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Up Close and Personal: A Consideration of the Role of Personal Therapy in the Development of a Psychotherapist

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... Theodor Reik (1948) has said the personality of the therapist is his most important tool... As with any craft, it is vital that the artisan or the scientist know in detail the capabilities and limitation of their tools so they can truly use them as facilitators of creativity rather than stumbling blocks between them and their work.

(Peebles, 1980, p. 261)

Friedman, in his 2008 *New York Times* article "Have you ever been in psychotherapy, Doctor?" writes, "A therapist should not start exploring a patient's mind without really knowing what is in his own."

Yalom (2002, p. 40) tells us, "To my mind, personal psychotherapy is by far the most important part of psychotherapy training."

This chapter will examine the role of personal therapy in the journey of becoming a psychotherapist. As a clinician practicing for 33 years, with the experience of personal analysis, group therapy, and the privilege of having supervised and been the therapist for many clinicians, I have a clear bias as to the personal and professional benefits of this experience. I do not, however, have to make a case for it. The empirical reality is that an overwhelming majority of therapists of all disciplines across different orientations, both nationally and internationally, seek personal therapy, often more than once, during and after training and for personal reasons (Norcross & Guy 2005; Orlinsky et al., 2005b). Therapists practice what they preach. What can we understand from this? How does it illuminate the role of personal therapy in the developmental journey of therapists? What can we pass on to those who follow us?

In this chapter I attempt to answer these questions. Drawing upon empirical findings, qualitative narrative studies, and personal experience, I recognize the inextricable mix of personal and professional dimensions in the functioning of therapists. I consider personal therapy as integral to a therapist's formative training and ongoing development across disciplines and orientations. I recognize personal therapy as expanding didactic training.

clinical experience, supervision, and cultural competence. While no single factor can guarantee the effectiveness of a therapist, I invite practitioners to more openly recommend and model the use of personal therapy as a crucial dimension in a therapist's journey.

This chapter will include a consideration of personal therapy in terms of the mix of personal and professional dimensions; empirical findings, prevalence, differences across orientations, reasons for use, and comparisons with the general population; trauma work, personal and professional benefits, and professional career development; "the person" of the therapist; the therapist's therapist; its value across theoretical perspectives; the interface with supervision; its role in developing cultural competence; the implications of mandated and required therapy; and the legacy of personal therapy.

The Mix of Personal and Professional Dimensions

In a qualitative interview study aimed at identifying learning arenas for professional development, Ronnestad and Skovholt (2001) illuminate the inextricable relationship of personal and professional dimensions in a therapist's development. Drawing upon the retrospective accounts of 12 senior practitioners, ranging in age from 61 to 84, and interviewed twice in a span of 11 years, Ronnestad and Skovholt identify three arenas of learning: (1) awareness of early life experiences, cumulative professional experiences, mentors, colleagues, and adult life experiences as opportunities for professional development; (2) recognition of the significance of processing and reflecting experiences in all domains; and (3) recognition of being a therapist as a rewarding choice that can be maintained despite age.

While a small qualitative study, the broad message offered is that being a therapist is a sustaining identity optimally developed by ongoing reflection and integration of personal and professional life experiences.

Reflected in my own life, I think it is no coincidence that my first professional book, co-authored with Fenster and Rappaport (1986), *The Therapist's Pregnancy: Intrusion in the Analytic Space*, marked the birth of my first son, and that my most recent book, co-authored with Kane (2008), *Healing Together After Trauma: A Couple's Guide to Coping with Trauma and Post-traumatic Stress*, marks the near-death and recovery of my youngest son.

With the first, I had been a therapist for 8 years before having children. The intrusion into the analytic space addressed by me and my co-authors reflected not just the break in the frame and intrusion in the space shared with patients but the intrusion in my definition of self, body, marriage, and my personal and professional life space as I knew it. It would of course result in an expansion of the frame that would be invaluable for me as a person and as a therapist.

