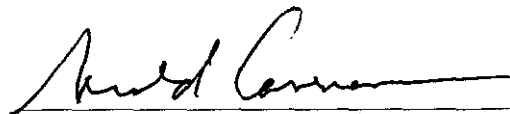
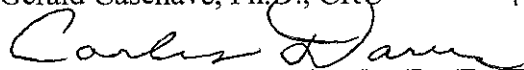


PERSONAL PSYCHOTHERAPY AND THE PROFESSIONAL DEVELOPMENT OF
TRAINEE THERAPISTS

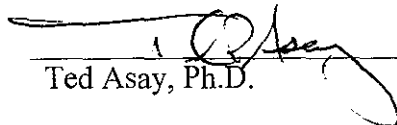
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DEDICATION

I wish to thank the faculty, especially Drs. Asay, Casenave, and Davis, for their support of my thesis project and my well-being in the program over the last two years. Thanks also to my classmates for their fellowship and solidarity.

PERSONAL PSYCHOTHERAPY AND THE PROFESSIONAL DEVELOPMENT OF
TRAINEE THERAPISTS

by

IAN CHRISTOPHER ABRAMS

THESIS

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Abstract

This paper aims to synthesize the literature on personal psychotherapy and graduate training in the helping professions to determine whether personal therapy should belong to the standard set of activities and competencies required of trainee psychotherapists. Though personal psychotherapy has a long history as a training tool, it is seldom formally required or recommended in programs today. Benefits to the clinician have been widely reported; whether clients benefit is a subject of ongoing debate. It appears that most psychotherapists eventually do enter therapy at some point in their career, but not necessarily in training. The paper attempts to determine what is of value to the trainee therapist and how it can be integrated with the goals of training programs.

TABLE OF CONTENTS

CHAPTER ONE: STATEMENT OF THE PROBLEM	5
Therapy for Therapists	5
A Note on Professional Classification and Terminology	7
CHAPTER TWO: REVIEW OF THE LITERATURE	10
What Is Psychotherapy?	10
Didactic Psychotherapy Training	28
Attitudes Towards Therapy and Help-Seeking	38
Psychotherapy Trainees	45
The Experience of Personal Psychotherapy	59
Ideal Programs and Mandatory Therapy	86
Criticism	93
Supervision	98
CHAPTER THREE: DISCUSSION	102
Recommendation of Personal Therapy	102
Conclusion	110
Summary	110
CHAPTER FOUR: SUGGESTIONS FOR FUTURE RESEARCH	112
Learning About Students	112
REFERENCES	118

CHAPTER ONE

Statement of the Problem

Where Does Personal Psychotherapy Fit in Graduate Training?

Therapy for Therapists

Within the literature, "personal psychotherapy" or "personal therapy" refers to therapy undergone by psychotherapy trainees and licensed professionals, as opposed to therapy provided to the general public. Personal psychotherapy has historically played a major role in the training process, and proponents claim numerous benefits, including personal and professional growth. Yet mandatory therapy is no longer *de rigueur* among training programs; indeed, it is uncommon.

The history of modern psychotherapy extends from Freudian psychoanalysis to the hundreds of present-day modalities. Rather than merely evolving, psychotherapy has had a schismatic course, with theoretical shifts in both technique and underlying conceptions of personality structure. What remains constant is that individual therapy is conducted between therapist and patient, that these roles are distinct, and that they are not exchangeable. Although feminist theory emphasizes attention to power dynamics, and several types of therapy use role-playing as a technique, no theory of psychotherapy defines the roles of patient and therapist as blurry, identical, or reciprocal; a therapist is always qualitatively different from a patient. The patient's honesty is requisite to any treatment, but a therapist's disclosure may be hazardous if he or she does not define boundaries. The patient may share the intimate moments of the sessions with anyone they choose, while the therapist has taken a legal and ethical vow of silence with few exceptions. Both therapist and patient must be in role for the process of therapy to function.

Psychotherapy is a high-stress career. Many therapists come from difficult backgrounds, with deep wounds of the sort that do not heal through the passage of time. The desire to heal and the achievement required to be accepted for training can coexist with personal distress. When trainees first provide therapy to others, the burden of their own issues may be too great for them to be of any help to a patient. If they have never received treatment, they may have no clue how a therapist ought to behave, let alone relate to the patient in front of them. Using the self, trying new techniques, or calling attention to process may exist only as suggestions from others. The job they are to perform may be unknown to them even as their suitability as patients is apparent.

Supervision is required of all trainee therapists, and the supervisory relationship continues to be a subject of research literature. Although supervisors are working therapists who provide consultation on psychotherapy, they are not directly accountable for the resolution of long-standing or acute distress in the trainee, even if it affects the latter's service provision. As with faculty mentors, supervisors have an active interest in the student's education and evaluation and as such risk a dual relationship by providing therapy or therapy-like services.

Attaining professional status does not immunize therapists from further distress. Many professionals suffer from impairment at some point in their careers, including marital problems, substance abuse, and mental illness. Therapy is often a necessary intervention, and it is typically a useful one. On the other hand, the illusion of unconditional competence may be particularly dangerous to clients and therapists alike.

This paper is concerned with how clinicians in development and practice are affected by personal therapy. The author hopes to determine where personal therapy belongs in the training of clinicians: whether personal psychotherapy merits a place in the curricula of training

programs, from which it is largely absent, and whether it should be promoted, either as a formal recommendation or a mandate.

The aim of this paper is to depict the place that personal psychotherapy occupies in the field with special attention to graduate training, and this requires surveying not just literature concerning students in therapy, but graduate training as a whole: the state of the training model(s), key competencies for student trainees, and the way that students are taught to think about psychotherapy at various stages of their development. The question is not only whether psychotherapy should or should not be required, but also how an individual goes from being a layperson to a therapist and where personal psychotherapy fits in to that journey; only after understanding that can what programs *ought* to do be assessed.

A working definition of psychotherapy will first be attempted by surveying professional organizations, clinicians, and prominent theorists in the field. The next section will provide a summary of the role of personal therapy in the lives of the key theorists studied in graduate training programs. The remainder of the paper will then address research on personal psychotherapy as it pertains to three stages: pre-training, graduate training, and licensed clinician. Attention will be paid to the preferences of programs regarding the character of the trainee as reflected by policies and procedures. Research focuses on attitudes towards psychotherapy, background experiences of psychotherapy trainees and professionals, and the outcomes of personal therapy in several populations and settings. The research will be synthesized to describe the rationale for revising training standards.

A Note on Professional Classification and Terminology

Most examples, citations, and data in this paper hail from the field of psychology. This is because the majority of research on personal therapy is conducted by psychologists;

psychologists as a field produce more research on psychotherapy than either master's-level clinicians or medical doctors. However, there is sufficient similarity between the training and professional activities of these professions to warrant generalization. To wit, there are psychodynamically-oriented counselors, social workers, psychiatrists, and psychologists. The same can be said of other theoretical orientations. Where results apply more specifically to a particular profession, it will be noted. The journey to become a psychotherapist exposes trainees in any profession to similar stressors, goals, and process, and for that reason, this paper addresses psychotherapists as a whole rather than drawing sharp boundaries between helping professions.

For the purposes of this paper, "patient" and "client" shall be used interchangeably to describe the recipient of psychotherapy if he or she is *not* a professional or trainee, e.g. "trainees work with clients..."; "the relationship of therapist and patient." This is in keeping with research literature that spans more than half a century and uses the terms interchangeably. In a therapy scenario, terms such as trainee, trainee-client, or therapist-client will be employed as necessary to avoid ambiguity.

Additional confusion exists between the terms "counseling" and "psychotherapy." Schoenberg & Shiloh (2002) employed the term "psychological treatment" in a study of hospital patients' views of therapy to control for preconceived notions about one term or the other. Lay notions of the two terms include the erroneous distinction that counseling is necessarily short-term, whereas psychotherapy is longer in duration (Pizzi, 2011). This may reflect a conflation of psychotherapy with psychoanalysis. In contrast to the paucity of scholarly research on the difference, the Internet has hundreds of web pages on the topic, none of which employ empirical findings based on the distinction. Both counseling and psychotherapy are unprotected terms, but counseling especially confuses by its attachment to non-therapeutic and/or nonprofessional

activity (e.g. vocational counseling, college counseling). For consistency, the terms "psychotherapy" and "therapy" will be used in this paper whenever possible.

CHAPTER TWO

Review of the Literature

Personal Therapy in Textbooks, Handbooks, Guidebooks, and Practice

What is Psychotherapy?

Medicine and police work provide subject matter for some of the most popular television shows, steeped both in realism (*ER*, *CSI*) and humor (*Scrubs*, *Reno 911!*). In either case, a template is provided for how the characters are *supposed* to behave, for what work they *ought* to be doing. The badge and the stethoscope are signifiers on television for characters we encounter in real life, with fairly predictable codes of conduct and patterns of action.

What does the couch signify? There are television therapists galore, as well, from *Newhart* to *Frasier* on the comedy end of the spectrum and *The Sopranos* and *In Treatment* on the more serious side. *In Treatment*, based on an Israeli show called *BeTipul* ("In Therapy"), is the only show that goes beyond a staged depiction of a therapist to focus on therapeutic process. It is not without its flaws and exaggerations, but makes an attempt at the realism tantamount to procedural dramas in other fields, complete with a flawed protagonist in Dr. Paul Weston. *In Treatment* has been classroom viewing in graduate psychotherapy classes (e.g. University of Texas Southwestern Medical Center at Dallas). This is a testament to its veracity, perhaps, but also to the lack of academic training materials illustrating therapy process.

Expensive videocassette(!) and DVD series are available that depict a number of masters at work, such as Yalom, Meichenbaum, and Ellis. However, these tapes are aimed for those who already have a firm grasp of therapy, and many can be watched for continuing education credits by licensed professionals (Psychotherapy.net, 2015).

So other than buying professional-grade materials or tuning in to semi-realistic cable series, how does one learn what a psychotherapist does all day? This is a broad question for the future of the profession. We see doctors and police at work every day in some capacity or another. Therapists remain mysterious. Unless a person entering psychotherapy training is the relative of a therapist or has been a client themselves, it is unlikely they have spent any time with one.

The question is comical: how can someone in school to be a psychotherapist learn what psychotherapy is? How can something ill-defined be learned, practiced, or benefited from? Clearly, all three things happen. It remains puzzling that in most helping professions, this abstract method is taught alongside quantitative methods, social justice, cognition and perception, vocational theories, and other subjects that have firm boundaries. How can psychotherapy be the task most pertinent to the future professional and yet the most opaque?

Who can do psychotherapy?

If psychotherapy is just one thing, then it is practiced by a number of different people in different fields. This is unlike medical care, which may happen horizontally, in specialized settings (rheumatology, cardiology) by practitioners on an equivalent level (M.D./D.O.), and vertically by variously credentialed professionals (e.g. doctors, nurses, medical assistants) within a practice. Either way, one would assume that the clinic down the street is practicing a recognizable version of medicine that all could agree on, and that everyone in the clinic is a member of the medical profession in some way.

Meanwhile, psychotherapy might be conducted in weekly, 45-minute problem-solving sessions in the psychiatrist's office upstairs from the clinic, where Dr. A is a medical doctor and licensed as such by the state. Dr. B. is across the hall, and treats individuals suffering from

phobic disorders with systematic desensitization techniques. He is not a medical doctor, but a psychologist, also licensed by the state. He likes his patients to call him David and not Dr. B.

Across town, Jeremy Mitchell, LCSW, sees patients an average of three times a week for psychoanalysis. He is a graduate of the local analytic institute, where he trained for five years after getting his Master's degree. He carries a social worker's license and is not a doctor. Nearby is the shared practice of Jim Duncan, a licensed professional counselor (LPC) and his wife, Patty, a marriage and family therapist (MFT). Jim uses a cognitive-behavioral framework with his patients, whereas Patty applies Minuchin's structural family therapy to her work with couples and families. Jim and Patty have their licenses from two separate state boards.

These five professions make up 98% of U.S. mental health providers, with the Master's level clinicians outnumbering the doctoral by a 3:1 ratio (American Psychological Association, 2014a). All are permitted to practice psychotherapy by virtue of their state licensure -- that is, there is not a dedicated "psychotherapy license" that is necessary. The average yearly earnings of a mental health counselor are around \$43,000, while psychiatrists earn nearly four times that much, but members of either profession can hang out a shingle as psychotherapists, practicing within identical modalities: in fact, a counselor, social worker, psychologist, and psychiatrist can all identify as psychodynamic therapists and be providing the same service under different licenses.

It has been suggested that the more heavily-trained (e.g. doctoral) practitioners are both more qualified to practice therapy (Mehlman, 1952) and perceived as more competent and knowledgeable (Gelso & Karl, 1974). This may be an artifact of history, as the progenitors of psychotherapy were medical doctors, and psychiatrists and psychologists were its first theorists and practitioners. According to data, however, a mental health consumer is more likely to

encounter a therapist with a master's degree, and this may be particularly true with managed care (APA, 2014a).

Where is psychotherapy learned?

Licensure requirements follow from degree requirements, based on curriculum, supervised practice, and evaluation. These are the common elements of all psychotherapy training. Each professional title has its own typical requirements in addition to these.

Psychiatrists must complete a four-year medical curriculum prior to their residency training, where they finally learn psychotherapy. Psychologists generally follow either the Boulder (scientist-practitioner) or Vail (practitioner-scholar) model, either one involving a degree of emphasis on scholarly work in addition to clinical practice and usually requiring a major scholarly project such as a dissertation. Clinical social workers are trained in the academic social work curriculum, which often focuses on micro- and macro-sociology and social justice.

An example of the diverse options for training in psychotherapy: in a 40-mile radius from Dallas, the Texas public university system grants degrees leading to each of the five licenses. The University of North Texas grants Ph.D degrees in clinical and counseling psychology, separate programs with minimal faculty overlap. On the same campus, degrees in Counseling (M.A, M.Ed, Ph.D) and Rehabilitation Counseling (M.S.) can be achieved in two different departments. UNT Dallas offers M.A. and M.Ed degrees in counseling, as well. Texas Woman's University grants an M.A. or Ph.D. in counseling psychology, an M.S. in Counseling and Development, and a M.S. or Ph.D. in Family Therapy. The University of Texas at Arlington offers a Master's degree in Social Work leading to the M.S.W. (LCSW). The University of Texas Southwestern Medical Center at Dallas offers training in Clinical Rehabilitation Counseling (M.S.), Clinical Psychology (Ph.D.), and Psychiatry (post-M.D.). These five public schools

average 3.4 different opportunities to pursue licensure as a psychotherapist. In the same geographical area, there at least four other private and/or religious institutions granting counseling degrees. Similar educational opportunities exist in other major U.S. cities.

Admission rates vary greatly within and between professional groupings. In 2005, doctoral programs in applied psychology (clinical or counseling) admitted an average of 21% of applicants with a median of 14-15%. Master's programs admitted about 59% (Norcross, Kohout, and Wicherski, 2006). Medical schools had a surprisingly high acceptance rate of 44.5% according to statistics from 2011-2013 (Association of American Medical Colleges, 2013), although this is reflective of an applicant pool that is extremely well-qualified as determined by a very demanding entrance examination (MCAT), among other factors. Programs in applied psychology may employ cutoff GRE scores to thin the applicant ranks (Norcross & Sayette, 2011). Future research should investigate whether there is a proportionate difference in therapeutic skills related to pre-enrollment grades and test scores.

Is there an official definition?

Among professional organizations, statements made about psychotherapy are vague and/or reductive and seemingly uninformed by practice. Several such statements follow which serve as official declarations of what constitutes psychotherapy. The American Psychiatric Association (2014) defines psychotherapy as follows:

Psychotherapy, sometimes called talk therapy, is a treatment that involves a talking relationship between a therapist and patient. It can be used to treat a broad variety of mental disorders and emotional difficulties. The goal of psychotherapy is to eliminate or control disabling or troubling symptoms so the patient can function better. Depending on the extent of the problem, treatment may take just a few sessions over a week or two or may take many sessions over a period of years. There are many forms of psychotherapy and

it can be done individually, with a family, or in a group. Some mental health [sic] require limited but ongoing treatment in order to manage chronic conditions

The official statement by the National Institute of Mental Health (2014) is very similar:

Psychotherapy, or "talk therapy", is a way to treat people with a mental disorder by helping them understand their illness. It teaches people strategies and gives them tools to deal with stress and unhealthy thoughts and behaviors. Psychotherapy helps patients manage their symptoms better and function at their best in everyday life.

The American Psychological Association (2014b) stated:

Psychotherapy is a collaborative treatment based on the relationship between an individual and a psychologist. Grounded in dialogue, it provides a supportive environment that allows you to talk openly with someone who's objective, neutral and nonjudgmental. You and your psychologist will work together to identify and change the thought and behavior patterns that are keeping you from feeling your best. By the time you're done, you will not only have solved the problem that brought you in, but you will have learned new skills so you can better cope with whatever challenges arise in the future.

The above suggest the following obligations of the psychotherapist: having a talking relationship, getting rid of symptoms, changing patterns, and teaching skills. Vague traces of the loan officer, crystal healer, auto mechanic, and tutor emerge, all professions with clear-cut duties, none of which require even a bachelor's degree. Again, what is it that makes defining psychotherapy and the career of the psychotherapist so elusive, and how does a postgraduate education help clarify those definitions?

Raimy (1950) offered an ironic definition: "Psychotherapy is an undefined technique applied to unspecified problems with unpredictable outcome. For this we recommend rigorous training" (Raimy, 1950, p. 150; in Skovolt & Rønnestad, 2003). Raimy's tongue was in his cheek: he is responsible for the creation of the prevailing Boulder model of clinical psychology training, and the clinical training lab at research-heavy CU Boulder bears his name. The Boulder

model originated the term scientist-practitioner and is emphatic about the role of research training in the development of the clinical psychologist, namely that training as a scientist should occur alongside training as a clinician (Norcross & Sayette, 2011). This includes the production of original research and a doctoral dissertation, and although these activities might be informed by psychotherapy, they typically concern with the non-therapeutic study of clinical subjects (e.g. designing a scale to measure relationship satisfaction; outcome research on smoking cessation in patients treated with bupropion vs. placebo). Depending on a student's interest in psychotherapy, he or she may decide after graduation not to seek licensure as a psychologist and instead pursue a career in academic research, teaching, or consulting.

More recently, the clinical science movement has affected graduate training in clinical psychology; the Academy of Psychological Clinical Science (APCS) was founded in 1994 and lists affiliated doctoral programs and internships which are dedicated to empirical clinical research. APCS programs place an clear emphasis on the scientist role in training. As one might expect, cognitive-behavioral orientations are most common among the training models of these programs (Norcross et al., 2008). APCS member programs would be a poor choice for the student aspiring to a career as a psychotherapist, and a number of programs such as CU-Boulder state this plainly on their websites. Others might argue that it would be unwise to pursue a doctorate at all when one could practice with a master's degree. McFall (2006) stated that the current forecast favors the role of the clinical psychologist in research rather than practice, basing the claim not on merit but on economic conditions and the specific requirements of a doctoral degree (i.e. scholarship) versus the general practitioner training common to the mental health professions.

There has been conflict among training models regarding emphasis of practice. In 1973,

the Vail model, known also as practitioner-scholar, was developed to provide a greater emphasis on practice, granting the Doctor of Psychology (Psy.D) rather than Ph.D. to emphasize the difference in emphasis. Though both degrees qualify one for licensure as a psychologist, the newer Psy.D has yet to achieve parity of reputation, and may arouse suspicion as Psy.D programs tend to charge more tuition on average, with larger class sizes (Norcross & Sayette, 2011). These statistics are often seen as a lowering of the bar when compared with the elitism of Ph.D programs, many of which remit their students' tuition entirely. Ph.D cohorts may be as small as four people, whereas the Massachusetts School of Professional Psychology charges \$57,421 for a year's attendance to a class of 82 students (Massachusetts School of Professional Psychology, 2014). Many programs endorsing a psychodynamic faculty orientation offer the Psy.D., (Norcross & Sayette, 2011), suggesting that students interested in the practical application of psychotherapy's tradition may need to pay more for the privilege.

More to the point, terminal degrees in psychology tend to be costly in proportion to their emphasis on clinician development, which sends a confusing message that it is a luxury to practice therapy with a doctoral degree, despite the fact that psychotherapy remains the representative activity of licensed psychologists (Norcross & Sayette, 2011). To wit, in a 2010 survey, 76% of psychologists performed psychotherapy and spent an average of 35% of their work week doing so, compared to 47% doing research for 15% of the week (Norcross & Karpiak, 2012). Addis and Krasnow (2000) found in a sample of 669 clinical psychologists in practice, only 33% did research.

By virtue of embracing two training models, one of which is clearly inclined towards scholarship, the APA shows an indecisiveness about what the place of psychotherapy is, other than to imply that it comprises either more-than-half, half, or less-than-half of advanced training.

