists' social work practice is affected by their own prior or current personal treatment.

Because you are a practicing clinical social worker who is either engaged in your own personal treatment, or have participated in your own personal therapy in the past, your insight on your experience would be extremely valuable to this study. While there will be no financial benefit for participating in this study, your experience can contribute to the development of our field.

In the tape recorded interview, you will be asked a series of questions pertaining to your experience of being a clinical social worker in your own therapy. Questions will not be geared towards the subject matter or issues with which you sought therapy, but with the experience itself and how it relates to your clinical social work practice.

To ensure confidentiality, you will be assigned a code number to serve as your name. In addition, any other identifiable information that would connect your experience specifically to you will be altered in such a way as to protect your anonymity. The tape recorded interview and disguised data analysis will only be shown to the researcher's thesis advisor. You will not be personally identified in any way in the final report of this research study. Materials gathered from this study will be stored in a secure location to ensure confidentiality.

Due to the nature of this study, it is possible that you may experience emotional distress upon reflecting on your experience in treatment. In the event of this possibility, you are encouraged to discuss such feelings with your current therapist, contact your past therapist, or you are more than welcome to contact any of the referrals for therapists I will provide to all participants upon beginning the interview process.

If at any time you wish to withdraw from this study you can do so. Materials you have contributed information to will be destroyed upon your withdrawal. If you wish to not answer certain questions asked you are welcomed to do so as well. Whatever information you can provide will be greatly appreciated and useful for this study.

If you have any questions regarding this research please do not hesitate to contact me at the number and email address provided below.

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

Signature of Participant: _____ Date: _____

Sincerely,

Leanne Lemire
Phone: (413) 330-1049
Email: llemire@email.smith.edu

Appendix C

Interview Guide

1. Do you have any questions before we start?
2. How long have you been a clinical social worker?
3. Are you currently engaged in your own personal treatment? If not, when did you partake of your own personal therapy?
4. How many years have you or did you participate in your own treatment?
5. How many times have you sought treatment?
6. What is/was the frequency of your treatment?
7. What was your motivation for seeking therapy?
8. How would you describe your experience as being the client? What did you like? What did you not like? What was difficult for you? What was easy?
9. Is there anything you experienced in your own treatment that you find yourself wanting to allow your clients to experience?
10. Is there anything you experienced in your own treatment that you would not want your clients to experience?
11. Can you give some general information of how your own treatment affected or affects your practice?
12. How does your experience in personal therapy relate to your work as a therapist? What do you think was helpful? Not helpful?
13. While working, do you ever find yourself relating to the client-role as you have/are experiencing it in your own treatment?

14. While with a client, do you ever find yourself recalling aspects of your own therapy? Possibly some conversations with your own therapist?
15. In what ways, if any, do you find yourself evoking to your therapist as you work?
16. What ways, if any, do you distance yourself from your therapist while working?
17. Have you experienced counter-transference issues in your work? If so how have you addressed these?
18. What role models did you model your personal therapeutic style after? Did they participate in their own treatment?
19. Among your clinical social work colleagues, approximately what percent would you say that have either experienced or are currently in their own personal treatment?
20. Upon reflecting on your own life, how do you think your practice and personal life would have been affected if you had not participated in your own personal treatment?