In addition to passing on to other couples an understanding of the vulnerability and resiliency shared by a couple facing trauma, my recent book

Healing Together After Trauma represents an integration of personal meanings of loss, professional training, and the gift of experience given by patients, be they runaway girls, rape victims, cancer survivors, widows, or grieving firefighters who invited me in to help them face the unthinkable.

Empirical Findings: The Best-Kept Secret

Resonating with this message, a little-known fact is that the majority of mental health practitioners choose to enter personal therapy. Summarizing the prevalence of personal psychotherapy among mental health professionals in the United States from 14 studies, Norcross and Guy (2005) found that with a mean and median of 72% to 75%, the majority of responding professionals have had at least one experience of personal treatment. Bike et al. (2009), in a 2007 replication and extension of a 1987 national survey of psychotherapists, including 219 psychologists, 191 counselors, and 192 social workers, reported that 85% sought therapy, with no differences across gender and professions.

The relevance of personal therapy is further corroborated by the data collected on the prevalence and parameters of personal therapy in Europe and other countries (Orlinsky et al., 2005b; Orlinsky & Ronnestad, 2005a, 2005b, 2005c). Using the Development of Psychotherapists Common Core Questionnaire (DPCCQ), filled out by 5,000 therapists, Orlinsky et al. computed the personal therapy experience of therapists from 14 countries.

The sample included primarily psychologists but also other professions, including social work, counseling, and nursing, primarily in New Zealand and Sweden. Although there was some variation between the countries with the largest samples (Germany, the United States, and Norway), gender was balanced. The orientations of therapists included analytic/dynamic, cognitive-behavioral, humanistic, and broad-spectrum eclectic. Findings reveal that despite many cultural differences, overwhelming majorities of therapists everywhere reported having at least one course of personal psychotherapy, with the sole exception of South Korea. The rates range from 90% in France, Switzerland, Sweden, Israel, and Denmark to a low of 72% in Russia and 66% in Portugal.

Prevalence and Orientation

The question arises as to whether similar value is attributed to personal therapy across orientations. Whereas the relevance of personal therapy for training and effectiveness with different orientations and models will be addressed below, national and international empirical findings suggest that the prevalence of personal therapy varies with theoretical orientation. In considering five representative studies, Norcross and Guy (2005) reveal that 88% to 97%

of self-identified insight-oriented mental health professionals choose personal therapy, compared with 44% to 66% of self-identified behavioral therapists. In between are humanistic, systems, and eclectic practitioners.

Orlinsky et al. (2005b) found similar differences in terms of orientation from their international database. With the exception of South Korea, 92% of analytic/psychodynamic therapists and 92% of humanistic international therapists reported having personal therapy, compared with 60% of behavior therapists. What is perhaps most important to note is that although a greater percentage of therapists with psychodynamic orientations use personal therapy, more than half of the behavioral therapists also seek personal therapy.

In their choice of personal therapy, most therapists choose a therapist with an orientation similar to their own. The exception to this is the choice of behavioral therapists. National and international findings suggest that 44% to 66% of behavioral therapists seeking personal therapy choose non-behavioral therapists, most commonly those from a psychodynamic perspective (Darongkamas et al., 1994; Norcross & Grunebaum, 2005; Norcross & Guy, 2005). This may reflect the changing view held by behaviorists over the past 20 years as to the value of personal therapy, from a training perspective, in terms of the importance of the development of interpersonal skills (Laird & Willutzki, 2005). It may also indicate that behavioral therapists, like most therapists, choose therapy for personal reasons. While they are expert in cognitive-behavioral models directed to behavior change and symptom relief, behavioral therapists may choose therapy for less symptom-focused reasons. It is perhaps a testament to their flexibility in terms of a best practice model that they are not held to singularity of orientation as a criterion for choice in personal therapy.

It is worth recognizing that in many cases choice of orientation is not static but rather represents ongoing integration of life experience, clinical practice, personal therapy, and further training. In *The Gift of Therapy*, Yalom (2002) describes the hundreds of hours he spent as a patient at different stages of his life: "I believe there is no better way to learn about a psychotherapy approach than to enter into it as a patient" (p. 42).