As fewer than half of applied psychologists do research, the scientist-practitioner archetype may be disingenuous, and APA-accredited programs sometimes reconfigure or revise the Boulder model for their Ph.D. tracks (for example, UT Southwestern uses "clinician-researcher," Texas Woman's University uses "practitioner-scientist," the University of Tennessee has its own "Tennessee Model"). Unfortunately, the attitude of many doctoral training programs remains shaming to those who would choose psychology as a career alongside psychotherapist as an identity, and this may force applicants to lie about their interest in research (Murray, 2000).

Outside of psychology, there is less ambivalence about professional practice, but a similar vagueness about what practice is. The American Counseling Association (2014) has a definition of counseling endorsed by 29 different organizations, including the Council for Accreditation of Counseling & Related Educational Programs (CACREP) and the Council on Rehabilitation Education (CORE): "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals."

Counseling organizations tend not to use the term psychotherapy in their literature, and one is faced with the dilemma of whether to consider the terms as separate or distinct from one another. The Michigan Counseling Association (2012) endorses a synonymous view:

The term psychotherapy does not refer to any particular mental health profession, and within the counseling literature, the terms counseling and psychotherapy are used interchangeably to refer to the therapeutic process, with no differentiation of the terms. As such, the scope of practice of Licensed Professional Counselors includes both counseling and psychotherapy.

The ACA definition is less exact than even the APA or NIMH definitions of psychotherapy, as it includes the variety of counselors (vocational, rehabilitation) who do not generally conduct psychotherapy as a primary task. However, in all 50 states there is a credential (e.g. LPC,

LMHC) which allows master's-level graduates of counseling programs to practice psychotherapy independently, which they do in large numbers. Despite the less-selective admission standards of most counseling programs, counselors have a brief training experience compared to psychologists or psychiatrists and are thus able to practice sooner.

What psychotherapists say.

It is evident by now that a meaningful definition of psychotherapy is lacking in the professional training literature. Yet there is no shortage of trenchant voices from the literature of practice. Many helping professionals have rich and thoughtful views about their work. Where does this come from? It seems unusual that a process so ill-defined by institutions can be spoken about eloquently by graduates of those same institutions. All of the psychotherapists quoted below are graduates of accredited institutions, and some hold or have held academic positions. Perhaps vagueness leads practitioners to speculate about what, in fact, they are doing.

Davis (2014) interviewed Dr. Jerry M. Lewis about the definition of psychotherapy, who said:

At its most abstract level I would define individual psychotherapy as an attempt in a collaborative relationship for two people to explore the subjective reality of one of the persons that focuses upon the repetitious patterns that are present in the patients' narrative in a way that hopefully leads to new learning and changed behavior.

Collaboration and subjectivity, absent from the official definitions of therapy, are here regarded by an experienced practitioner as fundamental to the process. This collaboration is echoed in Davis' (2014) interview with Dr. Martin Lumpkin:

What I think the therapist also does in that situation is to get the person to change the kind of conversation she is having with herself. By talking with me she brings a stunted conversation out into the open. She gets

another person to hear it, whose hearing invites her to hear it in a way that gets out of a sort of circular, self-critical way that she gets caught up inside. She begins to hear a story unfolding rather than repeated expressions of inadequacy. So that sets up expanded ways of listening to her on different levels. There is certainly the diagnostic level I would listen to. There is certainly the historic level I would listen to. But fundamentally, it's this laying on of psychological hands and trusting that tacit sort of way of knowing where the energy is stuck and where we need to spend time and deepen my and her listening to herself.

It should not surprise that practicing psychotherapists do not echo the sentiments of clinical science where evidence-based practice (EBP) is concerned. The *sine qua non* of EBP is the term "intervention." Sanderson (2002) called interventions "specific, time-limited psychotherapy protocols" and cites their usefulness for conditions like panic disorder, OCD, and other psychiatric disorders. He also stated that few practitioners were actually implementing them, despite evidence that they may generalize from the controlled conditions of the lab into therapeutic practice. Perhaps this speaks to a desire on the part of experienced psychotherapists to guard their more nuanced conceptions of the process.

A somewhat vague answer from Meltzoff and Kornreich (1970, p. 4):

Psychotherapy is the informed and planful application of techniques, derived from established psychological principles, by persons qualified through training and experience to understand these principles and apply these techniques, with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviors, which are judged by the therapist to be maladaptive or maladjusted.

Manualized treatment is an outcome of EBP's popularity. Studies are done providing a precise protocol of techniques, the implementation of which theoretically results in effective treatment of a mental disorder. To best generalize these results, treatment manuals are passed on to clinicians in the hope that they will recreate the "proven" therapeutic techniques. Occasionally, these

manuals give the nonspecific factors in therapy -- rapport building, warmth, genuineness -- their due. This predicted a more favorable outcome among clinicians (Addis & Krasnow, 2000).

Clinicians also had concerns about autonomy when conducting evidence-based therapies, particularly when they worked in private practice. Clinicians were more likely to approve of treatment manuals for anxiety and stress than they were for enduring pathology, such as personality disorders. And while manualized treatments emphasize the delivery of techniques rather than the personality of the therapist, Miller, Hubb, and Chow (2013) claimed that "available evidence documents that the therapist is one of the most robust predictors of outcome among factors studied" (p. 90). The authors also cited research that outcome variance based on therapist differences was greater than with evidence-based vs. placebo treatment.

The Beck Institute is the premier training organization for Cognitive Behavioral Therapy (CBT), the dominant evidence-based therapy taught in doctoral programs in psychology (Norcross & Sayette, 2011). CBT was developed by Dr. Aaron T. Beck and his daughter, Dr. Judith Beck, who directs the institute. The institute's official statement on psychotherapy reads as follows:

The goals of cognitive therapy are to help individuals achieve a remission of their disorder and to prevent relapse. Much of the work in sessions involves aiding individuals in solving their real-life problems and teaching them to modify their distorted thinking, dysfunctional behavior, and distressing affect. Therapists plan treatment on the basis of a cognitive formulation of patients' disorders and an ongoing individualized cognitive conceptualization of patients and their difficulties. (Beck Institute, 2014)

Here, patients are framed as disordered, complete with remission and relapse. This is in line with the nosological view of mental disorders that is intrinsic to the development of empirical treatments. The description goes on to endorse the development of nonspecific factors that contribute the alliance, as well as a developmental approach to working with personality

disorders. By and large, though, the Beck Institute's definition of psychotherapy shares more in common with the NIMH's explanation than with the sentiments of individual therapists. Perhaps this reflects an essential discrepancy between the subjective experience of the practitioner and the party line of larger bodies.

Bugental (1999) mediated the conflict between cognitive and interpretive views of therapy:

Psychotherapy is not what you think. It is about how you think. It calls attention to unrecognized assumptions in how you think. It makes a distinction between what you think *about* and *how* you do that thinking. It is less concerned with looking for *causes* to explain what you do and more concerned with discovering patterns in the *meanings* you make of what you're doing.

Safran and Segal (1996) described a cognitive therapy that tempers scientific theory with the subjective use of the therapist as an agent of change. In their view, a lack of attention to the therapeutic relationship

perpetuates a mechanistic approach to therapy that fails to recognize the fundamentally human nature of the therapeutic encounter and the change process. The assertion that psychotherapy is fundamentally a human encounter does not mean that there is no theory for therapists to learn and no skills for them to acquire. It does mean, however, that the relevant theory must clarify the process through which this human encounter brings about change, and that the relevant skills must include the ability to use one's own humanity as a therapeutic instrument. (Safran & Segal, 1996, p. 5).

Davis (2014) interviewed the analytically-minded Dr. Rycke Marshall, who stated that psychotherapy is "where two people come together to try to make sense of things. It is the responsibility of the therapist to guide that process and to create an environment where it feels safe and comfortable to engage in that kind of exploration."

Yalom and Elkin (2008) conceived a teleological view of therapy process that emphasizes the subjective contact between therapist and patient:

Once the patient's interpersonal behavior is recapitulated on the stage of the therapist's office, the therapist begins in a variety of ways to help the patient observe himself. The here-and-now focus on the therapist-patient relationship is thus a two-pronged one: first, there is lived experience as the patient and the therapist interlock in a curious paradoxical embrace, at once artificial and yet deeply authentic. Then the therapist, as tactfully as possible, shifts the frame so that he and the patient become observers of the very drama which they enact.

In the accounts of practitioners, there is an absence of words like disorder and treatment and an emphasis instead on collaboration and the relationship between therapist and patient. The official answers to "what is psychotherapy?" have an agenda of assurances to the public and the mental health consumer concerning the validity of the psychotherapeutic experience.

Practitioners of psychotherapy from various orientations emphasize the humanity, and thus imperfection, of the process. For this reason, their accounts will never find parity with the overviews given by organizations, but will have more to offer those inside the field, including students, and anyone curious about psychotherapy.

Why psychotherapy is unique.

Psychotherapy seems to be a collaborative process of exploration and listening with another, possibly with the aim of treating a specific mental disorder, possibly towards insight in order to make changes in long-lasting patterns, perhaps including both, and requiring advanced training. With this definition, psychotherapy has flexibility: it can help a frustrated artist, a veteran suffering from post-traumatic disorder (PTSD), an isolated individual with an eating disorder and a pattern of ruining relationships, or a psychotherapy trainee who seeks to examine their own blind spots and understand the client role. As this paper is concerned with personal therapy for trainees, it is fundamental that psychotherapy is be useful in the absence of a DSM-V diagnosis and also that insight be useful in the practice of psychotherapy.

"Work and love" have been cited as goals of therapy, attributed to both Freud and Erikson (Hazan & Shaver, 1990). Though the quote may be apocryphal, it has circulated among psychotherapists and is pertinent beyond the analytic tradition. "Work and love" emphasizes actualization, meaning, and the ability to perform the tasks of life over the resolution of pathology. This view of therapy, where the outcome is unrelated to whether one still meets five symptom criteria for a major depressive episode, may be unpopular with the guidelines of clinical science but is certainly a useful lens with which to view the therapy of the therapist-to-be. The sentiment reverberates especially through Eriksonian, existential-humanist, and contemporary psychodynamic approaches to therapy.

There are several reasons to define what is not psychotherapy. First, all psychotherapy must include confidentiality on practical and ethical levels. Fully experiencing a therapist-patient relationship requires the establishment of trust, particularly given the disclosure required of the patient to make progress. Violating this trust is more than detrimental to the therapist, however: with very few exceptions, breaking confidentiality is a universal ethical violation. Exchanges that do not expressly include confidentiality cannot be considered psychotherapy. This eliminates a great deal of consultation, advising, supervision, and coaching.

Second, psychotherapy has an ethical obligation to select effective treatments based on the client's needs. Theory is not one-size-fits-all, and a clinician is obligated to refer out patients whose problems lie beyond his or her scope of expertise. In the case of an individual without a distinct pathology, a psychotherapist is nonetheless obligated to refer the patient out if a sufficient working relationship cannot be established and the patient is not progressing. Failure to form a relationship is not an ethical violation. Practicing outside one's competence can become one (American Psychological Association, 2002).

Third, psychotherapists are required to set boundaries with clients. Some, like text message communication, are loose and vary by practitioner. Others, such as the proscription of sexual activity with clients, are rigid. Generally speaking, psychotherapists do not engage in dual relationships with clients; a psychotherapist cannot also be the client's friend, lover, or business partner. As mentioned at the outset, psychotherapists rely more than many other professions on the maintenance of boundaries and roles for the benefit of both parties.

Fourth, and most importantly, psychotherapy is ideally delivered by licensed graduates from accredited training programs. To our knowledge, no research exists comparing service delivery between non-accredited and/or non-licensed professionals with their counterparts, but it is acknowledged that there are some individuals operating outside any licensure. Life coaching is unregulated and does not require mental health licensure, and thus it does not qualify as psychotherapy, and this is redoubled by a lack of parity with psychological theoretical orientations (DeAngelis, 2010).

Coaches are not bound by confidentiality, and they rarely are willing to deal with the past in more than a superficial manner (Hart, Blattner, & Leipsic, 2001). Some coaches have no mental health background and are unprepared to deal with psychopathology; others are mental health professionals who choose to adopt a looser practice under the aegis of coaching, rather than psychotherapy. Green, Grant, and Rynsaardt (2007) found that high school students exposed to coaching showed increased levels of hope, agency, and cognitive hardiness as compared to a control group. Coaching may have a similar effect on graduate students, broadly speaking. However, to date no research has been conducted on the specific effects of personal coaching on the growth of psychotherapists in training. The salient difference is that trainees cannot relate to coaches as professional analogues, nor can they expect a full range of psychological services.

Ultimately, helping students to conquer their practical (and non-pathological) impediments to success may improve their chances of professional *attainment*, but likely will not affect the development of their professional identity and therapeutic skills in as direct a manner as personal psychotherapy.

This paper intends to focus only on programs of training that embrace a unified set of competencies for psychotherapists. This does not refer as much to micro-counseling skills (e.g. reflective listening) that may be learned from a book by laypersons, but rather working within a framework that values confidentiality, boundaries, professional conduct, and the completion of academic and supervisory benchmarks. These elements are found across codes of ethics and accreditation and distinguish psychotherapy over other forms of helping and healing that resemble it. Trainees seek to attain these competencies, and so personal therapy for denotes working with a therapist who holds a license to practice counseling, psychology, social work, or psychiatry and not visiting an unrelated professional. Being professionally coached might help a graduate trainee cope with scholastic pressure, but could also serve to confuse and undermine the trainee's professional practice goals by providing an incongruent role model.

This paper will give consideration to the topic of supervision, which is always required of trainees. Outside of the supervisory relationship, students may rely on program faculty for nurturing and advice (Bruss & Kopala, 1993) or self-care modeling (Thomas, Caputi, & Wilson, 2014). Alternatively, students may fear that faculty will diagnose them (Farber, 1985), which implies punishment and labeling rather than the insight and direction provided by diagnosis in the clinical process. In any case, interactions with faculty are likely to arouse admiration, anxiety, inferiority, and other strong feelings in the trainee, and these feelings are found in the psychotherapy process as well. Even if they are practicing psychotherapists themselves,

however, faculty interaction with trainees does not qualify as psychotherapy, and trainees will need to distinguish between the role of psychotherapist-as-instructor from the role of one's personal psychotherapist.

Does psychotherapy work?

Having reviewed what psychotherapy is, and how and by whom it is learned, this is a comparatively simple question. Yes. It *can*. The American Psychological Association's resolution on the Recognition of Psychotherapy acknowledged the breadth and depth of research into the topic and concluded after much bureaucratic shuffling that ample evidence exists supporting the use of psychotherapy as a treatment (Campbell, Norcross, Vasquez, & Kaslow, 2013). In contrast to the association's rather anemic definition of psychotherapy, this resolution presents a definitive endorsement of a range of different theoretical orientations. Psychotherapy would surely continue to be practiced in the absence of this validation, but it is a significant victory to gain the endorsement of a major accrediting body.

Whether psychotherapy works better than other treatments is a different question, and whether some types of psychotherapy work better than others is still another. *How* does it work? Do techniques work out of their theoretical context? Is an analogy to medicine appropriate, or ludicrous? Psychotherapy process and outcome research has been occupied with these questions for years; indeed, the entire March 2013 issue of the journal *Psychotherapy* is devoted to revisiting a debate between Eysenck (1964) and Strupp (1963) over whether therapy works, lingering over the measurability of the factors that indicate whether it *has* worked on an individual. Strupp and Eysenck's disagreement precedes the movement towards manualization of therapy treatment by decades and in revisiting them 50 years later -- after the death of both theorists -- *Psychotherapy* seems to affirm that this debate is in no danger of resolution.

Nonetheless, process and outcome research continues to benefit from the advancement of technology and particularly mixed-methods research. Hill, Chui, and Baumann (2013) noted a divergence in patient self-reports of their ongoing therapy outcomes (i.e. rated questionnaire responses) versus qualitative data gathered on their well-being (e.g. the emergence of their sense of humor; a single instance of assertion in a normally passive individual). In order to contribute meaningfully to our understanding of psychotherapy, Hill et. al (2013) suggested that the extra effort required to perform mixed-methods research can pay off in a greater understanding of the complex processes of longer-term work.

Acknowledgement of qualitative values in therapy research may suggest to students that they look outside a symptomatic framework in understanding patients. This is coherent with the focus on the normal population emphasized by counseling psychology (Norcross, 2000). However, the ability to view therapy as a process that may be both measured and understood experientially can apply to all therapy and might enhance its reputation among a wide variety of students. In most training programs, reading the literature on psychotherapy process and outcome is, like undergoing personal therapy, an extracurricular affair.

Didactic Psychotherapy Training

Textbooks on psychotherapy theories are similar in scope and consistent in the historical theories they feature (Archer & McCarthy, 2006; Corey, 2012; Corsini & Wedding, 2011; Seligman & Reichenberg, 2006; Sharf, 2011). These texts are used in APA-approved doctoral programs in clinical and counseling psychology (e.g. University of Illinois, University of Northern Colorado) as well as master's programs (e.g. Texas Woman's University, San Jose State University, University of Texas Southwestern Medical Center at Dallas) which prepare students for licensure as clinicians. CORE requires students to "communicate a basic understanding of

established counseling theories and their relationship to personality theory" as well as "articulate a personal philosophy of rehabilitation counseling based on an established counseling theory" (Council on Rehabilitation Education, 2013, p. 30).

Theorists form part of a standard curriculum and are intended to connect with the intellectual formation of professional identity, although didactic instruction is only part of theoretical orientation development (Vasco & Dryden, 1994; Buckman & Barker, 2010).

Theorists frequently mention their personal therapy, and these experiences may be relevant to students in their own decisions about whether to include therapy in their training. Theorists differ regarding whether personal psychotherapy is a necessary step, but a majority seem to have had experiences with it. The theorists below appear in almost any textbook of psychotherapy theories and are likely the most prominent professional and/or historical role models introduced in didactic coursework.

Psychoanalysis.

Generally regarded as the founder of psychotherapy, reading Freud serves as a departure point for theories classes. Psychoanalytic jargon is widespread: ego, compensation, repression, and other terms from classical psychoanalysis are in common (and sometimes incorrect) usage by non-therapists. Meanwhile, Freud's less popular concepts (e.g. the Oedipus complex, penis envy) are frequently taken out of context and allow for the portrayal of psychoanalysis as archaic and outmoded. Accordingly, Freud's personal life is poked at with a frequency that betrays his status as the world's most famous psychological theorist. In the film *Good Will Hunting*, Robin Williams portrays a psychology teacher who doubles as a therapist (and whose professional ethics are in serious question). Williams' character tells his class "see you Monday. We'll be

talking about Freud and why he did enough cocaine to kill a small horse" (Bender & Van Sant, 1997).

But Freud's presence in graduate coursework is hardly mockery. Although a minority of students will go on to be trained as psychoanalysts, beginning with Freud provides a lens through which subsequent therapies might be seen as alternatives to his theories of personality. Whether or not students cotton to analytic thinking, Freud is arguably the first psychotherapist, and the predecessor, rather than the contemporary, of all other theorists. For the trainee, studying psychoanalysis (usually Freud, Jung and Adler; rarely Sullivan, Horney, Klein, Kernberg or anyone else) introduces the complex, sometimes literary aspects of understanding personalities, and provides a frame of reference for understanding how personality is deemphasized in nonanalytic theories. Some will enjoy psychodynamic thinking, and others will reject it. There are ample academic opportunities for both types of student (Norcross & Sayette, 2011).

Moreover, Freud created a role, the psychotherapist, that would endure even as it changed its guises. The role is disparate and demanding, particularly regarding the management of transference and countertransference (Patterson & Watkins, 1996). These ideas are still used to describe psychotherapy process across theories, albeit not in a strictly Freudian sense and not always by name (Gelso & Bhatia, 2012). As a beginning, Freud's psychotherapist role addresses the accompanying processes in interpersonal relationships, and this may didactically send the message to uninformed psychotherapy students that the therapeutic role is different from advice-giving, paid friendship, or endless inquiry into feelings. It is instead a position that requires an awareness of one's underlying feelings about others and ability to evaluate the transference of patients. This level of self-knowledge was thought impossible by Freud in the absence of analysis. In *Analysis Terminable and Interminable*, Freud (1937) wrote:

Obviously we cannot demand that the prospective analyst should be a perfect being before he takes up analysis, in other words that only persons of such high and rare perfection should enter the profession. But where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession?

The answer is, in an analysis of himself, with which his preparation for his future activity begins.

Freud supported the notion of personal analysis on educational grounds, as a gateway to the profession. He did allow for self-analysis (his own, at least), as well as granting exceptions for those he saw as exceptionally talented (Jacobs, 2011). As it grew, the analytic tradition began to require personal analysis of trainees (Jacobs, 2011), and thus a training analysis is codified by the American Psychoanalytic Association (APSA, 2010, p. 3) and the International Psychoanalytic Association (IPA, 2013, p. 5-6). Freud's expectations set the bar for future therapists to examine themselves with rigor and to respect the complexity inherent in psychotherapy theory.