Reasons for Personal Therapy

In a national survey of United States psychologists, counselors, and social workers seeking treatment, Bike et al. (2009) asked if therapy was entered for personal reasons, professional reasons, or both. They found that 60% chose personal reasons, 5% chose professional reasons, and 35% chose both. The most common reasons were marital/couple distress (20%), depression (13%), need for self-understanding (12%), and anxiety/stress (19%). In a review of five studies, Norcross and Connor (2005) found that the majority of psychotherapists indicated primarily personal reasons for entering therapy. Norcross and Guy (2005), drawing upon a number of studies, reported that the three

most frequent presenting problems were depression, marital/couple conflicts, and anxiety.

Reasons Compared to General Population

The reasons for therapists seeking treatment are no different from those of educated people in the general population seeking treatment. My experience as a therapist's therapist for many years is consistent with this finding. Never has the presenting problem been difficulty with a patient, a practice issue, or a professional problem. Rather, mental health professionals have entered treatment to work on personal issues and, much like other professionals, their work hours and professional demands at times exacerbate personal problems.

Several studies indicate that a larger percentage of married therapists as compared with single therapists seek treatment (Norcross & Guy, 2005). One wonders if the profession exerts a toll on the therapist in terms of personal relationships. While one study suggests an impact on the practitioner in terms of anxiety, depression, and emotional under-involvement with family (Prochaska & Norcross, 1983), there is little evidence of self-reported negative marital consequences. The statistics on divorce for mental health professionals are similar to the general population (Meyers & Gabbard, 2008). There is perhaps a recognition among mental health professionals of the value of therapy in addressing interpersonal struggles, stress, and marital issues.

Prevalence of Use Compared to the General Population

While reasons for seeking therapy are comparable with the general population, the prevalence of use by therapists differs. In a review of 17 studies involving 8,000 participants, the mean and median of mental health professionals having had at least one personal therapy experience clustered between 72% and 75%. This is substantially higher than the general adult population: the estimates from national household surveys and epidemiological studies indicate that 25% to 27% of American adults have received specialized mental health care, and this includes psychoactive medications and psychiatric hospitalization (Norcross & Guy, 2005).

As suggested above, it seems likely that therapists truly believe in the services they provide. While being a therapist is no guarantee of interpersonal strength or capacity for intimacy, it is possible that the nature of the work raises one's consciousness about attachment, emotional pain, conflict, the meaning of symptoms, communication issues, and the possibility of change.

From a professional perspective, it may also be that therapists consciously and unconsciously understand that what they carry personally bears on who they are and how they practice professionally. Accordingly, they take presenting problems like depression, marital/couple conflicts, and anxiety very seriously and seek intervention.

Trauma Work and Personal Therapy

One field of mental health work that has been found to have a more direct emotional impact on therapists is work with traumatized patients. There is increasing evidence that heavy caseloads of severely traumatized patients and lack of training, ongoing supervision, and support in concert with continual exposure to the graphic and shocking details of war, natural disasters, and man-made terror can cause burnout, compassion fatigue, secondary post-traumatic stress, and vicarious traumatization (Cunningham, 2003; McCann & Pearlman, 1990; Palm et al., 2002; Pearlman & Saakvitne, 1995).

The tragedy at Ft. Hood, Texas, on November 5, 2009, illuminates an extreme of the collateral damage of unattended caregiver pain. It underscores the inextricable overlap of person and professional selves. In this case early history, isolation, religious tenets, incompatible ideology, lack of close colleagues, the refusal of personal therapy, and the fear and caution of colleagues collude and erupted with deadly consequences.

One military social worker returning from Iraq made it clear when sharing his experiences that it is not a question of whether caregivers are affected; it is how they are going to deal with the inevitable impact. Reflecting this in his comments about "compassion fatigue," an Army psychologist who planned a career in the military, but burned out after 5 years, reported: "I thought it was a bogus phenomenon, but it's true, . . . you become detached, you start to feel like you can't connect with your patients, you run out of empathy . . ." (Carey et al., 2009).