Freud appears to have written about the training analysis more than Jung or Adler, who typically follow him sequentially in psychotherapy textbooks, and both of whom were associates of Freud. Jung's mysticism and Adler's proto-humanism represent the different directions that psychodynamic thinking can be taken while retaining some fundamental tenets (e.g. interest in early development, intrapsychic and unconscious processes, dreams). Although there remains a clear differentiation of role between therapist and patient, much early psychoanalytic theory speaks to aspects common to the human psyche, notably Jung's collective unconscious and Adler's emphasis on birth order and social influences. Today, long-term Jungian and Adlerian therapies and training endure. Perhaps students can glean from reading about Freud's successors that psychodynamic thinking does not end with Freud, although it does begin there.

Cognitive and Behavioral.

Many therapists who were trained psychoanalytically broke from the tradition entirely to create their own theories, but often did so after undergoing their own training analyses. It is difficult to imagine a long stint in personal therapy not having an effect on the development of one's own theories, even if that effect is complete divestment from psychodynamic thinking. Albert Ellis, the founder of Rational Emotive Therapy (RET), was able to attain a training analysis and practice as a psychoanalyst with a doctorate in psychology -- unusual for his time -- before becoming entirely disillusioned (Ellis & Bernard, 1985). His personal analysis lasted two years (Warren & Ellis, 1987), and it is likely that during this time, he gained some insight into himself that either retained its value or redoubled his efforts to create a new system of psychotherapy.

Ellis emerged from training and personal analysis to create a system of psychotherapy based on reframing emotional reactions and experimenting with behavior change (Ellis, 2006). His theory allowed him to move the locus of change from understanding one's unconscious conflicts to reorganizing one's belief system and behavior in line with reason, denying the importance of the Freudian unconscious. Ellis modeled interest and interactivity for the Rational Emotive therapist, but did not feel that interpersonal warmth was a necessary condition (Warren & Ellis, 1987). At the same time, Ellis regarded his commitment to helping his patients overcome their difficulties as genuineness, saying that many clients responded favorably to this attitude. Responding to a survey on RET, Ellis endorsed that he did not concern himself with transference relationships, and stated that he saw 70 clients a week for problems that were 90% anxiety-related (Warren & Ellis, 1987). Ellis' methods employed personal examples, profanity, and other therapeutic risks (Patterson & Watkins, 1996). Though Ellis is inimitable, it is difficult

to imagine a therapist acquiring similar confidence and steadiness without experiencing firsthand the client's side of the encounter.

Aaron Beck, a psychiatrist, founded cognitive therapy (CT), the predecessor of the now-ubiquitous cognitive-behavioral therapy (CBT). Beck trained at the Philadelphia Analytic Institute and then underwent an analysis at the Horney Institute (Beck, 2006). He used psychoanalysis as a framework for testing hypotheses about the origins of depression, finding the notion of anger turned inward to be an insufficient explanation. Beck was castigated by the American Psychoanalytic Institute, who claimed that his inclination to conduct research was indicative of a failed personal analysis (Smith, 2009).

Beck went on to develop an hermeneutic style that opposed the psychoanalytic tradition in form and content. By conducting therapy in a face-to-face manner that allowed for back and-forth communication, the elicitation of automatic thoughts occurs in a Socratic fashion that opposes the psychoanalytic tradition (Smith, 2009). This opposition is represented in both graduate training and research as an overt binary (Jarrett & Melchiodi, 2013; Jones & Pulos, 1993). Weissman et al. (2006) found CBT and psychodynamic coursework and supervision to hold an equally strong presence in the psychiatric training (>97% of programs), with the former more prominent in the training of psychologists than other non-medical helping professions. Beck acknowledged influences on his work from various schools, including Alfred Adler and Karen Horney, who also departed from the analytic tradition, as well as Albert Ellis and Carl Rogers (Beck, 2011). There does not appear to be an official endorsement of personal therapy for cognitive therapists. Moorey (2014) found the idea problematic on the grounds that CT/CBT works best when distorted thinking is active and thus impairing, and also claimed that cognitive therapists may be uncomfortable with psychodynamic therapy. However, Pope and Tabachnick

(1994) found that over 70% of CBT therapists surveyed had received personal psychotherapy. Although cognitive theories of psychotherapy diverge from psychodynamic models of personality, they do not do away with interpersonal factors: Shedler (2006) and Gelso & Bhatia (2012) claimed that CBT repackages psychodynamic concepts such as transference.

The famous behavior therapist, Joseph Wolpe, claimed that psychoanalysis could be harmful and remained a critic throughout his career. Wolpe developed behavior therapy as an alternative treatment which conceptualized the mechanisms and process of change in an entirely different way (Wolpe, 1981). Behaviorism on the whole is a domain of psychology unconcerned with personality, filled with detachment and scientific terminology and associated as much with animals as humans. Punishment and deprivation are assumed (Wolpe, 1981). Wolpe's approach to behavior therapy, though, was compassionate, emerging in part from the belief that psychoanalysis places too much blame on the patient and that the therapist is not held responsible for the patient's progress (Wolpe, 1981). He wanted demonstrable effects on the patient (i.e. symptom reduction), unsatisfied with psychoanalysis' claims to unmeasurable changes (e.g. the development of insight), and felt that the latter was irresponsible as it kept worsening patients in the same therapeutic context (Wolpe, 1961).

Wolpe believed strongly in professionalism and that the behavior therapist was a complex practitioner, lamenting the exemplary use of simple phobias (e.g. snakes) in the literature (Wolpe, 1981). Behavior therapy, Wolpe claimed, was effective on the same neurotic formations as psychoanalysis, but with the benefit of lasting results in shorter amounts of time (Wolpe, 1961). He warned against practitioners oversimplifying the process, and characterized the behavior therapist as knowing more about their patient than in other theoretical orientations due

to the amount of information that must be disclosed to identify a patient's patterns of action and conditioned responses (Wolpe, 1981).

In a letter to the editor of *The American Journal of Psychotherapy*, Wolpe suggested that for behavior therapists to avoid personal therapy would be cynical and immoral, showing a lack of respect for the potency of their own theoretical orientation (Wolpe, 1988; in Norcross et al., 2005). This again acknowledged the necessity of therapists' preparedness to assume their role, and how personal therapy can assist that end. Naturally, Wolpe recommended behavior therapy (Wolpe, 1988).

Humanistic and Existential.

Rogers thought that psychoanalysis did not do enough to enact personality change, citing an example where he treated a pyromaniac with some improvement, only to have him start setting fires anew (Rogers, 1961, p.10). His alternative, which became person-centered therapy, recast the therapist from his role a blank slate into a real person. However, this person was to be free from agendas and to respect the person as knowing themselves best (Kahn, 1998). The requisite aspects of therapist personality, which he called "necessary and specific conditions", relied on positive qualities like warmth and genuineness. Rogers focused on the present and on the real relationship between therapist and client, and while this goes against the Freudian analytic tradition, Rogers was inspired by the proto-humanistic thinking of Freud's colleague Otto Rank (Kramer, 1995). The nondirective nature of person-centered therapy also precludes the adoption of protocols that emphasize the disputation or change of the client's thoughts or actions.

Unlike with many of his fellow theoreticians, it is difficult to locate information on the nature and extent of his personal therapy. It is known that Rogers disliked "patient" as a term,

reflected in his use of the word "client" (person-centered therapy is also referred to as client-centered). His theory avoided a medicalization of problems and the polarized role of doctor and patient (Kahn, 1998). A humanistic view of therapy may thus be easier to accept for a trainee who has a strong aversion to help-seeking. Rogers stressed the therapists' own self-acceptance, something that must be developed and maintained in order to effectively be with others (Rogers, 1951).

Humanist Abraham Maslow was a non-clinician but theoretically aligned with Rogers' concept of a fully-functioning person. His self-actualization pyramid is familiar to anyone who has taken an introductory psychology course. The goal of ascending this pyramid, rather than shedding symptomatology, is a developmental, rather than restorative approach to therapy. The idea of going to therapy not because of sickness, but rather to increase wellness, may deactivate the aforementioned help-seeking stigma. Ironically, Maslow is quoted as saying that he considered getting psychoanalyzed one of the peak experiences of his life (Maslow, 1965, p. 692).

Fritz Perls came from an analytic background that incorporated both classical and Reichian ideas, having trained under Reich himself (Smith, 1975). Gestalt therapy borrows some of the more progressive ideas from Perls' analytic background and melds them with existential philosophy and Gestalt psychology. Like Ellis, Perls was an eccentric and fearless clinician. In the well-known film *Three Approaches to Psychotherapy*, Perls' manner is highly confrontational, provoking, and committed to the idea that he is a human being in the present moment (Shostrum, 1965).

Gestalt training is available in the U.S. through institute programs but does not appear to hold much sway in the curricula of graduate training. Nevertheless, Gestalt theory, particularly in

its Perlsian incarnation, is generally taught alongside other classic theories. With Perls, as with other analytically-trained theorists who go in a different direction, the inference must be made Perls own therapy was an individuating experience. As for students of Gestalt therapy, Elliott & Partyka (2005) stated individual and experiential group therapies may be useful as training experiences and throughout the careers of Gestalt therapy, particularly in regards to maintaining one's authenticity.

Like many psychiatrists, Irving Yalom underwent an extensive psychoanalysis that lasted 600 hours (Yalom & Leszcz, 2005). Though not an analyst himself, Yalom claimed that this experience was crucial to his development and reiterated the familiar notion that this sort of work rests on the gains evoked from accurate self-perception and insight. Yalom also entered personal psychotherapy at different times in his life, emphasizing that with new life stages come new challenges and reasons to seek help (Yalom, 2002, p. 42). He called his personal psychotherapy "the most important part of my training as a therapist" (Yalom & Leszcz, 2005, p. 559), and also led a training group for mental health professionals so that they might have experience as clients in that setting.

Existential therapy is grounded in the idea that we all encounter our own existence differently, yet face the same ultimate questions. Yalom preferred to conceptualize his patients in a nonjudgmental, inclusive manner that did not emphasize pathology (Josselson, 2007). Yalom's therapy does not consider therapists "special," which would exempt them from treatment, but permits therapists to acknowledge the same *lack* of specialness that confronts all who exist. Patient and therapist relate to one another as humans bound to create meaning out of experience. The roadblocks to this sort of relationship might be the subject of an existential therapist's personal therapy.

Recent theories.

Psychological theory is a living science. Interventions such as acceptance and commitment therapy (ACT), dialectical behavior therapy (DBT), and functional analytic psychotherapy (FAP) have been developed in the last 30 years and become popular, and it is likely that the textbooks of the future will feature the theorists responsible for these therapies. More to the point, the students of today are going to be responsible for tomorrow's therapies. If their experience coheres with history, these students will have meaningful experiences in their own therapy which inform their theoretical ideas.

Fitzpatrick, Kovalak, and Weaver (2010) found that students often relied on reading within the curricular model for the development of their practice orientation, and seldom committed to a single orientation's philosophy or technical base. Norcross, Hedges, and Prochaska (2002) organized a Delphi poll of experts in the field, who concluded that eclectic/integrative therapy approaches, which borrow a variety of techniques, would be in the top five theoretical orientations in the coming future. The poll also ranked as unlikely the idea that psychotherapy will advance through revolutionary, rather than evolutionary, changes. This underscores the utility of understanding the theory base from a didactic point of view, as advancements in therapy will continue to build on established theories (Norcross et al., 2002).

Attitudes Towards Therapy and Help-seeking**Lay conceptions of psychotherapy.**

Because psychotherapy is a confidential affair between therapist and patient(s) (American Psychological Association, 2010), it follows that misconceptions will be made about the process and those that receive it due to a lack of firsthand exposure. Media depictions of therapists and therapy are commonplace (Maier, Gentile, Vogel, & Kaplan, 2013; Bram, 1997) and often

inaccurate, further distancing the public from an accurate conception of what goes on in the therapy room (American Psychological Association, 2004). Media representations are thought to contribute negative attributions through their depictions of people with mental illness and therapy-seekers as well as psychotherapists themselves (Maier et al., 2013).

Furnham and Wardley (1990) surveyed beliefs about therapy in a sample of 200 laypeople. More than half had read books about therapy, but only 15% had seen a therapist. Nearly three-quarters of the sample said they had never considered it. The authors found that most participants held beliefs that were accurate ("the establishment of rapport is of major importance during the early stage of the therapy"), somewhat accurate ("psychotherapists aim to teach clients better self-understanding of their motives"), and inaccurate ("a major component of all psychotherapy is teaching about relaxation, which helps people cope with anxieties"). They showed a knowledge of the theoretical diversity of psychotherapy (e.g. psychodynamics, exposure therapy), though they were not asked to name the theories. Despite this, they conflated therapeutic activities like dream work, confronting irrational thoughts, and exploring sexual issues, suggesting that these things happen across orientations (Furnham & Wardley, 1990). The results also showed a difference by age, with older people showing greater pessimism about psychotherapy. Predictably, having visited a psychotherapist was correlated with knowledge of the profession.

Along these lines, Murstein and Fontaine (1993) surveyed participants' knowledge of nine helping professions and found that individuals who had previously made contact with psychologists, psychiatric nurses, marriage counselors, or telephone counselors were better able to describe the profession than those who had not, although the work of psychologists and marriage counselors was less understood on average. The sample reported little knowledge of the

amorphous category "psychotherapist" (which overlapped five other professions). It is possible that psychotherapy was viewed by the sample as a career rather than a professional activity. It appears that *specific* knowledge did not play a role in opinion-forming when recommendations were considered: participants endorsed psychotherapist as the professional they would recommend to a friend with the same frequency as they endorsed social workers, and nearly twice the frequency as psychiatric nurses (Murstein & Fontaine, 1993).

Attitudes of college students towards therapy.

A contributing factor to the stigmatization of therapy is the rejection of a continuum of mental illness and functioning. There is a tendency to dichotomize individuals into "sick versus well" that may result in similar attitudes being held about current and former mental patients (Calicchia, 1981) as well as recipients of outpatient counseling for unspecified problems (Sibicky & Dovidio, 1986). Maier et al. (2013) found that perceptions of mentally-ill individuals portrayed in the media affected perceptions of help-seekers more generally. Students studying psychology at the undergraduate level are prone to making generalizations via this dichotomy. Sibicky & Dovidio (1986) found that when participants were acquainted with other students in two conditions, one where the students were depicted as clients receiving services at a college counseling center. Participants rated the fake clients differently than the controls in a number of dimensions. The fake clients were rated less attractive, less warm, less sensitive, and more sad. This suggests that students hold a prejudiced view of people seeking psychotherapy that may extend to judgments about character, state, and/or other factors.

Vogel and Wester (2003) found that attitudes towards seeking professional help were related to help-seeking intent, and that attitudes are determined in part by personal approach and avoidance factors. Students who are comfortable disclosing personal information were more

likely to have a positive attitude about therapy and vice versa. Positive experiences in personal therapy were also correlated with more favorable opinions of help-seeking (Vogel & Wester, 2003).

Bram (1997) conducted a survey of students to determine their attitudes about both the process of therapy and the role and characteristics of the therapist. Concurrent with Furnham and Wardley (1990), responses displayed a mixture of correct and stereotyped answers. Students endorsed the idea that therapy is a process with many styles and variations, valuing the therapist-patient relationship, and that therapists are highly-trained and ethical professionals. On the whole, they trusted the profession and understood that therapy is about more than feeling good.

However, students endorsed the idea that most therapists think "many psychological problems begin in childhood" and that someone would be less likely to go to a therapist who was in therapy him or herself. In response to an open-ended question about ethics, over 20% of students believed a therapist would abandon a client who was insulting them and that the most common response to a client's sexual advances would be for the therapist to reciprocate (Bram, 1997). This is in spite of the previous endorsement of therapists as ethical.

An interesting factor in the open-ended portion was the effect that students' personal therapy had on responses. Students who had undergone personal therapy were less likely (16.9%) to believe that a therapist would respond to sexual advances with personal interest versus those who had not had therapy (25.6%). Likewise, 12% who had sought therapy believed that a therapist would abandon a client, whereas 21.6% of the non-therapy subset believed this (Bram, 1997). Personal experience with therapy suggests a more favorable appraisal of therapists' roles and ethics.

Both Bram (1997) and Sibicky & Dovidio (1986) recruited their sample from an introductory psychology course, as is often the case with student sampling. This may affect the generalizability of findings, but additionally could be misleading regarding the likely psychological-mindedness and/or interpersonal sensitivity of the student sample; participants in introductory psychology courses do not necessarily go on to pursue careers in applied psychology. Further, the texts for standard introductory courses broadly survey realms of psychology outside psychotherapy, such as sensation and perception, social psychology, and neuroscience (Kalat, 2013; Plotnik & Kouyoumdjian, 2010). The undergraduate curriculum in psychology is not intended to train specialists, and interpersonal sensitivity and psychological mindedness are not relevant to the introductory course any more than bedside manner is requisite for foundational coursework in biology.

To wit, Warner and Bradley (1991) presented 120 undergraduates in an introductory class with a questionnaire assessing their knowledge of the differences between counselors, psychologists, and psychiatrists, including professional activities and education. They averaged 53% accuracy, demonstrating that the roles of mental health professionals may be confused and conflated. In particular, subjects tended to regard the professions as being associated with the seriousness of the problems they address, with psychiatrists tackling the most "severe" dysfunction. One implication of these results is that visiting a counselor may be perceived among students as less grave than seeing a psychologist or psychiatrist.

Thomas, Caputi, and Wilson (2014) found that only 22% of an undergraduate introductory class sample would consider entering treatment in the event of a mental health problem. Attitudes predicting therapy use included thinking that emotional problems required professional help and the belief that, in the event of a breakdown, professional help would be the

first course of action. These two beliefs describe a faith in the psychotherapy process, perhaps as an emergency measure, and yet they appear to be uncommon in this younger, educated sample. Further research might investigate the composition of introductory psychology classes on measures like sensitivity, psychological-mindedness, and knowledge of applied psychological professions as related to individuals who continue on to graduate study.

Matteo (2013) used open-ended questions to gather qualitative data regarding undergraduates' views of mental illness, including writing about causal factors and associated words ("psychiatrist", "therapy") in addition to watching a video, interacting with mentally ill members of the community, or an educational lecture. Among all groups there was a tendency to harbor negative views and integrate outside concepts of dysfunction such as developmental disabilities into the construct of mental illness. However, increased use of empathic language was found in the post-test writing sample among those who had been exposed to either the contact or video conditions.

Prior (2012) suggested that conflicting attitudes about counseling exist in early and middle adolescence. Two narratives expressed an initial stigma through fear of being "psycho" and wariness over developing a personal association with a person who treats mental illness. In both these cases, self-stigma was mitigated by reframing the process as a collaborative problem-solving effort. Participants also showed resistance towards the stigmatization of their counseling by others and depicted the process as courageous and pro-active (Prior, 2012). The validating, person-centered approach to therapy described by Rogers (1957) resonates with adolescents' apparent desire for a real relationship in a therapeutic setting.

Research involving students and laypeople suggests a complex view with inconsistent biases regarding therapist, client, and process. A finding common to much of the above research

is that personal exposure to therapy or therapy patients can have positive effects, including more accurate knowledge (Wade et al., 2011; Bram, 1997; Furnham & Wardley, 1990); Murstein & Fontaine, 1993), increased empathy (Matteo, 2013, Aggarwal et al., 2013), lessened stigma (Wade et al., 2011), and a more positive attitude about therapy (Vogel & Wester, 2003). However, direct encounters with providers may be less fruitful when a student presents with high levels of self-stigma (Kendra et al., 2014).

Both Maier et al. (2013) and Tucker et al. (2013) differentiated the self-stigmata of mental illness and help-seeking. Maier et al. (2013) considered perceptions of help-seeking to be partially the precipitate of mental illness as the two are depicted on television, while Tucker et al. (2013) found that the self-stigma constructs of mental illness and help-seeking were not identical, but both affected health service utilization in samples of community and undergraduate participants. It appears that negative feelings about psychotherapy emerge from multiple sources and thus are not likely to be addressed with a single intervention.

Graduate students in general are also prone to stigma and other factors that prevent them from seeking help. Hyun, Quinn, Madun, and Lustig (2006) surveyed over 3,000 graduate students in various disciplines and found that nearly half experienced problems related to stress or psychological issues in the year prior. Difficulties were reported significantly more often by women and students involved in the humanities. Other predictors included financial insecurity, being unmarried, lack of contact with friends, and competitiveness within their programs. Females were more likely to hear about counseling services overall, including from friends, peers, health center staff, and websites. The Internet was the most common information resource used (Hyun et al., 2006).

Developmental associations with psychotherapy seem to have a profound effect on later attitudes about help-seeking. The next section deals directly with psychotherapists-in-training, and it is very likely that as a population, they have experienced similar levels of developmental biases and inaccurate impressions of their future vocation.

Psychotherapy Trainees

Definition.

A trainee is defined as a person seeking to become a psychotherapist and who is involved in a postgraduate educational program. This includes those obtaining a master's degree in a licensable field (e.g. counseling, social work), a psychiatric resident, or a student seeking an academic doctoral degree to practice as a psychologist. Trainees undergo at minimum a two-step process of academic study of psychotherapy followed by practicing psychotherapy with clients under supervision. They may or may not have an experiential component to their coursework.

Academic admission and predicted success.

Programs in the helping professions frequently include a statement regarding the personal qualities of the applicant. Baylor University's clinical psychology doctoral program states on its website that "in reviewing applications, we look for a combination of academic ability and experience, clinically related experience, and the personality and social skills conducive to a successful career in professional psychology" (Baylor University, 2014). The University of Texas at Arlington's master's program in social work looks for "personal qualifications considered essential to the successful practice of social work including leadership ability, personal maturity, motivation for a human service profession and experience in social work" (University of Texas at Arlington, 2014). The University of Texas Southwestern Medical Center at Dallas (2014) asks the following of applicants to their Master's in Rehabilitation Counseling

Program: "personal suitability for a career in rehabilitation counseling, including ability to relate to others, warmth, empathy, and a sincere interest in psychological processes."

To ask for more from the applicant in the way of personal qualities might veer into discrimination. Applicants are discouraged from mentioning their personal therapy experiences in personal statements and interviews, as this may signal to admissions committees a lack of judgment regarding disclosure and professional boundaries (Norcross & Sayette, 2011).

Quantitative measures like GRE scores and GPA are no doubt intended to predict the success of students with didactic coursework and time management, but do not measure professionalism. The qualitative requirements for admission seem to address that shortcoming, with personality being the recurrent criterion. In a survey of more than 100 heads of doctoral programs in applied psychology, on-site interviews were rated the most useful method of determining well-functioning in potential trainees, followed by interactions as part of a group. Self-awareness was the key aspect thought to contribute to success as a trainee by both program heads and practicing psychologists (Schwebel & Coster, 1998).

As compared to laypeople and undergraduates, it is assumed that trainees accept psychotherapy as a process and psychotherapist as a career identity, at least outwardly. However, the maintenance of this attitude is important; Norcross et al. (2006) found attrition rates in psychology programs to be 2.5% for doctoral and 5.2% for master's programs over time. However, a much higher rate of departure was found for first-year students in these programs (~10% and 12-19%, respectively).

Winerman (2008) wrote that departure from doctoral programs is often a product of students finding that "the career is not for them." However, it appears that no research to date has surveyed the beliefs of departing students regarding their expectations versus the realities of

psychotherapy specifically, so it is unknown whether aversive experiences relating to psychotherapy training are behind decisions to leave programs. The first year may include role-modeling, exposure to theories, in-class exercises, or other intellectual activities, but practicum experience is unlikely to be included in the first semester, although there are exceptions. The relatively long wait for practical experiences may discourage eager trainees. However rigorous admission standards may be, any training program is prone to admitting individuals who are unprepared for that program's training model, workload, or professional identity.

In the helping professions, a trainee's concept of therapist identity may be less realistic than their knowledge of other professions (lawyer, pediatrician) whose role in society is less controversial and more defined. While laypeople have repeatedly displayed a misunderstanding of psychotherapy (Furnham and Wardley, 1990; Maier et al., 2013), culture does not compel them to correct it. The culture of professional training, on the other hand, requires a conception of psychotherapy that is congruent with theory, research, and the stated goals of the training program.

Influences on trainee attitudes towards psychotherapy.

Expectations.

Herron (1976) found that trainees who had been practicing therapy for a short time (<2 years) held complex views of therapy that viewed both the career and professional role with ambivalence that leaned towards the positive. Most found it more difficult than expected, but also more enjoyable. Generally, trainees were dissuaded from previous notions that therapy is a cure-all. Respondents cautioned that personal characteristics of psychotherapists stood a chance of getting in the way of successful treatment, as did an unfamiliarity with theoretical concepts. They believed therapists could be "powerful helpers" (Herron, 1976, p. 492). Revealingly, the

students responded that insecurity was the biggest problem they faced as practitioners; they felt that personal therapy and general self-improvement, as well as personal experiences, were most important to maximizing the experience of being a therapist. It appears that trainees' practice of therapy has a positive and broadening effect on their opinion of the personal therapy and on the value of the therapist to the process.

Attitudes towards research.

Didactic coursework and research provide arguably the most objective exposure to psychotherapy for students. While the teaching of psychotherapy theory is standard, research on psychotherapy is only one of thousands of scholarly topics, and many programs do not conduct or review such research as part of the standard curriculum. Of those that do, many state that they expressly prepare students for careers in research and not psychotherapy ("Prospective Clinical Psychology Graduate Student Guide: University of Colorado, Boulder", 2014; Norcross & Sayette, 2011). Widdowson (2012) found that psychotherapy trainees often felt intimidated by research on psychotherapy, both as producers and consumers. In addition to questioning its ethics and relevance, only 10% of respondents relied on psychotherapy research as their primary means of gathering information about their field (Widdowson, 2012).

Despite the preponderance of the scientist-practitioner model, students' impressions of the dual-role clinician correspond to the findings of Norcross and Karpiak (2012) that professional psychologists are more concerned with practice. It should be noted that graduates of some programs move into academia and do not get licensed despite their eligibility; this may be reflected in lower licensure rates overall (University of Iowa, 2014). This group may include students who decide that they prefer research to psychotherapy for various reasons. A direction

for further study would analyze the practical experiences and personal characteristics of those psychologists who choose not to use their clinical training as practitioners.

Developmental influence on psychotherapy as a career choice.

Ivey and Partington (2012, p. 166) viewed the correlation between a troubled past and a career as a healer as a "truism." Ronald Fairbairn is quoted by Guntrip (1975, p. 146) as saying "I can't think what could motivate any of us to become psychotherapists, if we hadn't got problems of our own." Guntrip himself had suffered total amnesia as a toddler following the death of a younger sibling, and he viewed the lengthy and ultimately successful resolution of this trauma as the foundation for his career. Geller (2013, p. 641) stated plainly that therapists should acknowledge their motivations and histories openly:

In my ideal psychotherapy training program, students would write and read to their classmates an answer to the question, "How have my genetic predispositions, family's provisions, and the historical context into which I was born contributed to my ideas about what it means to *be* a therapist and *do* the work of therapy?"

In addition to normalizing a number of experiences, such a requirement might unveil how stigma relates to being in a training cohort.

Some professionals have a history of mental illness and/or hospitalization. Sawyer (2011) described her own extensive therapy as contributing to her survival as well as her success as a therapist, describing frequent hospitalizations that were so severe she experienced re-traumatization upon revisiting her history while writing her story. Now a professor at the Yale School of Medicine and a psychotherapist for 30 years, Sawyer functions at the top professional tier even with a history of having been its problematic subject. Jamison (2009) endured a similar trajectory from the "bottom" of the mental health system to a professorship at Johns Hopkins University; she credits psychotherapy along with medication for her ability to succeed in spite of

the impact of her Bipolar I disorder. Cain (2000) interviewed 10 working therapists from social work, psychology, and psychiatry who had had experiences of psychiatric hospitalization with varied diagnoses. Participants found themselves able to identify with clients regarding a number of painful experiences even if their own hospitalizations had occurred far in the past, and their personal experiences as hospital patients and consumers in the mental health care system they presently work within may enhance their ability to practice (Cain, 2000).

Beginning with Freud, a large body of literature suggests psychotherapists experience a greater than average amount of suffering in their early development (Racusin, Abramowitz, & Winter, 1981). This suffering tends to involve unresponsive or restrictive family environments, direct physical or sexual trauma, and/or the necessity of the therapist-as-child taking up an adult emotional role (Heathcote, 2009; Racusin et al., 1981). Elliott and Guy (1993) conducted a large study comparing mental health professionals versus the general population on measures of early distress and current functioning, the mental health professionals were more likely to have had any kind of childhood trauma ($p < .001$). However, the two samples were generally similar in terms of current psychological distress, and on measures of depression and anxiety, mental health professionals actually endorsed lower ratings (Elliott & Guy, 1993), suggesting that they may have obtained better coping skills during or after their training.

Medvene (1969) separated various career paths in psychology into person-oriented and non-person-oriented categories (e.g. experimental psychology). The author surveyed the parental relational experiences of psychology students who aspired to each career path, finding that students who had avoiding relationships with their parents were more likely to enter non-person-oriented areas of psychology. Huynh & Rhodes (2011) found that positive role models were cited by undergraduate students as being important to their aspirations to being a

psychologist/therapist, although their findings are prospective. They reported positive experiences with helping professionals as contributing factors to their career choices, but also that various distressing situations had led them there, often citing the development of empathy for others in their situation(s) (Huynh & Rhodes, 2011).

Childhood problems ranging from loneliness to physical and sexual abuse have been noted among therapists. Pope and Feldman-Summers (1992) found that more than one-third of female and one-quarter of male therapists had experienced some form of abuse as children or adolescents. Adams and Riggs (2008) studied trainees who were working with trauma victims and found that 38.7% reported having a personal history of trauma themselves. In a study comparing practicing applied psychologists with academic social psychologists, Murphy and Halgin (1995) discovered that the therapist group endorsed significantly more experiences of problems, including abuse. Given the personal nature of this sort of disclosure and considering the unlikelihood of false reporting of abuse in a professional/preprofessional population, it is possible that the above numbers are an underestimate. The difference between processed and unprocessed trauma is significant, and it is possible that students are bringing the latter to training programs, in which case therapeutic intervention would be highly advisable lest the student's progress be interrupted by sequelae of their trauma. In therapy, however, the desire to solve problems played a lesser role in vocational selection compared to more positive influences, such as role models (Murphy & Haglin, 1995).

Therapists may be vulnerable to retaining undesirable traits and tendencies that have their origin in childhood, persisting through the trainee role and into their performance as professionals. Glickauf-Hughes and Mehlman (1995) cited parentification, a developmental tendency towards caretaking and/or mediating adult arguments. The relevance of this distorted

role to the professional identity of the psychotherapist is obvious. Providing a space to explore this trait may be a worthwhile outcome of personal therapy. The authors also reflected on the concept of audience sensitivity, which is developed by children who are objectified by narcissistic parents (Glickauf-Hughes & Mehlman, 1995, p. 214). This can create the heightened ability in the therapist to experience the *mood* of others (different from empathy, where feelings are experienced). High audience sensitivity might direct individuals towards a career where that tendency can be useful. However, the inability to negotiate between the professional demand for attunement and the need to withdraw from the therapist persona in one's personal life can cause interpersonal distress. The authors made a general connection between these types of unresolved wounds as both motivators for practice and professional dangers, particularly concerning the possibility of burnout.

One's own past can contribute to self-stigmatization regarding a career in the helping professions, and it is important to recognize that a history of trauma and/or distress is not tantamount to exclusion criteria. Ivey and Partington (2012) found that clinical psychology graduate programs viewed applicants who presented as "normal" with regard to childhood experiences and family relationships with suspicion. Conversely, applicants with an extant history of psychological difficulties should be aware that programs expect and often appreciate such experiences in their applicants, so long as they are presented in an appropriate manner (Ivey & Partington, 2012).

Environment.

Research on psychotherapy training sometimes focuses the fields' own theoretical lenses on the process. For example, Bruss and Kopala (1993) framed the issues faced by graduate trainees in the language of British object relations theorist D.W. Winnicott: the institution itself

provides the "holding environment" by which an infant (i.e. trainee) is able to develop his or her individuation and autonomy as an adult (i.e. professional). If this process meets interference in the form of unsupportive criticism or intolerance, these "impingements" can in turn block the student's development as a professional (Bruss & Kopala, 1993, p. 689). Trainees enter professional programs as legal, physical, and intellectual adults, but for the purpose of training they are psychologically immature and must develop essentially from the beginning (Bruss & Kopala, 1993).

Once the role of therapist is accepted and practicum begins, many pitfalls arise from naive expectations of the therapeutic role (Zaro, 1977; Skovholt & Rønnestad, 2003). Anxiety is a common theme; taking on a professional role is a performance, and both client and supervisor may be disappointed by a poor one. The complications of being evaluated on progress even as one is trying to explore can confuse the trainee (Zaro, 1977). Trainees both search for a personal ideal, which Skovholt and Rønnestad (2003) called the practitionerself, and attempt to impress their evaluators. In so doing, they may fail to address their own boundaries, including the crucial distinction between the role of therapist and friend. Alternately, they may lack the confidence to relax overly firm boundaries, manifesting in a refusal to disclose anything to a client or shying away from questions that are difficult to ask (Skovholt & Rønnestad, 2003).

Kleinberg (1987) compared trainee identity to the Eriksonian model of psychosocial development. Students are seen as being in a state of identity diffusion, a crisis associated with adolescence rather than infancy. This might make students sensitized to disturbances in their expectations of being a therapist and destabilize their comfort with their new role (Kleinberg, 1987). Whether viewed as infants or adolescents, developmental metaphors state that true growth needs to occur to produce a psychotherapist from a trainee. This process is supposed to be

contained within a program, comprising supervision, didactic work, and faculty support (Skovolt & Rønnestad, 2003; Bruss & Kopala, 1993). These three factors are found in all training programs. While students' actual practica take various forms and be quite separate from the training institution, nourishment from the program comes from these three sources.

In order to choose individuals who will be able to succeed and become licensed clinicians, programs look for students with qualities like motivation, intellect, and creativity, as well as emotional stability (Appleby, Keenan, & Mauer, 1999). While intellect is considered a relatively stable trait, even it can be dulled in periods of emotional turmoil. Certainly motivation suffers. "Self-care" is a term frequently employed in the literature to describe activities that center an individual and add to their emotional stability, and can include hobbies, art, and exercise, as well as psychotherapy (Mahoney, 1997). Barnett and Cooper (2009) call for a "culture of self-care," emphasizing the need for encouragement towards these activities among graduate students, 59% of whom reported that they received none. Psychotherapy is a key example provided by Barnett and Cooper (2009), and the authors emphasize that it should not be stigmatized or associated with sickness.

In sum, being a psychotherapy trainee involves emotional/affective demands and role demands, and neither is explicitly promised relief by the structure of graduate study. Personal psychotherapy is geared to address emotional stress and may also affect a trainee's perspective of the role they are to one day assume. The next sections of this paper will address research on personal psychotherapy from a variety of perspectives. Attention will be paid to the current state of mandatory personal psychotherapy. This review will provide insight into the curricular role personal psychotherapy ought to play in training programs, if any.

Confidentiality and cost.

In a survey of 262 graduate students in clinical/counseling psychology, 70.2% had undergone therapy before or during their training, with 54.3% in therapy during training (Dearing, Maddux, & Tangney, 2005). Not surprisingly, the sample held positive attitudes about therapy and its importance to their training. Confidentiality and cost were of particular concern in a student's decision to be in therapy. Years ago, Wampler and Strupp (1976) found that in a survey of 69 clinical psychology programs, 87% had at least one provision for low-cost or free therapy. The most popular options were reduced-fee therapists in the community and college counseling centers that were not affiliated with the programs. However, other options would raise confidentiality concerns among any students: faculty members providing therapy to students or a dedicated therapist hired by the program for trainees (Wampler & Strupp, 1976). Doctoral programs in psychology today may advertise reduced-fee therapists to students via their website. In the case of the University of Memphis, reduced-fee therapy in the community is mentioned in the same paragraph as financial and academic counseling services that are offered by the institution. (University of Memphis, 2014). Other institutions offer a list of therapists on their site for perusal (e.g. Texas Woman's University, 2013).

No current research exists that replicates the diversity of practices found in Wampler and Strupp (1976), but it is likely that reduced-fee practices are fairly common, if not standard practice. It is quite likely that the practice of employing program faculty as therapists has been eradicated. Bruss and Kopala (1993) suggested a model that was endorsed by 9% of programs in Wampler and Strupp (1976) wherein faculty from unaffiliated programs offer services on an exchange basis. This would provide affordability and relative confidentiality, although it would necessitate a geographic area populous enough to support several training institutions. Lack of

unaffiliated therapists is a problem for professionals, as well (Deutsch, 1985), who may have difficulty finding someone with whom they are unacquainted to treat them. Ironically, reduced-fee services for members of the public are plentiful and often provided by student trainees.

Generally speaking, psychotherapy is costly business. The annual mean wage of American workers in 2013 was \$46,440 (Bureau of Labor Statistics, 2013). Paying \$100 per hour for 50 weeks of therapy each year would cost 10% of before-tax earnings for an "average" worker. Lanouette et al. (2011) found that psychiatric residents disagreed that psychotherapy is too expensive, and particularly residents who had had personal therapy saw the cost as reasonable. A majority said they planned to provide "a great deal of formal psychotherapy" in their emerging practices, and the personal therapy group endorsed this with greater frequency. From the perspective of a training psychiatrist who has both benefited from psychotherapy and stands to gain financially from a career providing it, the benefits appear to outweigh the costs. Perhaps this is associated with the mean annual wage of \$186,600 for psychiatrists, along with the increased flexibility of prescription privileges (Bureau of Labor Statistics, 2013). On the other hand, Dearing et al. (2005) found cost to be the most important obstacle to therapy among clinical and counseling psychology graduate students. McEwan and Duncan (1993) and Holzman, Searight, and Hughes (1996) also listed finances as a significant issue regarding therapy attendance for trainees.

Concerns about money may persist outside the student population: Deutsch (1985) found cost to be a somewhat important reason for nonmedical mental health professionals to avoid seeking therapy, and among a sample of professional psychologists in Mahoney (1997), nearly half reported concerns about the financial investment of personal psychotherapy.

In 2008, median yearly tuition for an applied psychology program (doctoral or master's) in-state at a public university was around \$6,000. At a private institution, they were nearly twice as much. Studying out of state in general cost a median \$10,000 for master's and \$17,000 for doctoral programs (Norcross et al., 2009). A year of weekly therapy at a reduced rate of \$50 per session would cost \$2600. Although many doctoral programs provide stipends and tuition remission, none appears to include the cost of therapy, although student counseling services may be accessible to psychology students under student fees. However, there is an inherent conflict of interest if the training clinic is also a practicum site. Generally speaking, graduate students are not known for their disposable income, and creating more debt for students than expected in order to pay for personal therapy may underlie the difficulty of making it mandatory or highly encouraged.

Therapy for remediation of impaired trainees.

The American Psychological Association has ethical guidelines that address the personal therapy of trainees, but they pertain to the parameters for therapy as it is required by programs rather than to standards regarding its necessity or utility. As such, ethical guidelines concern the type of provider that may be solicited (licensed), economic viability (affordable), not dually-related (ethical), culturally-competent (sensitive), and clear in terms of consent and limits of confidentiality (ethical, again); this is the extent of the organization's involvement (American Psychological Association, 2010). Being a licensed, affordable, ethical, and sensitive practitioner is an excellent set of guidelines for any therapist. Because so few psychology programs require mandatory therapy, this list pertains to the most common use of therapy for trainees: remediation (Elman & Forrest, 2004).

The issue of therapy as a restorative measure for professionals will be revisited in a later section on professional impairment. In the case of trainees, impairment can manifest outside of (and before) clinical work. Psychology programs at the master's and doctoral levels have defined the term broadly, allowing for the detection of impairment formally or informally, and using as a standard criterion "an inability or unwillingness to adaptively manage personal stress, dysfunction, or excessive emotional reactions that interfere with academic/professional functioning" (Seton Hall University, 2013; Ball State University, 2006). Personal therapy is mentioned in these programs, and a host of others, as a potential component of a larger remediation plan, and at that point, the APA guidelines begin to make more sense (although they cover only doctoral programs; the APA does not accredit programs on the master's level).

Requiring personal therapy for impaired trainees sends a mixed message. It is an unambiguous statement that personal therapy works in the student demographic, at least to instruct the student in taming "excessive emotional reactions" and other distress interfering with a trainee's performance. Ethical guidelines prevent programs from therapizing the student into poverty or mismatching them. The other side of this message is that personal psychotherapy is by nature a corrective intervention. Trainees enter their programs with professional identities that are less than fully-formed, and though faculty may be astute, there are no guarantees against Type I or Type II error in determining who is in need of remediation. Some students may hide dysfunction well, and if psychotherapy attendance is *officially* viewed as correctional or worse, punitive, then it is unlikely that it will be sought by those that are not compelled to do so.

Revisiting issues of confidentiality, program involvement in the therapy of remediated students varies widely (Elman & Forrest, 2004). There seems to be a downside to either end of the spectrum: an overly involved program may leave a student feeling micromanaged, while a

program that is hands-off may seem to be exiling a student to therapy. In either case, it seems difficult to see more additive or preparatory outcomes through the lens of remediation. There is no question that it is necessary to protect the student and the public from poor practice (Elman & Forrest, 2004). In so doing, though, programs must be careful not to stigmatize the same process they are training students to conduct.