My own work in providing "care of the caregiver" programs nationally and internationally for civilian and uniformed mental health professionals (military, fire, and police) as well as spiritual caregivers sensitized me to the need to train caregivers about the impact of trauma work and to provide a safe venue for them to normalize reactions, share feelings, and bear witness to the imprint of trauma they have been asked to contain.

One of the common countertransference responses to trauma work is to deny helplessness in the face of the horror or loss by not seeking help, support, or consultation. For seasoned professionals there can be an expectation of performance that makes symptoms of anxiety, self-doubt, and burnout something to hide rather than something to address in supervision, group therapy, or individual therapy (Phillips, 2004).

The impact of trauma work on caregivers trumps language, culture, and location. Working at one international meeting, I experienced caregivers from different countries struggling to understand and translate for each other, as well as to corroborate the secondary post-traumatic stress symptoms, feelings of helplessness, horrific images, anger, and isolation felt when working with people who had faced the unspeakable. The intensity, connection, and relief associated with sharing, making meaning, and receiving support in this context were palpable. In trauma work, the caregiver's willingness and capacity to

make use of interventions such as group training and group process experiences. supported by group and individual therapy, is a necessity.

Personal Benefits

Regardless of discipline, nature of work, or orientation, another reason for the significant use of personal therapy by therapists may be the reported positive personal outcomes. In national and international studies, over 80% of therapists report positive treatment outcome (Orlinsky et al., 2005a). In their 20-year replication study of 500 psychotherapists, Bike et al. (2009) noted that therapists reported significant improvements in three dimensions: behavioral symptoms, cognitive insight, and emotional relief. In this study, 95% of the sample indicated no harmful effects.

Professional Benefits

What is extremely important about the reported outcomes of therapists' therapy is that although personal reasons are predominately given for seeking treatment, there are consistent and significant findings of positive professional gains. According to Bike et al. (2009), the reported professional benefits include awareness of the importance of a therapist's reliability and commitment; competence and skill; warmth and empathy; patience and tolerance; the value of having the experience of being a patient; and the opportunity to see that therapy can work. Pope and Tabachnick (1994) found that the personal therapy of therapists improved self-awareness, self-understanding, self-esteem, increased openness to and acceptance of feelings, and enhanced the therapists' personal relationships. Linley and Joseph (2007) found that therapists who received personal therapy or were currently in personal therapy reported more personal growth and less burnout.

Professional Career Development

The professional benefits of personal therapy are consistent with the reported findings by Orlinsky and Ronnestad (2005a) in their extensive international study, *How Psychotherapists Develop*. They report that when asked the question, "How important to you is your further development as a psychotherapist?" 80% to 90% of 4,700 therapists of different disciplines, theoretical orientations, career levels, gender, and nationalities rated development as highly important (4 or 5 on a scale of 5). Further differentiating professional development into current development and career development, Orlinsky and Ronnestad (2005b) found that the strongest and most widely endorsed positive influence on current development was "experiences in therapy

with patients.” The next most widely endorsed positive influence was personal therapy (rated 80% by those having had or in personal therapy).

Marching qualitative analysis with empirical data in terms of career development, Orlinsky and Ronnestad (2005c) found two variables that predicted 40% of the variance of career development. They were breadth and depth of case experience and level of currently experienced growth, which in turn was a function of clinical experience and personal therapy. According to these findings, client experience, supervision, and personal therapy emerge as the major triad of positive influence on therapists’ career development. One important conclusion, as suggested by Orlinsky and Ronnestad, is that therapists place much greater emphasis on interpersonal influences than intellectual ones.

The Importance of “The Person of the Therapist”

Hans H. Strupp (1978) considers a therapist’s theoretical orientation as an overrated variable, maintaining that “techniques per se are inert unless they form an integral part of the therapist as a person” (p. 314).