The Experience of Personal Psychotherapy

Geller, Norcross, and Orlinsky (2005) provided an overarching objective for personal psychotherapy that does not oversimplify the process, nor attribute the goal to a single element:

Namely, the goal of the psychotherapists's personal treatment is to alter the nature of subsequent clinical work in ways that enhance its effectiveness. The actual mechanism of this process is as complex and individualized as the number of psychotherapist-patients (and their therapists). (p. 9)

A fundamental mechanism of personal therapy is experience-near learning (Elliott & Partyka, 2005). That is, learning by experiencing rather than through acquisition of details *about* the experience. This explanation is simple and perhaps obvious, but it underlies any gain made through personal therapy, which is by nature experiential and not didactic. If it is presumed that personal therapy is a mode of increasing competence, then it seems to belong with the didactic and supervisory components of training; why would a program ignore such a force, provided it does what it is supposed to do?

It follows that personal therapy must do something for the therapist-trainee that exceeds in scope the gains made by the layperson, who might see therapy as a process of becoming a "better" person, getting ahold of one's "issues", or being less "crazy". Fleischer and Wissler (1985) suggested that therapists may have more complex motivations for seeking therapy than ordinary patients. Nonetheless, personal therapy cannot be solely professionally-oriented and interested in the self-minus-practitioner if it is to be justified as a measure for trainees. It is

unlikely that personal therapy for clinicians will spend much time in the public court of opinion, and it is difficult to visualize a channel to communicate to laypeople the value of therapy for therapists. The literature reflects little about the way lay clients would feel knowing that their therapist had had therapy, although the Internet is swarming with discussions of this issue and the more complex topic of whether persons would feel comfortable being treated by a therapist who had been in treatment for a mental disorder. Owing to the demonstrated stigma that exists against psychotherapy among laypeople, it seems intuitive that therapists in therapy would be a population that is looked upon with mixed feelings, including suspicion.

As long as they have a choice whether or not to have personal therapy, students must weigh the noted benefits of personal therapy against the discomfort that personal therapy may be outside their immediate culture and the distal professional one. This may manifest in a lack of willingness to discuss their personal therapy, if students choose to have it: Holzman et al. (1996) found that over half of trainees did not mention their personal psychotherapy to supervisors, and 10% were worried about confidentiality.

Prevalence.

Reports of prevalence vary according to several factors. Professional title, theoretical orientation, and trainee vs. professional status seem to show the most variation. Particularly the latter is confounding, as professionals are often asked if they have *ever* had therapy, but the chronology is not solicited, and it is only an assumption that the experience coincided with, or preceded, their graduate training.

Nonetheless, in nearly every study involving professionals, therapy exceeded no therapy by a simple majority. Norcross and Guy (2005) summarized therapy prevalence rates in 13 studies, all of which surveyed more than 150 participants, and three of which included over 900

respondents. All but two studies surveyed practicing professionals (one study also surveyed clinical training directors, and another, trainees.) Personal therapy prevalence rates were above 50% in all studies, with 7 above 80%.

Examining theoretical orientation, Norcross (2005) confirmed that 100% of psychoanalytically-identified therapists in the U.S. had had personal therapy. Other orientations, including eclectic, ranged from 86%-76%, with the exception of behavioral and cognitive behavioral therapists, who were nonetheless in the mid-60s. Orlinsky, Norcross, Rønnestad, and Wiseman (2005) found 58% of cognitive-behavioral therapists reported experience with personal psychotherapy, with other orientations reporting participation rates of 80% or higher.

Trainees showed a tendency to participate in therapy as well, but it was not as robust. Bischoff, Barton, Thober, and Hawley (2002) found that 69% of marriage and family therapy students had personal therapy in their first year. Dearing et al. (2005) reported 70.2% of early psychology trainees (first-year and doctoral applicants) had been in therapy. More time in training was thought to predict likelihood of seeking therapy. Following a 75% prevalence of therapy in their sample of clinical psychology graduate students, Holzman et al. (1996) suggested that a wide estimate of 38-75% within that demographic attended therapy. Respondents that answered in the affirmative reported an average of 79.5 sessions.

An in-depth analysis may show discernible patterns, but for now it appears that both professionals and students are interested in receiving personal therapy. Norcross (2005) found that therapists tend to go to therapy more than once, with an the average range of visits at 1.8-3.0. An equal number of therapists (1/3) sought therapy on one occasion vs. two occasions (Norcross & Guy, 2005).

Benefits of personal psychotherapy.

One might expect that reports of personal therapy from the literature emphasize both clinical and personal benefits to the trainee, and this is indeed the case. Norcross and Connor (2005) compiled data from five studies examining the reasons cited by psychotherapists for entering therapy. They found that the majority of therapists entered for personal reasons, followed by personal and training reasons, with between 10-30% choosing to enter solely for training reasons. The literature shows benefits in both domains, though it is unknown what role the clinician's initial motivation may play in the distribution of these gains.

Geller et al. (2005) mentioned six benefits and the clinical improvement that accompanies them. Daw and Joseph (2007) cited four, as did McEwan and Duncan (1993). Macran, Stiles, and Smith (1999) listed twelve themes, but used three headings to describe their overall function, and Murphy (2005) cited four phases comprising nine categories. Research has not found definitively through statistical procedures the actual number or nature of personal and clinical gains that occur when clinicians receive personal therapy, and this may not be possible. The following are common findings from the literature citing the benefits of therapy for the clinician.

Personal growth.

It is difficult to imagine personal growth in the absence of problem resolution, although it is evident that certain trainees will have a larger psychic burden than others upon entering personal therapy. Personal growth and problem resolution are not clearly differentiated in the literature; therefore, this section focuses on both topics.

Holzman et al. (1996) reported that personal growth was a key reason for attending therapy, cited by over 70% of their sample. Further, personal growth and improvement were cited as reasons for future attendance among those that had never attended therapy but planned

on it. Wampler and Strupp (1976) spoke of the importance of self-understanding that comes from a course of personal psychotherapy:

first-hand experience of one's own dynamics is one of the best, if not the best, guarantors of high-quality professional work. Conversely, it can be taken as axiomatic that no one can expect to help others deal adequately with an interpersonal difficulty that has not been personally confronted. (p. 200-201)

Personal development is a recurrent theme in trainee experiences of therapy. Von Haenisch (2011) found that some trainees viewed personal therapy as a growth experience, reporting more confidence and self-acceptance as a result, but also as a novel opportunity disclose difficult issues to another person (p. 152). One reported an ability to "judge who is a good therapist" as a result of personal therapy.

Maintenance of the self.

The ability to use the self has been mentioned in connection with personal psychotherapy in training. Murphy (2005) cited one therapist who likened "looking after me" to a plumber maintaining his tools (p. 30). In those theoretical orientations that explicitly value authenticity, this use of oneself is dependent on maintenance of the same. The therapist in question identified himself as person-centered, and considered self-awareness and self-acceptance to be paramount to his therapeutic ability. Peebles (1980) found that graduate trainees' hours in personal therapy were correlated significantly ($p > .05$) with higher ratings of empathy and genuineness. Zaro (1977) stated more generally that "we view psychotherapy as another educational tool that increases the student's self-awareness and general experience" (p. 210).

Wedding (2005) shared that his graduate training in psychology overemphasized the understanding of pathology (e.g. depression) at the expense of more universal human experiences (e.g. falling in love) and believed that contemporary programs should cast more focus on interpersonal competency. It is uncertain how this might be achieved in training, but it

is more apparent that through personal therapy, a therapist-client might at minimum recognize the therapy's attention to elements of their own interpersonal functioning, as opposed to psychopathology, widening the lens through which they see clients to include normal experience.

Resolution of difficult issues is also mentioned by trainee therapists. In addition to gains regarding emotional and cognitive well-being, Von Haenisch (2011) described physical relief in trainees following the disclosure of difficult material in therapy. Murphy (2005) found that therapists were helped by personal therapy in the acknowledgement and resolution of problems that had arisen in their personal lives during counseling training, and Zaro (1977) cited personal therapy along with supervision as useful in resolving such difficulties.

Additionally, Guy and Liaboe (1986) suggested personal therapy for graduate trainees as a prophylaxis against a variety of negative outcomes that can emerge due to practice; psychotherapists may find themselves drained and unable to participate emotionally in their personal relationships, as well as experiencing more clinically severe problems such as alcoholism and suicidality. Truell (2001) surveyed six recent graduates and found that each reported losing friendships and having difficulty with their partners while learning to be a psychotherapist. Interestingly, the graduates reported improved relationships in life after school, suggesting that adaptation to a new role may be involved in interpersonal functioning. Here again, personal therapy is given mention as a useful tool during training (Corey, Corey, & Callanan, 1993, p. 54; in Truell, 2001). Truell (2001) also mentioned the development of "unrealistic beliefs and non-useful ways of coping" and that feelings about training (e.g. anxiety related to the process of learning counseling) were not addressed adequately in supervision (p. 86).

Developing psychological-mindedness.

Psychological-mindedness is a construct measuring a person's ability to understand themselves and others on a psychological level, and it has been studied for more than a century (Farber, 1985). The techniques of cognitive-behavioral therapy, i.e. the recognition of one's thoughts, feelings, and behaviors, exemplifies a task that requires a degree of psychological mindedness; the same may be said of identifying one's defenses or the defenses of other people. Yalom and Leszcz (2005) claimed that clients in group therapy needed a certain level of psychological-mindedness to contribute to the group and their own success.

Unsurprisingly, the therapist role requires a high level of psychological-mindedness. Farber (1985) mentioned personal therapy as one of the aspects of professional acculturation that collectively can lead to an overabundance of psychotherapeutically-oriented thought. Like Truett (2001), Farber (1985) found positive and negative effects of this thinking on interpersonal relationships: some relationships may be deeper and more authentic, but friends and family may also be the subject of psychological analysis. It is an unresolved question whether personal therapy can be of aid to the graduate student in managing a tendency to "psychologize" his or her surroundings, or whether personal therapy itself is part of the problem.

Perhaps the answer is less black-and-white, and personal therapy for graduate students needs to consider the ongoing development of a cognitive style that is disposed to clinical evaluation, or the underlying presence of such a style (Farber, 1985). Also to be considered by the graduate student's therapist is the idea that such individuals may manifest anxiety born of an environment where evaluation and analysis of others is likely and encouraged (Farber, 1985). Psychological-mindedness is another example of how the trainee-as-client places different demands on the therapeutic situation: it is possible, perhaps likely, that they will manifest needs beyond the development of insight and *development* of psychological-mindedness.

Coping with demands.

As mentioned in the section on suitability, graduate programs take pains to attract students with the requisite characteristics to succeed not only academically, but as clinicians. Vacha-Haase, Davenport, & Kerewsky (2004) investigated the behaviors of problematic psychology students leading to their remediation or termination. 52% of 103 surveyed programs had terminated a student over the past 3 years, and the majority of terminations were due to inadequate clinical skills. Along with lack of clinical skills, defensiveness in supervision and deficient interpersonal skills were the top three problems listed by training directors (Vacha-Haase et al., 2004, p. 117). Personal therapy was recommended in 60% of cases, implying that these problems may be amenable to resolution in the therapeutic process. Pope and Tabachnick (1994) listed "improved clinical skills" as the third most mentioned benefit of therapy among a sample of 476 psychologists.

Truell (2001) mentioned the high performance goals held by trainees, such as impeccable performance and responsibility for others. Being the subject of remediation or termination may be a devastating blow to these individuals, many of whom feel a powerful calling to become therapists (Farber, 1985). Personal psychotherapy in remediation may need to address this emotional content as well, particularly if it is the student's first time in therapy.

Managing countertransference.

Countertransference is an analytic term that has been generalized to describe similar processes in other forms of therapy (Gelso & Bathia, 2012). Countertransference was defined by Shedler (2006) as "our own emotional reactions to our patients" (p. 25). Shedler (2006) argued that transference-countertransference is a component of effective therapy and that successful clinicians attend to it regardless of their stated orientation. However, MacDevitt (1987)

suggested that psychoanalytic/psychodynamic leanings in the clinician were more correlated with attention to countertransference. Nonetheless, Gelso and Bathia (2012) described countertransference as being present in therapies such as CBT that do not overtly attend to such concepts. As all therapists are bound to have emotional reactions to their patients, the broader topic of how those emotional reactions are managed is relevant to the training of clinicians.

Various opinions exist as to whether countertransference ought to be reduced (Strozier & Stacy, 2001), utilized positively (Cain, 2000; Jacobs, 2011), or considered as therapeutic blind spot(s) (Wampler & Strupp, 1976; Jacobs, 2011). For example, cognitive-behavior therapists may be inclined to view negative countertransference as more problematic and attempt to address it via cognitive techniques (Beck & Butler, 2005). On the other hand Cain (2000) wrote that some therapists view countertransference as an opportunity for profound growth and self-understanding, and Bugental (1992) saw working with countertransference as a significant and valuable aspect of his therapeutic work (p. 8).

There is evidence across professions that a therapist-client's relationship with countertransference is affected by their personal therapy. Brenner (2006) mentioned the emphasis of countertransference management in training and that personal psychotherapy may increase a trainee's ability to identify and manage feelings in the therapeutic relationship. Strozier and Stacy (2001) found that 25% of faculty and 20% of students in a social work program ranked countertransference reduction in the top three benefits of personal therapy. McConaughy (1987, p. 306) stated that countertransference issues affect the work of the family therapist, providing "valuable information about pressures within the system," and Patterson (1991) claimed that certain schools of family therapy embrace the concept more than others, while cautioning that personal therapy is not the sole means of addressing countertransference issues. Nonetheless,

working psychologists surveyed by MacDevitt (1987) displayed greater countertransference awareness corresponding to the amount of personal therapy they had received.

Fleischer and Wissler (1985) suggested that difficulties with countertransference management are an important reason to seek personal therapy, as they can affect the therapist's ability to properly empathize with patients due to their own emotional reactions. Herron (1976) asked graduate trainees about the pitfalls of conducting therapy and found their most frequent answers concerned countertransference. However, specific disorders and situations may present a particular challenge to trainee therapists' countertransference. For instance, borderline personality disorder (BPD) is characterized by idealization and devaluation of attachment figures, and clients with BPD are frequently viewed as emotionally challenging for the therapist (Cambanis, 2012). For trainee therapists, working with borderline clients may be emotionally provocative, particularly if the trainee is unused to mood dysregulation and unstable identity in clients.

In order to be effective, therapists must manage what is likely to be a large amount of countertransference, and Cambanis (2012) recommended personal therapy as a means for managing the anxiety of this psychic burden. Elliott and Guy (1993) connected the relatively high incidence of childhood trauma in therapists' lives with a need for didactic instruction towards managing countertransference when working with abuse victims; perhaps personal therapy would be of use in this demographic, as well.

Macran et al. (1999) listed countertransference management as a recurring theme in personal therapy outcome. Norcross (2005) also found the theme of countertransference theme across various studies Hamilton & Kivlighan (2009) discovered that therapists who had had some personal therapy demonstrated less projection of their own wishes in their evaluations of

transcribed relationship episodes. Similarly, Dubé and Normandin (1999) surveyed 27 trainees, about half of which had had personal therapy, examining their countertransference responses to several therapeutic vignettes. The personal therapy group displayed a greater ability to provide a detailed reflection of the therapeutic experience in terms of the relationship and understanding the client; those who had not had personal therapy tended to disengage early. This was labeled reflective mental activity as opposed to reactive or rational-objective (the most basic of the three). It should be noted that therapists with personal therapy showed similar levels of reactive countertransference to controls, suggesting that personal therapy does not eliminate the tendency to experience countertransference but rather enhances the ability to understand it.

Countertransference may also be viewed differently in supervision versus personal therapy. Mackey and Mackey (1993) surveyed 30 clinical social work graduate students and licensed practitioners. Personal therapy was reported to be a method of addressing countertransference on the level of the individual; that is, while supervision deals with countertransference as an impediment to the student's therapeutic work, personal therapy views those issues through the lens of the student as an individual, including examination of the student's past. One student called personal therapy "very important in the work that I am doing. I need a third hour, therapy, to be able to connect [countertransference] to my own developmental and family issues" (Mackey & Mackey, 1993, p. 106). This division of therapeutic roles may persist into professional life. Schoener (2005) recalled that the professional management of countertransference issues in an impaired professional therapist-client required differentiation of the supervisory (and collegial) role with that of the personal psychotherapist.

There appears to be space for countertransference within the medical model of mental health training. Guidelines for psychiatric residents in the United States also stipulate that "the

resident should be able to recognize, utilize, and manage aspects of transference and countertransference" (Brenner, 2006, p. 268). In the absence of the opportunity to extensively observe longer-term therapy of others, residents may be able to develop the above competencies through participation in personal therapy (Brenner, 2006).

Being in the client's seat.

The perspective of the client may be the optimal vantage point for understanding the nature of therapeutic activity. Bike, Norcross, and Schatz (2009) cited research in the U.S. and U.K. confirming that "knowing what it feels like to be a patient" was one of the key themes emerging from samples of professionals looking back on their personal therapy (p. 26). Bike et al. (2009) reported the percentage of professionals who had sought therapy at 80%. Though this figure does not differentiate based on when therapy was sought (i.e. in training versus post-licensure), it suggests that the majority of practicing therapists have an idea of what it is like to be in the client's seat. The practice of psychotherapy is over 100 years old; if 80% of professionals in 2009 have been clients, then personal therapy begins to look like a bona fide tradition.

Parity is the most obvious benefit of knowing the client's role first-hand. Being the subject of therapy adds a symmetry to the experience of therapy as work and helps align therapy with other trained professions where it is typical to have experienced both roles (e.g. having been a medical patient, a lawyer's client, a managed employee). Trainees are likely to have perfectionistic impressions of their role (Truett, 2011), and symmetry might provide a space for a more realistic perspective to develop. Macran et al. (1999) conducted an interpretative phenomenological analysis of therapists who had been in therapy. One participant found value in the rough patches:

I'd recommend to every trainee therapist the experience of being totally misunderstood by one's therapist. I mean it happens in all therapy I think, and it's absolutely salutary; it's horrible, it's incredibly painful, but as an experience for somebody who is planning to be a therapist, it's really useful. (p. 425)

It may be already evident to the trainee that therapists are fallible, but being the subject of this fallibility is illuminating on several levels. Being a frustrated client can lend understanding to future clients' frustrations. This in turn can create more tolerance in the therapist-client for the negative emotions in the therapeutic dyad. Alternatively, the therapist-client might question whether their frustration is an artifact of their own intrapersonal processes or whether some technique of the therapist's is suffering.

Further, the therapist-client may experience growth through understanding that not every therapeutic encounter is a seamless execution of techniques. Macran et al. (1999) described the value of being a client in observing the way that subtle factors like transference (client towards therapist) affect processes within the client as well as in the dyad. One therapist reported that in the absence of being a client herself, she would not have been able to understand and use the concept of transference. This necessity of personal experience might generalize to other complex ideas that are taught didactically or discussed in supervision; moreover, actually experiencing transference (or projective identification, intellectualization, displacement) may normalize these psychological elements for the trainee, increasing their empathy for the client. This could deter trainees from adopting a distanced, nosological approach to processes that are typical. Truett (2001) emphasized that the graduate training experience is fraught with comparisons: to clients, to peers, to mentors, and even to theoreticians (p. 69). These comparisons can hinge on trainee's self-evaluations of their psychological health. This comes at a time where trainees are also required to consider intrapersonal processes, which invites self-analysis (in the informal sense).

The upshot of understanding client processes in the first person may be a greater sense of equality with future clients. Macran et al. (1999) described the realization that the roles of client and therapist are subordinate to the humanity of both parties. When therapist-clients conduct their own therapy, they can bring with them a sense of being themselves and having the ability to reach beyond their role. After absorbing theoretical notions of how a therapist ought to be, experiencing a therapist being in role could add a healthy ambivalence to a student's grasp of theory and specifically the prescriptions for therapist behavior.

A less obvious aspect of understanding humanness in the client's seat is understanding when the therapist is resisting the call of their humanity. It may be inappropriate for the therapist to assuage the therapist-client's discomfort, despite the instinct being there (Macran et al. 1999, p. 426). Perceiving one's therapist as a complex figure who can contain both humanness and an obligation to a therapeutic role could help trainees relax their notions of stiffness and looseness regarding their adoption of the therapeutic identity. Lafferty, Beutler, and Crago (1989) surveyed 30 student therapists who were separated into effective and ineffective groups to determine the differences in their personal characteristics and in-session values. The latter displayed a more robust difference: effective therapists showed significantly more empathy and less supportiveness or directiveness than the therapists who were rated ineffective. In-session values are observable, and trainees might better understand the way that qualities like empathy and non-directiveness interact by being the subject of a session with an experienced and effective therapist.

Modeling professional activities.

Geller et al. (2005) averred that personal psychotherapy is regarded as an important positive influence in the development of psychotherapists. Farber, Manevich, Metzger, and

Saypol (2005) suggested that the informal mentoring relationship that occurs in personal therapy can help reinforce the therapist-patient's career choice. The ability of the therapist-mentor to inspire confidence in the patient may be connected with their ability to convey intellectualism and enthusiasm for their profession. If they are in a position that affords them multiple options, personal therapy may also contribute to a student's choosing a more clinical direction for their career (Farber et al., 2005).

If a trainee has never seen a therapist, it is unlikely they have spent time in a therapist's office. A large number of therapists enter private practice at some point in their careers, which entails a considerable degree of autonomy. The manner in which the client is initially greeted, the waiting area, billing procedures, and any number of other factors are left to the discretion of the practitioner. Of particular relevance to the trainee is the fact that the therapist is incorporate clinical techniques, from intake to diagnosis, with a less clinical manner than in a training setting. This lack of stiffness may come as a welcome surprise to students, who are carefully trained to follow procedure. A competent therapist may be able to model procedure while demonstrating warmth and individuality. Freed from the kind of structure typical of training or hospital settings, the private practitioner is also responsible for managing their time, and this can be a valuable lesson to the trainee (Macran et al. 1999).

Most literature surveying the benefits of personal therapy lists among them the modeling of extra-therapeutic elements of practice (Rizq & Target, 2010; Macran et al. 1999). This may be especially useful for therapist-clients who are insecurely attached and/or have less ability to be reflective. In a small study, Rizq and Target (2010) found that therapists with these characteristics may respond more to behavioral modeling than to other potential gains such as managing their emotional responses to clients.

The benefits of this behavioral and professional modeling are unique to the therapy of psychotherapists and trainees; a layperson would have little to glean from mundanities like office arrangement. A client may have a preference as to how his or her therapist dresses, and the profession itself allows everything from denim to business attire. Anyone who solicits professional services makes judgments and reflects on them, perhaps in relation to the cost of the service, respect, or other factors. For a therapist observing a therapist, though, there is an opportunity for a parallel process: being affected by the aesthetics of the therapist and their environment as a client (like the layperson), but also as a model.

This parallel process also affects the linguistic and prosodic elements of therapy. It is a given that questions and interpretations can be performed in a number of ways, and learning to do so in a therapeutic way is a task addressed by all facets of training in addition to personal therapy. The spaces before, after, and between sessions, though, represent a setting for developing and maintaining rapport. Does the therapist shake hands? Wave? Open a door for the client? Send scheduling-related text messages or emails, or leave that to a secretary? Discuss billing with the client during a session? Are they *on time*? The only guarantee is that graduate programs do not answer these questions. Provided a therapist is acting within their ethical guidelines, there is much room for interpretation, and these actions are sure to affect therapist-clients on the modeling side as well as in their real relationship with the therapist.

Rizq and Target (2010) provided one clinician's insight into the modeling effect of their personal therapy:

I could never have, could never have been a counsellor or therapist without having had therapy. I couldn't imagine being a therapist without knowing how a therapist sits, moves around, talks, questions, what would I be basing it on? To suddenly read all these books and get thrust into a room? No, I needed to see people doing what I was doing, or doing what I wanted to do.

At best, having personal therapy may give insight into the parts of the "how to be a therapist" question that are left unanswered by other elements of training; it may function best both by showing what works or what doesn't (Curtis, 2011).

Modeling boundaries.

Sex is endemic to therapy. It appears in Freud's theory of personality and Maslow's hierarchy of needs (at the foundation, in both cases). Drive models are out of fashion, but whether a client is experiencing a satisfactory expression of their sexuality is a perennial therapeutic concern. Part of this may be that sexual problems are difficult to discuss with either strangers or close friends, so closely tied is sex to the potential for discomfort and humiliation. Trainees may have their own issues as part of a difficult past (Pope & Feldman-Summers, 1992), or may simply have trouble with this facet of their lives. The widespread availability of pornography, the anonymity of the Internet, and the detachment from one another that may result all point to the continued presence of sex in the therapy room. Again, the ethics course is the most likely venue for developing professional standards regarding sexual behavior, but to our knowledge, there is no curriculum material that expressly teaches the therapeutic use of sexual material or the associated interpersonal behavior that facilitates a safe environment to do so.

Pope and Tabachnick (1994) found in a survey of 476 therapist-patients that 26% reported being *cradled* by their therapist. They cited inappropriate humor in the therapy room, and sexual acts were among the most common causes of reported harm. 20% withheld information from their therapists, and 10% reported violations of confidentiality. These figures stand in contrast with the fact that 85.7% of the therapist-patients found the process helpful, and over half thought that personal therapy should be required for licensure. The results of this study are troubling; if inappropriate behavior can take place in the context of therapy that is viewed as

helpful, then perhaps what is being modeled is a lack of consequences. Perhaps this speaks to the need for more explicit guidelines regarding the touching of clients in therapy, or at least qualitative research on such behavior in clinical settings. Pope and Tabachnick (1994) found among the portion of the sample that found therapy helpful that improved self-awareness and self-esteem were cited as beneficial outcomes. It is possible that a negative experience in therapy (having one's confidentiality broken) could lead to a confrontation and a positive outcome for the client, expanding on the concept of learning what not to do.

Pope and Vasquez (2010) detailed the ethical obligations of clinicians when faced with sexual feelings towards their clients, a problem with a relatively high prevalence (4.4%). Among other steps towards resolution, the authors suggested that the therapist attempt to view the situation from the client's perspective before applying any intervention (e.g. discussing feelings with the client). In such cases, having been a client in psychotherapy would certainly make this an easier task.

Building an alliance.

Like countertransference, the concept of the working (therapeutic) alliance has psychoanalytic roots but has generalized to encompass the relationship between client and therapist and their attitudes towards the work they do together, similar to a bond. Horvath (2001) cited the alliance as a factor in therapeutic success that precedes theoretical orientation and related techniques and consistently predicts therapy outcome, which often in turn displays a consensus between therapist and patient on the strength of the alliance. Aveline (2005) considered it part of the therapist's fundamental qualities for practice that he or she be able to notice and mend breaks in the alliance.

Gold and Hilsenroth (2009) compared therapeutic alliance ratings between patient-therapist dyads where therapists had received personal therapy versus those who had not. The patient ratings on measures of alliance (e.g. confident collaboration, bonding) did not differ between the groups; both were reported as good overall. However, there were several significant ($<.01$) differences in *therapist* ratings of working alliance factors, with the personal-therapy group reporting less disagreement about goals, more confidence, and higher mean scores on the Working Alliance Inventory (WAI). The benefits to personal therapy may be more relevant to the therapist than the patient at this early stage of clinical training, perhaps allowing the former to view the process more authentically or with less ambiguity.

Zaro (1977) cited the tendency of inexperienced students to adopt a somewhat stereotypical (which is to say, ill-informed) therapist's attitude, providing undifferentiated warmth and perhaps sympathy towards clients who may or may not benefit from this approach. Student therapists may also attempt to problem-solve for their clients and to experience discomfort when negative emotions persist (Zaro, 1977). It would be interesting to see if there is a stronger tendency towards these early-stage clinical behaviors in trainees who have not been in therapy. It follows that a personal therapy of any real depth would necessarily progress beyond a "feel-good" environment, and the maintenance of an alliance through periods of negative affect might normalize the experience for the therapist-client in their own work. Safran, Crocker, McMain, and Murray (1990) discussed the tendency of trainee therapists to disregard the rupture of a therapeutic alliance with their patients, and suggested that this occurs even when the value of alliance maintenance is understood on an intellectual level.

Like transference-countertransference, it is likely that the therapeutic alliance and in particular, its natural tendency to rupture, are elements of psychotherapy that might be safely

approached from the client's seat. The alliance has been depicted as a relationship between adults (as opposed to one that infantilizes) that is constructed in real-time from relational interactions of varying quality (Safran, 1993). For a novice therapist, tending to this element of therapy with a patient while being evaluated might be less intimidating if a similar sort of relationship has been enacted in the trainee's own therapy.

Taking risks.

The value of risk-taking is demonstrated to students by watching tape of master practitioners who invariably surprise with their techniques in what amount to therapeutic performances. Other simulated therapy (e.g. *In Treatment*) relies on risk-taking in the service of the dramatic arc. Risk-taking is also emphasized from a historical perspective through psychotherapy textbooks, which occasionally include transcripts of therapeutic encounters. Some of psychotherapy's most notorious risk-takers, such as Ellis and Perls, seem poised for study from an archeological perspective as much as an instructional one. It is difficult to imagine a trainee who is being taped for evaluation venturing to tell a client, à la Ellis, that they feel like "a shit" (Patterson & Watkins, 1996, p. 214), and yet that is *exactly* what the therapy performance implies is helpful.

There are several possibilities for why these kind of interventions are avoided. First, Ellis in particular presents a bravado that is almost cartoonish. Given the variation in backgrounds and culture comprising the therapy classroom, it is unlikely that there will be a uniform comfort level with the use of assertion and profanity in therapy. Nor are the nuances spelled out in the text: the REBT chapter does not encourage the use of "shit" as a descriptor nor advise against other forms of playfully labeling the client. REBT is seldom endorsed as an orientation by psychology faculty (Norcross & Sayette, 2011), which may contribute to a mistrust of the method despite its

appearance in textbooks and training videos. Students may self-select out of the orientation out of deference to faculty or just as likely out of the awareness that it requires exceptional risk-taking.

There does not appear to be a curricular goal of teaching different types of risk, how to handle them, and what is acceptable and unacceptable. These elements of practice may be conveyed tangentially through ethics courses, supervision, and additional reading. Tsai, Callaghan, Kohlenberg, Follette, and Darrow (2009) suggested that students can build their own comfort level with risk-taking by sharing regular emails that describe emotional risks they have taken during the previous week. It would be difficult to implement this as a required measure, however.

Nonetheless, it is evident that therapy involves some degree of risk-taking. Haven (1986) associated risk-taking with active listening and interpretation. He proposed deepening the relationship with the client by listening and reacting authentically, stripping away the potentially distancing language of the stereotypical therapist. By turns, this approach is playful, supportive, and challenging. A client evincing anger and fear about a tumultuous holiday with their family may elicit an (earnest) response like "to think of spending Thanksgiving with those awful people!" rather than "it seems like you are really concerned about seeing your family." Havens (1986) suggested that these kind of activities are likely to be difficult for the prototypical therapist:

Therapists have difficulty expressing love for themselves. Politicians and salesmen find it easier.

Therapists tend to be at least superficially modest and self-effacing, often to the point of spookishness.

Speaking such words as "you must love me so much" is more or less the equivalent of standing on one's head. It is to be hoped that more therapists will interest themselves in making such empathic efforts,

because they can marvelously deflate positive transference psychoses. They do not interfere with the patient's and therapist's appreciation of one another. (p. 135)

Havens echoed Bugental (1992) in his desire to exist in the moment with the client; this is its own risk, as it *appears* to relinquish the formal role of the therapist and could thus incite panic in the trainee who is being held up against that role. Moreover, if Havens (1986) is correct in asserting that therapists generally have problems with self-love and false modesty, this supports the use of personal psychotherapy to explore these elements of their real selves (as opposed to their therapeutic personae).

Macran et al. (1999) and Geller et al. (2005) cited the observation of clinical techniques as a key benefit experienced by psychotherapists in personal therapy. Risk-taking certainly qualifies, and may be especially valuable when observed from the vantage point of the client. Risks may be seen in their failure as human error and if successful, as human contact. With a decent therapist, the therapist-client may in the moment be apart from anxiety about their competence and free to not only witness technique but to experience their therapist as a fellow human being. Extrapolating such interactions to one's own practice is likely to be easier than distilling the advice of textbooks, supervisors, or video material because they function as experience in addition to example.

Self-disclosure.

Learning to use self-disclosure in therapy is a complex process for trainees. New therapists may receive mixed messages from their various training outlets (e.g. program, supervision) and struggle with developing their views on the subject, particularly if those views are communicated didactically rather than experienced first-hand (Botrill, Pistrang, Barker, & Worrell, 2010). Much as with transference-countertransference, a personal therapy provides an opportunity to both observe and experience the effects of a therapist's self-disclosure behavior,

which may be a particularly memorable experience for some therapists (Geller, 2011). On the other hand, non-patients/non-clinicians are able to notice that certain types of self-disclosure (e.g. gratifying therapist's needs by switching the focus to them) can negatively affect professionalism and perceived depth.

Norcross, Bike, and Evans (2009) found that avoiding excessive self-disclosure was the most common feature of therapists' personal therapy that they were able to employ with their own patients. It is possible that trainees can emerge from personal therapy more attuned to the way a typical interpersonal process can have ramifications in a therapeutic setting.

Belief in process.

Farber, Manevich, Metzger, and Saypol (2005) considered personal therapy to influence some individuals choice of therapy as a future profession. The aforementioned struggles with psychopathology revealed by Sawyer (2011) also served to garner faith in the healing potential of psychotherapy. Geller (2013) differentiated greatly between his experiences with different therapists, depicting therapists as imperfect instruments for a process that has underlying value.

It is notable throughout the literature that therapists and therapist-trainees report making gains in several areas during therapy. It is still unknown empirically whether their beliefs before and after therapy are affected; greater faith in the process would likely be a gain in itself in terms of professional functioning or pre-professional performance. An argument can be made that there is a qualitative difference in the belief in process that arises from observing change in others versus experiencing therapeutic change for oneself. Since therapeutic change clearly occurs in the psychotherapy of psychotherapists, it would be worthwhile to investigate whether this subjective change has a positive effect on their performance as therapists.

The influence of psychodynamic theoretical orientation.

Through the course of training, theoretical orientation is developed with or without the influence of personal psychotherapy. No research exists to date on whether personal psychotherapy contributes to satisfaction with theoretical orientation, stability of theoretical orientation, or the stepwise process of committing to a theory or theories of psychotherapy. A trainee's orientation is more of an affiliation, as no formal declaration is required on the trainee's part, although supervision and practice may be canted one way or another. It is difficult to determine when students become bound to certain theories, and some researchers (e.g. Vasco & Dryden, 1994; Buckman & Barker, 2010) have examined personality traits as an influence on orientation choice. It may be that therapists-in-training are suitable for different types of therapeutic work based on personality just as doctors may be predisposed to work in different specialties of medicine. Personal therapy does have an association with trainees and practitioners of certain theories more than others. It remains to be seen whether one's inclination towards therapy and certain theoretical orientations are determined by similar constructs; for now, there are some meaningful correlations.

Psychodynamic psychotherapies.

It would be ideal if enough material existed in the research literature to fill a subsection for personal therapy vis a vis each of the major theories described in the introduction. What is clear is that the psychodynamic psychotherapies have the most robust association with personal therapy for clinicians. However, this does not necessarily imply that personal psychotherapy works best for psychodynamically-oriented therapist-clients, or that only psychodynamic training programs ought to encourage the practice of seeking personal therapy.

Research suggests that psychodynamic psychotherapists seek personal therapy most often, while behaviorists seek it the least (Norcross & Guy, 2005). Psychodynamic therapists

also recommend mandatory personal therapy more strongly than their cognitive-behavioral or humanistic counterparts, as well as endorsing it for professional development (i.e. optionally) or for disciplinary use (Bike et al., 2009). This is not a new trend: more than a quarter-century ago, Garfield and Kurtz (1976) found that psychoanalytically-inclined therapists endorsed personal therapy more than behavioral, existential, or humanistically-oriented peers. Norcross, Bike, Evans, & Schatz (2008) surveyed 119 therapists who had never had therapy and found cognitive-behavioral therapists overrepresented at 26%.

In one study, after concluding their training, a majority of therapists who sought personal therapy chose psychodynamic or psychoanalytic therapists (Liaboe, Guy, Wong, & Deahnert, 1989; in Norcross & Grunebaum, 2005). Cognitive-behavioral therapy was endorsed by 6% of the sample, 14% of whom *identified* as cognitive-behavioral therapists. Norcross and Grunebaum (2005) found theoretical infidelity among most orientations, with even behaviorists preferring eclectic practitioners to fellow behaviorists at about 7:1. The exceptions, unsurprisingly, were psychodynamic and psychoanalytic therapists, who preferred to see their own kind.

The question of theoretical loyalty could be considered an issue of expertise -- that is, a therapist of a certain orientation may feel that knowledge of that orientation precludes benefit. Conversely, a therapist experience therapy as more of a client if they remained at least partially ignorant of the nuances of their therapists' orientation. However, ideological gulfs between theories are still present, and a cognitive theorist going to a psychoanalyst might be a set-up for a joke, or else it could resemble an orthopedic surgeon visiting a chiropractor.

Psychoanalysts on personal therapy.

All psychoanalysts are psychotherapists, but very few psychotherapists are psychoanalysts. Analysis is the historical foundation of modern psychotherapy, but may be

viewed by students as overly rigid, unempirical, and antiquated (Shedler, 2006). Ironically, psychoanalytic thinking is more expansive and divergent than other schools of therapy, and psychodynamic and psychoanalytic psychotherapy are its freer-thinking offspring, finding their way into a number, if not a majority, of doctoral psychology programs (Norcross, 2008) and advanced social work training (American Board of Examiners in Clinical Social Work, 2004).

The American Psychoanalytic Association (2014) lists 31 institutes that provide training in adult psychoanalysis. Conventionally, psychoanalytic training is reserved for people who have already completed graduate training and received licensure. After years of being open only to psychiatrists, such institutes have gradually opened their doors, and many accept the gamut of graduate-trained mental health professionals (Shedler, 2010).

The larger irony, then, is that a form of psychotherapy viewed with so little interest by beginning students has long been a goal for dedicated and experienced clinicians. Even more fascinating is the notion that for many years, being a practitioner of psychoanalysis was the minimum for people who practice what is now called psychotherapy. This is unthinkable in the 21st century, when one can practice independently as a therapist with as few as three or four years' experience.

Where this relates to personal therapy is now evident: three to four years is the length of a brief *training analysis* for a psychoanalytic candidate. For every candidate in every U.S. institute, training analysis is one of three key elements of psychoanalytic education, along with supervision and didactic work (APSAA, 2010). This has been the case since the inception of psychoanalysis (Freud, 1937). This creates a small but highly-trained cadre of mental health professionals who assuredly have undergone therapy, perhaps more than their own patients ever will. What specific benefits do these professionals claim who are heavily-therapized by default?

The analytic view of outcome is varied. Guntrip (1975) reflected on his analysis with Donald Fairbairn, who saw analysis as working within an established personal history that could not be altered, and the restorative aspect comes less from being interpreted than from being understood. Fairbairn showed concern for something like the real relationship despite an observed formality and distance (Guntrip, 1975). Guntrip also underwent analysis from Winnicott, and he remembered his therapist's statements well enough to transcribe them, concluding that a positive view of an analyst was not only transference but an authentic experience that illustrates the need for the psychically wounded to find a "good object" (Guntrip, 1975).

Geller (2013) expanded on how his realistic experiences his many analysts contained "processes of imitation and identification" that allowed him as a student-therapist-patient to determine aspects of his own professional style, including technique. He also considered analysis to be a dialectical exchange. However, he considered a genuine dislike for the therapist to be a real possibility and one that would stymie the personal and professional benefits of the experience. Strupp (1958a, 1958b; in Garfield & Bergin, 1971) found therapists who had undergone analysis as students improved in two ways: higher empathy and greater comfort with silence and distance. The therapist and client may benefit from these gains in tandem as professional boundaries and therapeutic efficacy grow, with the therapist able to mitigate their own emotional reactions and stay in role.

Contemporary analytic training reaches beyond the training received by most graduate students, the majority of whom will not seek training as analysts. Student trainees would do well to acknowledge that the character of analysis outside of the traditional Freud-Adler-Jung triumvirate is more relational in its focus and contains valuable ideas that may migrate to their

therapeutic work. In terms of personal therapy, it would be better still if the ample testimony to the value of analysis could be seen as reflecting the benefits of psychotherapy (in any modality) to growing professionals, who ought to be fostering a belief in the process themselves.

Ideal programs and mandatory therapy.

Guidelines.

Division 29 (Psychotherapy) of the American Psychological Association formed the Psychotherapy Curriculum and Consultation Committee on Psychotherapy Training, which released in 1970 a set of standards for doctoral programs in psychology related to the teaching of psychotherapy. Some guidelines pertained to the characteristics of faculty members (e.g. some faculty members should be model therapists) and others to the needs of trainees (e.g. trainees should be taught supervision techniques). Personal therapy is subsumed into "Principle 21: Methods for enhancing the student's self-awareness, sensitivity, and personal growth should be an integral part of psychotherapy education" (Bookbinder, Fox, & Rosenthal, 1971, pp. 153-154). A 1973 survey of 96 out of the then-106 APA-accredited training programs found that none had implemented personal individual psychotherapy as a requirement (Jorgensen & Weigel, 1973).