At present, we do not have direct corroboration of a cause and effect from the patient’s perspective of the personal therapy of the treating clinician as a variable in treatment outcome. We do, however, have consistent findings over time that the “person of the therapist” and the therapy relationship are crucial to therapeutic outcome regardless of theoretical orientation (Engel, 2008; Strupp, 1978; Wilson et al., 1968). Quoting a University of Pennsylvania study, Stossel (2008) reports findings that most successful therapists, regardless of their orientations, are considered to be honest and empathic and able to connect quickly and well with other people. The consistent finding is that the effectiveness of treatment across orientations is not a function of technique but “who the therapist is” (Norcross, 2002).

This recognition of the importance of the “person” of the therapist in therapeutic work bears on the value of personal therapy in the developmental journey of the therapist. It suggests that those very aspects of self (self-awareness, self-esteem, capacity for empathy, and interpersonal skills) reported to be enhanced by personal therapy are intrinsic to therapeutic effectiveness despite orientation.

The Therapist’s Therapist

Perhaps the strongest corroboration of the crucial role of the “person of the therapist” comes from a consideration of those factors identified by therapists in their choice of a therapist. In a study of 509 psychologists, Norcross et al. (1988) found that the four top reasons for a therapist’s choice of a therapist were perceived competence, clinical experience, professional reputation, and

interpersonal warmth. In their review of multiple studies, Norcross and Grunebaum (2005) underscore the consistent finding of interpersonal qualities as openness, flexibility, respect, and caring, in addition to competence and professional reputation. As Grunebaum (1983) concludes, “therapist-patients seek a personal relationship with therapists—one in which they feel affirmed, appreciated and respected by another human being whom they like, appreciate and respect” (p. 1338).

The Value of Personal Therapy from Different Theoretical Perspectives

While the predominant feeling across orientations or perspectives is that personal therapy enhances the personal and professional development of the therapist, there are differences reported when considering personal therapy as necessary and essential to therapeutic effectiveness.

Psychodynamic Perspective

Freud had considered that the unanalyzed analyst could go only as far as her or his own limited experience with the unconscious would let him or her go. As such, the analyst’s analysis was an absolute necessity (Freud, 1915/1958). Against this backdrop, the personal therapy or analysis of those therapists working from a psychoanalytic/psychodynamic perspective has always been considered a crucial and integrative component in the development of a psychotherapist (Fromm-Reichman, 1950; Macran et al., 1999).

Historically, the conceptualization of the therapist’s feelings in response to the patient was termed *countertransference* and warranted the therapist’s own analysis as a way to handle and resolve the emergence of such feelings. As the definition of countertransference has expanded to a totalistic perspective that includes the therapist’s conscious and unconscious feelings and verbal and nonverbal responses to the patient based on the therapist’s theoretical perspective, training, experience, person, personality, history, and current life events, as well as the impact and transference of the patient, the need for self-understanding is ever more important (Racker, 1968; Roth, 1990). Essentially, evolving psychoanalytic thinking makes psychotherapy for the therapist more important. Whereas the goal of a classical training analysis was to prepare the candidate to become the all-wise and the all-knowing analyst, today, those who subscribe to a relational/psychodynamic perspective no longer presume to “know.” Evolving psychoanalytic thinking moves the therapist into a co-participant model that accepts that reality is subjective (Ehrenberg, 1992; Hirsch, 1996). Accordingly, this warrants on the part of the therapist a willingness to know more about self (Aron, 1996; Wachtel, 2008). It demands a tolerance for being affected by the patient’s conscious and unconscious.

In concert with this, related issues including the recognition, use, and misuse of countertransference, self-disclosure, enactments, consideration of a dynamic unconscious, and the collaborative use of dreams, make personal therapy a necessary journey of finding and knowing self. To ask whether a therapist from this perspective can be effective without personal therapy is to fail to grasp the use of the therapist's self as necessary in facilitating the patient's self-journey.

It is based on these perspectives that psychoanalytic and psychodynamic training programs view and require analysis and/or psychotherapy of the therapist as central to training and development.