Ten years later, they were found to exist in many training programs (one imagines that they were already present in some, and so *implemented* would be misleading). Rachelson & Clance (1980) surveyed 192 practicing psychotherapists and Division 29 members for their responses to the guidelines; the authors extracted data on mandatory personal therapy and the provision of free or low-cost therapy. A purpose of this study was to determine whether effective therapy skills are best learned in graduate school or somewhere else, using the question "did you learn more about being an effective therapist in ____?". The most common response was one's

own practice (37%), and personal therapy came second (20%), endorsed with twice the frequency of graduate school (10%).

When asked whether each of the 1970 guidelines would be included in an idealized training program, the same sample endorsed every guideline at 80% except for one: personal therapy, which only 62% of the sample felt would be included in personal training (6% did not respond to this item). Put another way, almost a third of respondents took issue with the requirement of therapy while all other recommendations were comparatively noncontroversial. 76% reported that personal therapy was not part of their training, while 34% believed it facilitated competence (Rachelson & Clance, 1980). The varied responses within this group do not elucidate how important (or unimportant) psychotherapy should be for students. A theme in the research that is re-iterated here is that opinions about the good of personal psychotherapy differ when the subject is referring to themselves or to others, on the student or professional level, and as a recommendation versus a requirement.

The compulsory issue.

In the United States, compulsory therapy for training purposes is more of an idea than a practice (with the perennial exception of psychoanalytic training). As mentioned earlier, therapy for the remediation of deficits continues to be included in programs, at least conceptually, and in the case of accredited psychology programs, it is delimited by the APA Ethics code.

There is no repository of data on programs requiring personal therapy. As such, findings could not be cross-checked, nor was the search expansive enough to include programs in counseling and social work. Combing the online catalogs of programs in clinical psychology, the author identified four that required personal therapy. All were in California, all were private institutions, two identified as Christian universities, and two are not APA-accredited. The

number of hours of required personal therapy varies. Biola University (2007) expressly identified the purpose of therapy as giving students the experience of being clients, and the school involves their faculty in the design of the student's therapy program. They also suggested that students see psychologists for therapy, and their time requirement is 50 hours. Palo Alto University (2014) and Antioch University (2014) require fewer than 25 hours and label the process "critical" and "vital", respectively. Unlike Biola, neither appears to require the direct involvement of faculty, although the latter asks students to communicate their fulfillment of the requirement to the registrar.

Cursory examinations of programs in non-psychology fields revealed little in the way of personal therapy requirements, leading us to believe that any program with this requirement is an outlier. It would be useful if the ratio of programs requiring therapy versus those which do not was reasonably close, allowing for program-level study of whether graduates of one type of program on another routinely do better on some standardized outcome. As it currently stands, graduates of programs requiring personal therapy are likely underrepresented in the literature on American trainees and psychologists, and concurrently, the data reported therein represent those who have undergone therapy for reasons other than compulsion by their programs.

Given that Division 29's recommendations for experiential work had not been interpreted and quickly adopted as the requirement of personal therapy (Jorgensen & Weigel, 1973), and that little has changed in the last 41 years to reflect new interest in making personal therapy mandatory, it would seem that the jury is in on the matter. But that is not so: Pope and Tabachnick (1994) surveyed 476 experienced psychotherapists and found the majority supported not only mandatory personal therapy for trainees, but personal therapy as a requirement from licensure. Their reasons for encouraging personal therapy cohere with those listed in Geller et al.

(2005). Fouad et al. (1990) surveyed students in three counseling master's programs and found that two-thirds endorsed personal therapy as a graduation requirement. Per usual, this is in absence of an extant requirement in their program.

A professor and practicing psychologist, Curtis (2011, p. 804) stated that "personal therapy should be required of all therapists" and recommended both individual and group experiences, detailing her time in both; she cited the familiar experience of being a patient, using the analogy of a "swimming teacher who had never been in the water" to describe a therapist who had not undergone their own therapy.

Strozier and Stacey (2001) surveyed faculty and students in MSW programs, finding that only 7% of faculty reported that their programs had policies related to personal therapy. Students endorsed therapy as "essential" -- tantamount to an endorsement of a therapy requirement -- three times more often than faculty. Nonetheless, both faculty and student endorsements of mandatory therapy were recorded in response to open-ended questions, as were opinions from both ends that therapy could be very helpful but should only be voluntary. 70% of the students in the survey had already had personal therapy.

There is a dearth of research examining the issues raised in Strozier and Stacey (2001) more directly; rather, their study focused on broader ideas about whether therapy was thought to be useful by students and faculty and how so. It would be useful to acknowledge the widely reported positive characteristics of personal therapy and instead focus on opinions about mandatory therapy among various groups. For instance, applicants to graduate programs in psychotherapy could provide insight into how a personal therapy requirement would contribute to the applicant's evaluation of a program. Moreover, data need to be gathered as to what fair

parameters for required therapy might be, given the variation in hours demonstrated by the few programs that require it.

In almost all cases, endorsement of a personal psychotherapy requirement by active trainees, faculty, and professionals is artificial and hypothetical, as the implementation of the requirement would affect only future students. A rejection, on the other hand, reflects a desire to maintain the status quo, and particularly for persons in administrative positions, the status quo may represent a well-reasoned process that would be difficult to change (or to justify changing), regardless of benefit to trainees. For example, a mandatory exercise program for students might have demonstrable benefits, but trying to justify its inclusion in an already full curriculum would require more than the ample evidence that exercise helps improve mood and physical functioning.

Another possible belief is that, in order to justify personal psychotherapy as a requirement, there must be something malfunctioning with the current system. If the vast majority of programs produce competent professionals in the absence of compulsory personal therapy, then the argument cannot be made that it is vital for producing good clinicians. However, since a majority of those clinicians seek therapy anyway and in retrospect might have appreciated it being a requirement, the therapy itself is not be dispensable.

Ethics of compulsory therapy.

The APA Code of Ethics permits mandatory psychotherapy (Knapp & VandeCreek, 2003; in Ivey, 2014), but requires that students be informed of the requirement prior to commencing training. Although both briefly mention personal therapy in regards to remediation, self-care, or availability of non-affiliated personal therapists, neither the ethics code of the

National Association of Social Workers (2014) nor the CACREP standards (2009) address the ethics of mandatory personal therapy in training programs.

In a comprehensive article, Ivey (2014) highlighted several potential ethical problems in requiring personal therapy. One concern is the likelihood that many, if not most trainees will not meet criteria for a mental disorder. If psychotherapy is viewed as analogous to medical treatment, treating these trainees would be the equivalent of an unnecessary medical procedure. On the other hand, psychotherapy can be viewed as augmentative and presumed to serve a purpose in bettering the clinician. This raises a second question of whether psychotherapy can be said to "work" in terms of demonstrable client outcome. This particular issue will be revisited in the final section of the literature review. Ivey (2014) suggested that benevolence may imply that the proximal results of personal therapy would go on to foster better relationship with clients. However, Ivey (2014) contended that there is an issue with the various biases and errors that render the subjective feelings of therapized therapists an unreliable outcome measure. At the same time, the authors suggested that current standards for psychotherapy outcome research are insufficient to measure client outcome with the rigor necessary to inform ethical judgment.

As mentioned earlier, subjecting the particulars of a student's therapy progress to monitoring by program faculty is widely disliked (McEwan & Duncan, 1993) and a violation of confidentiality and autonomy (Ivey, 2014). Other forms of harm are possible, of course, and many are concurrent with risks faced in therapy by the general population, such as sexual misconduct (Pope & Tabachnick, 1994) and ineffective treatment; the latter would likely manifest in trainees as a failure to achieve the growth points referenced throughout this paper.

Ivey (2014) suggested that it is the implementation of mandatory personal therapy that poses the ethical risks and that the process in itself can be implemented ethically according to

guidelines that address the rights of trainees. Concerns about cost, therapist selection, and privacy are paramount in these guidelines and mirror the concerns of trainees.

Strategies for implementation.

To the author's knowledge, there is no extant research directing graduate training programs in psychotherapy towards the adoption of mandatory psychotherapy. It is difficult to determine what it would take for such a maneuver to take place; even in the presence of robust outcome research demonstrating that personal psychotherapy in training shows reliable and significant differences in terms of client improvement or client harm reduction, it would take massive reorganization of programs to sanction and implement personal therapy alongside curriculum and practicum. The availability of training therapists surely varies between Wyoming and New York. In order to demonstrate efficacy of personal therapy across different theoretical orientations and in theoretically heterogeneous dyads, a larger consensus would need to exist explicitly endorsing the common factors model of psychotherapy for the purposes of personal therapy outcome.

If mandatory personal therapy were to be adopted, there would be numerous instrumental issues. Time frame is an important one: should programs allow students to waive therapy hours completed before entrance to the program? If not, does that indicate that there is something unique about the concurrent use of personal therapy and didactic/supervisory training? How many hours of therapy ought to take place and how should they be distributed?

Outside the United States.

Orlinsky, Rønnestad, Willutzki, Wiseman, and Botermans (2005) surveyed a large sample of therapists from 14 different countries. South Korean therapists reported the least use of

personal therapy (36.1%), while French therapists displayed the most with 98.9%. The United States measured 88.3% in this sample.

Standards for licensure vary widely outside the United States. Orlinsky et al. (2005) reported that Germany had recently begun to require personal therapy for licensure as a psychotherapist, while in 2005, Britain repealed a longstanding requirement of 40 hours (British Association For Counseling and Psychotherapy, 2002; in Malikiosi-Loizos, 2013). An overarching body in Europe, the European Federation of Psychologists' Associations (EFPA) requires at least 100 hours (EFPA, n.d.; in Malikiosi-Loizos, 2013) but membership in this body does not appear to be a condition of licensure in European countries.

Criticism.

The client outcome issue.

As stated in the introduction, this paper attempts a review of the personal therapy practices of psychotherapists in relation to the training process and the development of professional competency. What that competency is *for* is unambiguous: to foster positive change in clients as seen through any of the various lenses in the introductory sections on psychotherapy. Research on psychotherapy must necessarily be turned towards this outcome. With therapist-clients, though, things become more complex. When therapist-clients are the subject of therapy, they become the outcome. Yet much research has examined a rather different question: is a therapist who is a former therapist-client apt to create greater change in *their* client? If so, how? If not, what is the point?

There can be no definitive answer to what percentage of therapy cases improve, as that answer would need to encompass the outcomes of clients in a myriad of settings (e.g. private practice, college counseling centers, veteran's hospitals, state institutions, prisons), with differing

disorders (e.g. adjustment, depression, schizophrenia, personality disorder), performed by therapists with different levels of training (trainees, new professionals, late-career) and credentials. What goes on between a first-year practicum student and a deeply troubled individual with long-standing patterns of personality dysfunction can be therapy, because with the proper circumstances and performance, it can work. That is to say, therapy by trainees is practice (in more than one sense) and not *simulation*.

Outcome research tends to identify factors in the therapeutic exchange leading to positive client change (hence "process and outcome research"). Various methods are used to measure outcome, including client self-report data that is gathered over time. It is known that the therapeutic alliance is important to therapy and that the therapist should be genuine, for instance, but how does a therapist use this data? If it was discovered that alliance accounted for 60% of the therapeutic outcome, while genuineness only counted for 5%, would the therapy curriculum de-emphasize genuineness?

Ethically, a patient cannot be assigned a "bad" therapist, nor a good one that intentionally sabotages alliance-building. If a graduate student who lacks empathy is ineffective with a client, undergoes therapeutic remediation, then returns and the client improves, what does this prove? Time cannot be turned back to see what would happen if the therapist continued to be insensitive. The therapist cannot be supplanted with a more empathic one to see if the client recovers more quickly. In the meantime, the therapist has become a client, and there is more than one outcome to worry about.

What if personal psychotherapy does little for a single client, but allows the therapist to better engage in self-care and reflective practices that allow him/her to practice more competently? It is true that some clients are less challenging than others. Maybe for those clients,

the outcome is less likely to vary across any number of therapist variables. On the other hand, a therapist's ability to work with seven such clients in a row may be a true test. Alternatively, a new therapist may be able to handle several clients with severe personality pathology, containing their efforts at manipulation, dramatic gestures, and black-and-white evaluation of the therapist. The variable here is resilience. Perhaps the desire to shine as a new professional keeps the therapist motivated, or resolving the cognitive dissonance of being a helper who turns away from those who need help muddies the evaluation of one's own needs. It is possible for therapists to take on in the short term more than they can handle in the long term, and it is not until later that the consequences of overwork and burnout show. Perhaps a more useful client outcome is the obvious harm caused to clients who come expecting (and deserving) a therapeutic alliance and instead receive an exhausted, compromised professional.

It does not seem coincidental that Strupp was involved in both research on personal psychotherapy and on the subjectivities that impede outcome research (Wampler & Strupp, 1976; Strupp, 1963). Wampler and Strupp (1976) remarked on "our gross lack of useful data concerning the effects of personal therapy on clinical practice (p. 198). Decades later, the limited ability of outcome research to piece apart who therapists are, rather than what they do, and relate it to the therapeutic outcome appears to still be very limited.

This paper is broadly concerned with what personal therapy does for therapists personally and professionally, and while that ought to be correlated with outcome, it is not synonymous with it. Certainly, a workforce full of self-assured therapists who caused harm would be a nightmarish scenario, as would be the case if a majority of therapists were miserable and insecure but improving the lives of their clients. It is unlikely that personal therapy produces delusional clinicians.

To what degree ought personal therapy be encouraged? Making something mandatory can be humorously thought of extreme encouragement, while a more moderate approach would be more akin to promotion. The status quo in the U.S. resembles vague suggestion. If it could be proven that therapists who have had therapy are *significantly more likely* to experience worse client outcomes, and that undertaking therapy was certainly the cause, rather than extant psychopathology or other factors, then *discouragement* might be in order, even banning the practice. This wanders into the territory of sex with clients, business transactions, or other areas where the clinician exerts power over the client in a way that can cause psychological harm. Having a robust sense of one's professional role and identity hardly seems analogous.

In fact, the positive data supporting personal psychotherapy are unmatched by proof of worse outcomes either for clients or therapists. Studies comparing therapized and untherapized therapists on any measure are bound to small, nonequivalent samples, making for a weak case that therapy doesn't matter one way or the other. Research has not found reports of traumatization from having been a therapist in the client's seat. It should be remembered that personal psychotherapy is not a homogeneous intervention. It is certainly a tradition, and a robust one with demonstrated positive effects. To conceptualize it solely in terms of outcome is to treat it as the former and disregard the aspects of the latter that have made it perennial.

Further criticism.

MacDevitt (1987) wrote that "empirical exploration of the professional value of therapists' receipt of personal therapy has been attempted, but for the most part it has been inadequately designed, poorly focused, or over-ambitious in scope" (p. 693). These issues have not been entirely addressed in recent years. Greenberg and Staller (1981) questioned previous

studies that relied on unmatched groups and yet drew conclusions supportive of personal therapy towards the adjustment and subsequent career success of trainees.

It is worth noting that several key studies showing that personal psychotherapy is harmful are more than 40 years old. A frequently-cited study by Garfield and Bergin (1971) found that therapist outcomes were worse among trainee therapists who had many hours of personal therapy. Their sample included only 18 trainees with rather inordinate amounts of experience as patients (seven had between 200-450 hours of therapy) and used *patient* MMPI ratings as outcome. This returns to the issue that client outcome seems to be the predominant mode for measuring therapist efficacy, but remains inadequate at operationalizing the subjectivity of therapists' experience as patients. Despite this, Clark (1986) insisted that demonstrating positive client outcome is a necessary first step.

Generally, therapists' self-report of harmful experiences in therapy are infrequent. One exception is found in Buckley, Karasu, and Charles (1981), who reported that 21% of their sample felt their therapy had harmful effects. There are several caveats, however: the sample consisted of older psychiatrists, their therapy was psychoanalytic, and they were grouped according to whether they thought their therapy had *some* degree of harmful effect, as opposed to it doing more harm than good. The harm usually consisted of countertransference/attachment orientations towards the therapist. Similarly, Rake and Paley (2009) reported that therapists generally found therapy harmful at times, but also unanimously found it to be essential.

Pope and Tabachnick (1994) found that around 14% of their sample thought therapy was not helpful, but generally cited characteristics or behaviors of the therapist as harmful. This reiterates the difficulty that arises from so many variables being in play. One important

consideration is whether more hours in therapy reflects greater dysfunction, as may have been the case in Garfield and Bergin (1971).

A recent review by Dimidjian and Hollon (2010) reiterated the difficulty of measuring harm in psychotherapy concerning the general population and called for measures like randomized controlled trials (RCTs) to better assess the possibilities that given treatments cause harm. Such trials necessarily depend on monitoring the continuity of specific disorders and therapist behavior and again rely on client outcome as a variable. These proposed studies mirror drug trials in their methodology. When the outcome is improvement of psychotherapeutic skills in a therapist-patient, however, this analogy is not suitable for determining harm. Dimidjian and Hollon (2010) also noted that harm may be reflected directly (i.e. worsening symptomatology) and indirectly (e.g. expenditure of financial resources on an ineffective treatment). Ample evidence exists that personal psychotherapy has predictable gains that are not analogous to symptom remission. Future research on harm might address the separation of the therapist-client's well-being from their therapeutic performance as outcome variables

Supervision

Research suggests that supervision is different from personal psychotherapy. Supervision is required across the board for trainees in the helping professions. As mentioned earlier in this paper, confidentiality is treated rather differently in supervision, and supervisors are by definition bound to program faculty through the evaluation process. In addition to being mandatory, supervision is generally free for trainees.

It does not appear that supervision acts as a substitute for personal therapy, and this is evident in the fact that the two processes often take place concurrently and that trainees report withholding information from supervisors that may be more appropriate for personal therapy

(Mehr, Ladany, & Caskie, 2010). Because supervision deals with the therapeutic capacity of the trainee, it follows that certain personal material may be seen as germane for supervision, such as countertransference reactions. However, these reactions may in fact be "saved" for personal psychotherapy or explored more deeply than in supervision (Geller, 2005).

It seems evident that differential disclosure to supervisors versus personal therapists would be due at least in part to the former's responsibility for the trainee's practice and their evaluation of the trainee; Mehr et al. (2010) reported that impression management and perceived negative consequences were two reasons cited for lack of disclosure to supervisors. They might just as well be patterns to work through in personal therapy. In fact, Geller (2005) mentioned that therapy might allow trainees to be more honest with supervisors, becoming aware of the difference between privacy and secrecy (p. 387).

Mehr et al. (2010) also listed negative supervision experience and negative perception of the supervisor as commonly withheld information in supervision. When dealing with an evaluating presence, even in the context of a mentoring relationship, holding back negative appraisals of the evaluator is certainly adaptive. In contrast, it is hard to conceive of a therapist of any orientation treating their client's negative appraisal as anything less than grist for the mill. Supervision does not appear to benefit from examining the relationship dynamics of supervisor and supervisee in the same way therapist and client might examine their own.

Nonetheless, successful outcomes in supervision depend partially on a strong working alliance, just like personal therapy. Mehr et al. (2010) found that working alliance in supervision was correlated with lower anxiety, higher disclosure, and lower non-disclosure from supervisees. Disclosure and anxiety are commonly viewed as outcome variables in supervision research, falling under the general aegis of supervisee development and reflect a relative lack of research

on client outcome data (Freitas, 2002). This is rather in keeping with research on personal psychotherapy and client outcome, as discussed in the prior section on outcome issues.

It is worth noting that supervision employs methods outside of conversational exchange: videotape and audio recording are standard procedures in psychotherapy training. As such, there is some form of agenda that is created from outside the trainee-supervisor dialogue. It would be illuminating to see how the proportionate use of observational versus discussion-based methods in supervision affects the working alliance; to our knowledge, this is an unexplored area. There is some evidence that live supervision using a one-way mirror and allowing for occasional in-room commentary from the supervisor fosters a more positive alliance between trainee and client than does tape review (Kivlighan, Angelone, & Swafford, 1991; in Freitas, 2002). The variation between types of supervisory roles is immense and it is likely the degree to which the therapist-client schema is active varies accordingly.

Freitas (2002) contended that methodological issues in supervision outcome research have improved little since the 1980s. The last decade of research has yet to revolutionize the psychotherapy outcome literature (Horvath, 2013), and if the focal points of the therapist-client relationship cannot be discussed, conceptualizing supervision as though it has proximal effects on client outcome barges ahead of the additional research needed regarding the supervisor-therapist relationship.

Personal psychotherapy is no more likely to become mandatory across the board than therapy supervision is likely to become optional. Perhaps the latter stands as testament to what psychotherapy programs are willing to ask of their students. It is interesting that both psychotherapy and supervision suffer from the same unmet ideal of being measured through client outcome, instead showing their effects on the personal and professional development of

trainees. Supervision purports to prevent harm, but it would be unethical to survey under-supervised therapists to determine whether it really does so.

Mehr et al. (2010) suggest that more research is needed to determine how to facilitate more disclosure to supervisors. If supervision can work without disclosure, and personal psychotherapy cannot, then they appear to be working towards different, but perhaps complementary goals for the trainee.

CHAPTER THREE

Discussion

Recommendation of Personal Therapy

Why recommend personal therapy?

The research overwhelmingly suggests that therapists both seek personal therapy and subjectively benefit from it. The question is thus unpacked into two parts: one, if therapists seek therapy anyway, why bother recommending it, and two, are subjective benefits sufficient to indicate the endorsement of personal therapy by formal entities like training programs?

Because therapists seek therapy in such large numbers, ranging from a clear majority (Norcross & Prochaska, 1986; Strozier & Stacy, 2001; Bike et al., 2009; Bischoff et al., 2002) to a sizable minority (Bae, Joo, & Orlinsky, 2003), with a majority finding it helpful (Pope & Tabachnick, 1994; Bike et al., 2009), it might seem superfluous to recommend a course of action that will produce an already likely outcome. Yet many who have undergone therapy endorse the more rigid formal requirement of personal therapy for trainees and/or licensure (Pope & Tabachnick, 1994). Respondents' therapy was often voluntary, rather than compulsory, so it is less a matter of recommending an identical experience to their own as it is speaking out on the importance of their own therapy and applying this to an idealized training program. Their enthusiasm must be tempered with the logistical and ethical difficulties that exist with the implementation of mandatory personal therapy. This is less of an issue with formal recommendation, as outlined below.

The subjective benefits of personal therapy have been outlined throughout the literature review. In order to require therapy, it would seem necessary to demonstrate that these subjective

benefits are likely to occur and that they quantifiably affect client outcomes in a positive direction, two variables that have thus far been difficult to measure.

To be fair, the consistent requirements of programs, such as coursework, supervision, and (sometimes) thesis/dissertation cannot be said to quantifiably affect the outcome of therapy in a positive direction, either. It would be unethical to under-educate a statistically significant group of students on theories of psychotherapy and see how they measure up to a control group on client outcome. One might argue that the EPPP or LPC exam would be a better measure of theoretical knowledge, but ultimately knowledge and clinical ability (including professional identity) are not identical.

It is unethical to provide less-than-adequate supervision, although the concept of adequate supervision does not seem particularly beholden to empirical research, either. Dissertation and thesis reflect the abilities to synthesize literature and/or conduct original empirical research. In the context of the scientist-practitioner model, this component of training is meant to address the growth of the scientist. Nearly all Ph.D psychologists and many master's-level clinicians have completed a lengthy dissertation or thesis, and to our knowledge, research does not exist suggesting that this process creates clinicians that are more self-aware in their applied work.

A viable solution is to implement a recommendation for personal therapy that does not pretend to supersede the importance of coursework and supervision, despite research suggesting that personal therapy is frequently considered to be a key element of therapists' growth (Norcross, 2005; Strozier & Stacey, 2001). A formal recommendation of personal therapy would be a humble one, meant to normalize and convey acceptance of the therapy process to combat reluctance in the student that is born of stigma and fear. Perhaps the effect of such a

recommendation would be tantamount to an optional textbook added to a didactic syllabus, where a minority of students purchase the book in hopes of learning more about the subject. The effect might nonetheless be significant.

Caveats of requiring therapy.

Of the few programs requiring personal therapy, all charge a sizeable tuition. Palo Alto University requires 16 hours of personal therapy for their clinical psychology doctoral program, which is on the low side for programs with a mandatory number of hours. These hours must be with a doctoral-level practitioner (Ph.D., Psy.D., or M.D.) and the program website provides students with a list of sliding-scale therapists as well as recommending they consult the *Psychology Today* classifieds. Tuition at PAU in 2014 was \$41,333 per year, plus \$4,650 in institutional fees, which amounts to \$184,000 in four years. Presuming a generous sliding-scale rate of \$100, 16 hours of therapy would cost \$1600, which is less than 1% of the cost of four years' attendance and a third of a year's fees.

The university explains the rationale behind the 16-hour requirement on their website: "It is the perspective of PAU that the personal experience of psychotherapy is critical to the ability to work therapeutically with others" (Palo Alto University, 2014). It is arguable that an experience considered critical ought to be included in the considerable cost of a training program. Of particular interest is the fact that no research is cited by the university to justify the requirement of personal therapy, despite an abundance of suitable studies. Instead, the necessity of therapy is conveyed somewhat dogmatically as the opinion of the university.

An impetus for this paper was the author's inability to locate a program that embodies the ideal values of personal therapy: formal or informal endorsement citing actual outcome research as well as trainee-specific values, and maintaining affordability as well as distance from program

evaluators. Similarly, the author did not find any training program that expressly discouraged the receipt of therapy by trainees, and indeed the widespread inclusion of therapy as a remediation tactic is a tacit endorsement.

One training experience.

The author has a long-standing interest in the therapy-seeking habits of individuals, believing that it is the obligation of any professional to understand the emotional and intellectual perspectives others hold towards his or her work. Having spent several years training to become a psychotherapist, it has been a particular fascination of the author's to observe his fellow trainees' attitudes towards personal psychotherapy as well as the informal endorsements of therapy by two training programs. Generally, individual instructors have been candid about attending personal therapy in the past and recommend it for trainees. At the University of Texas Southwestern Medical Center at Dallas, Professor Robert Drake shares with his Master's-level supervision class that he credits several years of counseling with his ability to be a good counselor (personal communication, 2014).

In the author's experience, students have been candid about having undergone or avoided personal therapy, but rarely discuss the particulars, and have not cited faculty encouragement as a motivating factor for seeking therapy. The message that is left hanging in the air is something like 'there exists a way to learn to do what you are *about* to do in a way that benefits you and your patients, and you should look into it. It will help. But of course, you don't have to and we can't make you.'

Whether or not this is an effective promotion cannot be determined at present, but it is the form that advice on therapy is likely to take, so long as it remains mere advice. It is difficult to imagine a faculty of applied psychologists speaking out *against* personal therapy, although it is

evident that fear of faculty reprisal is on some students' minds (Wampler & Strupp, 1976).

Writing an optional endorsement of personal psychotherapy into program training manuals seems cumbersome: "students are encouraged but not required to seek personal therapy." Such statements may exist, but their impact may be compromised as part of what is essentially reference material. They might be included as an overt acknowledgement that it is safe to seek therapy as a trainee, but coming from a manual instead of a human being, they are unlikely to engage on a personal level. The following section addresses how personal therapy might look as a recommendation.

Recommendation of therapy by training programs.

The recommendation of therapy by programs could begin during orientation, where attendance by every student is likely and the values and purpose of training and coursework can be established. It is up to individual programs to find moments where the overarching concepts of professional development can be discussed, and relying on anecdotes that fill the spaces in classroom teaching is insufficient. Some programs require professional identity development courses (e.g. Texas Women's University). Others feature guest speakers who are clinicians working in the community. If a program is to effectively encourage students to undergo therapy, as many students as possible should be present to receive the message and it should be delivered in a context where professional identity development is the primary topic.

Once safety is established (i.e. trainees are aware that the program cannot check on their progress or otherwise inquire into their therapy practices; there will be no "show of hands"), there is a space to discuss the costs and benefits of attending therapy, and according to the literature review, there are more benefits than costs. The literature could be explained with relative ease by distributing any of the reviews endorsing personal therapy (e.g. Norcross & Guy,

2005) as well as those suggesting that it is ineffective (e.g. Garfield, 1971), and this can add weight to the personal endorsements of therapy that are informally conveyed by instructors, which may be ineffective on their own.

As every program has its benchmarks, many commensurate with licensure, an understanding of psychotherapy's benefits ought to be conveyed alongside the proper way to score assessment protocols, write reports, and behave around clients. It is here that a minimal acknowledgement should be made of psychotherapy as something that works. Just as programs do not define psychotherapy, neither do they place emphasis on understanding the mechanisms by which it functions or the outcomes. If it is beyond the scope or willingness of a program to address personal psychotherapy for its trainees, then the curricularization of therapy outcome research, including outcomes of trainee psychotherapy, would be a satisfactory compromise that might have positive effects on trainee attendance. This represents a more passive approach that may have a lasting benefit, much as learning how to give a WAIS-IV is bound to correct preconceptions about intelligence testing gleaned from years of being a layperson.

Norcross and Karpiak (2012) found that the number of psychologists in private practice has steadily increased from 17% in 1960 to 41% in 2012. Private practice is also an option for most other mental health professions providing psychotherapy. Yet private practices are not the sanctioned venues for learning in therapy programs, nor is it common for programs to advise students on how to run a practice. Personal psychotherapy would not -- and should not -- walk a trainee through how to draft informed consent, magazine the waiting room, or select a couch. But the effect of mere exposure to these elements should be considered, as they may be important to conceptualizing one's future career. Add to this the more functionally important behaviors of the psychotherapist that can serve as a model (or anti-model) for the future. Granted, supervisors

may share aspects of their private practice with students, but there is no denying that the students are treated differently from the supervisor's therapy patients. It seems reasonable to allow budding therapists the opportunity to experience private practice as a client-observer; after all, they have plenty of opportunities to watch academics do what they do best. Private practice remains a mystery to the untherapized despite the high likelihood of it being a trainee's career setting.

Asking for help.

Do psychotherapists need to be *helped* by therapy? This depends on a broad view of the profession as a whole over time, incorporating robust findings that therapist characteristics are a crucial determinant of outcome across theoretical orientations. For many years, 100% of therapists underwent rigorous analysis. Today, a sizeable majority still do, but by no means all, especially when controlling for the psychodynamically-oriented, who are overrepresented. What would the field look like if this number went down to 20%, 15%, even 5%? Therapists fit inside this circle of suffering, not on its periphery; they suffer from depression and marital problems, for example, just like the rest of the world. If the mental health field starts to think it is too well-adjusted to benefit from psychotherapy, then an impaired workforce could be the result.

Given the private world of the psychotherapist, avenues to personal development may be difficult to imagine. Continuing education in the form of weekend seminars does little to address the emotional effects of containing thousands of people's troubles over the course of one's career. The difference between a naive therapist and an experienced one might be simply expressed by the ability to manage this demand. Or perhaps it peaks and dips throughout one's career, causing re-entry into personal therapy when new professional exigencies arise.

A majority of doctoral programs in psychology prohibit full-time work during enrollment, and many more programs across disciplines discourage the practice of adding a 40-hour work week to classes, research, and supervised practica. It is inevitable that many students will be unable to pay full price for therapy. Programs will need to acknowledge the possibility that students will need financial help seeking therapy. It would be ideal to adopt as standard practice the enlistment of local practitioners to serve as reduced-fee therapists for students. Another possible solution would be a modification of student health plans, which most programs require, to allow therapy trainees to visit practitioners outside of the student clinics (which may well be their future training sites).

The practice of vocally endorsing personal therapy for students should not carry with it the caveat that students must make large financial sacrifices in order to reap benefits. It may seem hopelessly idealistic, but if students are able to receive therapy in an unobtrusive manner, certain of them may later be able to pay back the system and serve as reduced-fee therapists themselves. Since training programs are typically small, it would be possible in a mid-sized community for several therapists to see one or two students at reduced-fee rates. In this regard, programs should look to the practices of analytic institutes, which nearly always facilitate the location of training analysts for their students.

Providing avenues to lower-cost therapy should not be confused with dictating *who* a student can see, and care should be taken that lists of therapists are not misconstrued in this fashion. Part of being the client is experiencing the process of selecting one's therapist, replete with stress and the potential for disappointment. Guidance towards certain practitioners in the community should emphasize the accommodation of a student's circumstances rather than limit their options.

Conclusion

It could be that some students do not need programs to tell them personal therapy is a good thing. Those resistant to the idea may be unmoved by *any* effort, simply growing up to become untherapized therapists. Analysts would gasp, the psychodynamic crowd might shake their heads, behaviorists might nod theirs. And it might not matter. The dividing line between effective and ineffective therapists is not drawn neatly over the issue of personal therapy.

Training programs vary in their approach to therapy. Psychodynamic training in psychology doctoral programs is not a given, and the meteoric rise of EBTs de-emphasizes the role of intrapersonal processes. CBT trainees seek therapy, but less often. If therapy is viewed solely as intervention, there is little room to encourage 'treatment' for the 'well' practitioner.

Whatever investigations continue to be made into efficacious therapies, the fact that subjective therapeutic factors are crucial to therapeutic success is beyond question. Training is the professional setting for the development of subjective factors, and personal psychotherapy has been proven helpful for their development. It stands to reason that a relationship should be fostered between training programs and personal psychotherapy that acknowledges this utility and offers support and validation to students that elect to make it part of their process.

Summary

The recommended points to be adopted by graduate training programs in psychotherapy are as follows:

- Formally adopt a supportive, non-punitive, and non-stigmatizing stance towards students seeking their own therapy while in training, conveyed in program materials and during initial orientation.

- Accordingly, normalize the experience of heightened stress during graduate training and the option of receiving treatment for personal growth *or* personal difficulties
- Encourage faculty to disclose personal experiences with psychotherapy, when appropriate, to illustrate experiences relevant to their professional development
- Incorporate literature on personal psychotherapy into the curriculum to foster an understanding of how clinician development may be affected by the process, alongside broader readings on therapeutic process and outcome commensurate with trainee's clinical responsibilities
- Provide access to reduced-fee therapy providers and materials that allow students to make informed judgments about preferred theoretical orientations and settings

CHAPTER FOUR

Suggestions for Future Research

Diversity, Personal History, and Commonalities

Learning about Students

In writing this paper, the author anticipated topics concerning diversity: what about therapeutic help-seeking in LBGTQIA-identified master's-level trainees versus their doctoral counterparts? Do African-American counseling psychology students seek therapy more often than those in clinical psychology? Do women rank professional growth as a benefit of personal therapy differently depending on which part of the country they received their diploma?

There is presently little to no research available in these areas. The most promising avenue to learn about personal therapy seeking in trainees is surveying them in a systematic way and looking for differences. Some typical questions asked in therapy research are whether or not the student has had therapy, what their proposed theoretical orientation is, and how many sessions they went to. Given the participation of a large enough number of students, many other demographic factors might come in to play. Perhaps the most important question is where students and professionals differ in their response to personal therapy. Research on this topic generally portrays a large circle of professionals who have *ever* received therapy which then encloses a smaller circle of trainees who receive or have received therapy. If it is found that therapy is of greater benefit when first learning to be a therapist, a stronger case might be made for recommending or requiring it. As of now, this is unknown.

What about students who come in fresh from undergraduate study as opposed to older students? Or students that enter having majored in a non-psychology area? Students of color, of

varying genders and sexual orientations, or with particular life experiences (family of origin issues, divorce, job loss) would be another area to explore.

Since the ultimate outcome of trainees' therapy-seeking is professional functioning, professionals might be surveyed qualitatively about their experiences as students -- what it was like finding a therapist, what their peers thought about therapy, how therapy was presented to them and whether that was effective or not. It is apparent that practitioner attitudes towards personal therapy are generally positive. The development of that attitude is more mysterious. In tandem with the earlier recommendation that faculty be encouraged to share experiences with students, adding this perspective to the literature might be valuable. In particular, the narratives of faculty and/or professionals might illuminate the moments in their early practica that indicated a need for personal therapy and how they benefited. Personalizing these narratives could enhance the role-modeling effect of such disclosure.

Returning to students, another area for investigation would be the students' theoretical orientation and their impressions of what is required of a therapist. Personal therapy appears to work even when therapist and client are of different theoretical orientations, and that even those with a cognitive-behavioral orientation sometimes prefer psychodynamic therapists. What are the impressions that students have of this incongruence initially, then afterwards? Do they grow more open-minded and likely to integrate therapy techniques, or are their impressions of psychotherapy theory the same?

In the manner of Norcross et al. (2008), Pope and Tabachnick (2004), and others mentioned in this paper, survey methods should be applied comprehensively to graduate students in clinical fields. While it is probably true that graduate students in psychotherapy have faith in the process they are studying, they may still harbor misconceptions. Anecdotally, the author has

encountered students that have sought and endorsed personal therapy only after beginning to counsel others, both out of perceived incompetence and the struggle of suddenly needing to contain so much affect from others. Trainees could be surveyed at baseline and then once they are practicing as interns, identifying the beliefs that have changed and stayed the same and to what students attribute the change (grouping them into therapy and no-therapy subsamples).

On the level of individual programs, it might be illuminating to survey which programs attract students who are inclined to seek personal therapy. While certain theoretical orientations are more associated with personal therapy than others, students applying to programs more than likely have not settled on a theoretical orientation. Likewise, as therapy attendance correlates with career direction, perhaps the relative emphasis placed on clinical work within a program is related to a student's willingness to seek therapy.

At the master's level, some programs train solely for practice. It would be worthwhile to study personal therapy as it relates to outcomes within the shorter training schedule and more focused professional outcomes in master's-level training program. With relatively less didactic work and fewer hours of practica, students studying for licensure as counselors or social workers may react differently to personal psychotherapy than the psychologist samples that make up the overwhelming majority of the research. Also, within clinical practice, master's-level clinicians may find themselves in any number of settings, from private practice to community mental health to administration, and the number of hours spent providing one-on-one therapy may vary. If personal therapy cultivates a disposition towards therapeutic practice in psychologists, who arguably have a broader career outlook, perhaps a similar focusing effect exists for master's-level practitioners.

In recent years, the analytic field has opened its doors to the majority of licensed therapists. Nonetheless, analytic training is still relatively a rare undertaking. As it is the only modality that consistently requires personal psychotherapy, it would be interesting to see how the analytic training decisions of LPCs, social workers, psychologists, and psychiatrists are influenced by personal psychotherapy undergone during their graduate training.

The above research directions focus on descriptive data, and care must be taken to create space for negative experiences in therapy. One of challenge facing this kind of research is a tendency to evangelize based on the weight of positive outcomes, although negative outcomes have been described by several researchers (e.g. Pope & Tabachnick, 1994). More direct comparisons could be made between negative therapeutic outcomes in trainees versus the general population; it seems intuitive that trainees with bad therapy experiences would be less inclined to disclose them, as they might represent a threat to personal or professional identity. Laypeople sometimes draw the conclusion that therapy is not for them, but the same conclusion in a psychotherapy trainee could be life-altering. It would be interesting to see if trainees who had negative experiences in therapy tended to return to the process with a different therapist, to reject the process as a whole, or to develop negative values surrounding it.

Generally, the less that is known about individual experience in therapy, the wiser it may be to pursue qualitative research as a way of informing further quantitative inquiry. Diversity is a massive dimension of psychotherapy process and outcome, but relatively understudied as it relates to the qualitative experiences of minority groups in training and personal psychotherapy. Potential positive outcomes (e.g. processing of difference/other-ness, inclusion and acceptance, developmental identity issues) and negative outcomes (e.g. experienced discrimination/alienation in therapy) might be gleaned through the examination of personal narratives.

It is the author's opinion that the shifting dynamics and demographics within the helping professions over the past several decades begs for focused replication of research concerning the overall perception of psychotherapy among different demographics with regard to professional development. Through informal Internet research, the potential to misconceive the means and ends of therapy has never been greater. How graduate students think about therapy must be examined in relation to the general population to reveal the same "blind spots" which personal psychotherapy hopes to address. To revisit an early section of this paper: psychology undergraduates leave with opinions about psychotherapy informed by textbooks. It cannot be assumed that they possess special expertise concerning psychotherapy beyond what can be gleaned from diligent research online or in the library. It is also true that training programs look for outside experiences, such as volunteering at a crisis center, to demonstrate suitability for clinical work. But where do undergraduates, or future therapists, start to believe therapy works? What does wanting a bachelor's degree in psychology have to do with it?

Research into personal psychotherapy is inextricable from research into professional development, which is likely influenced by personal development. Personal therapy also fosters competence both personally and professionally. No field has remained unchanged by the technological and economic developments of the last several decades, and the relationship between personal and professional development in the helping professions must continue to be explored with the acknowledgement that it is a dynamic system. Nonetheless, the therapist as an individual continues to be paramount. Research needs to strive towards an understanding of the factors that allow the individual can develop into an effective practitioner. Regarding the dearth of research addressing personal psychotherapy on the process level, Norcross and Grunebaum

(2005) stated that "the silence is deafening" (p. 201). Perhaps what are missing most are the voices and footfalls of individuals who are learning both sides of the process.

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BIOGRAPHICAL SKETCH

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EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education,*

INSTITUTION AND LOCATION	DEGREE (if applicable)	YEAR(s)	FIELD OF STUDY
Connecticut College	B.A.	2003	English
The University of Texas Southwestern School of Health Professions	M.R.C.	2015	Clinical Rehabilitation Counseling Psychology

Positions and Employment

2006-2010 The National Captioning Institute

2011-2013 The Suicide and Crisis Center of North Texas

Clinical Experience

2014-2015 University Rehabilitation Services, UT Southwestern

Professional Memberships

2014-2015 Dallas Society for Psychoanalytic Psychology