Cognitive-Behavioral Perspective

From a cognitive-behavioral perspective, which sees change as due to learning and the proper application of therapeutic methods, personal therapy has not been seen as crucial to effectiveness (Laireiter & Willutzki, 2005; Norcross, 2005).

In the past 20 years, while not viewed as a standard training element and still considered by most behavioral therapists to be of limited value, personal therapy has been increasingly acknowledged by cognitive behaviorists as helpful in enhancing important training goals (Laireiter & Willutzki, 2005; Geller et al., 2005).

From this perspective, the therapist's personal therapy is not a model of treatment but an opportunity to improve self-reflection, self-knowledge of blind spots, habits, and interpersonal patterns. Personal therapy also offers the therapist the experience of having been in the role of client, which is valuable in terms of empathy for the feelings of the client. Personal therapy also offers incidental learning and modeling of strategies and methods experienced in the relationship with one's own therapist. One cognitive-behavioral therapist shared that it was not until he was the client that he could recognize how difficult it was to change patterns and how much he valued his therapist's patience.

Experiential-Humanistic Perspective

Those coming from an experiential-humanistic perspective, as in person-centered or gestalt therapy, work with the immediate experience of the client and emphasize personal agency. This perspective necessitates attunement to the client, self-awareness, authentic response to the client's reactions, and comfort with complex feelings in self and other. From this perspective personal therapy is seen as valuable but as only one of many possible opportunities for personal growth, which can also be found in training workshops, journaling, growth groups, and other sources of personal expansion (Elliott & Partyka, 2005).

Systems Theory Perspective

While the systems theory (Haley, 1976) perspectives of family and couple therapy have discounted the relevance of personal therapy for the therapist, the more psychodynamic fields of family and couple therapy (Bowen, 1978; Scharff & Scharff, 1987; Whitaker & Keith, 1981) recognize personal therapy as crucial in terms of the therapist's authenticity and handling of counter-transference. In this light, it is interesting to note that they recommend individual therapy, not necessarily family or couple therapy, as a crucial component of training. Whereas family or couple therapy will foster self-understanding in terms of these contexts and may enhance empathy and skill, individual personal therapy is seen as more likely to foster understanding and use of self in the face of family and couple issues.

Group Perspectives

Group interventions can be conducted from many perspectives: psychodynamic, cognitive-behavior, self-psychological, psycho-educational, and so forth. Drawing upon my own personal group experience as well as my professional experience conducting groups, and training and supervising group therapists, it is my opinion that the practice of group therapy necessitates the therapist's having had a personal group experience of some kind.

In terms of psychodynamic groups models, for example, the leader's experience as a member of a psychodynamic group dealing with the structure, process, and inevitable interplay of group dynamics, levels of functioning, multiple transferences, group unconscious, and individual and group resistances is integral to his or her development and effectiveness as a group psychotherapist (Ormont, 1980, 1992).

The leader's personal group experience is also crucial for effectiveness in group therapy with other models (e.g., cognitive processing, cognitive-behavioral protocols, time-limited theme-centered, psycho-educational groups). Regardless of the "agent" or model of change for a group, the crucial component in outcome is the leader, through whom all other components of group experience flow. The leader's capacity to utilize the protocol of change, the dynamics of the members, and the structure, frame, and process in a way that facilitates positive outcome results from the leader's training as well as personal group experience (Bieling et al., 2006; Burlingame et al., 2004).

Yalom (2002) tells us, "Only by being a member of a group can one truly appreciate such phenomena as group pressure, the relief of catharsis, the power inherent in the group-leader role, the painful but valuable process of obtaining valid feedback about one's personal presentation" (p. 43).

The Interface of Supervision and Personal Therapy

Regardless of orientation, supervision is intended to expand technique and interpersonal capacities. It invites the supervisee to identify with the

supervisor as a mentor as it offers skills that foster autonomy. Reflecting the overlap of personal therapy and supervision, one of the gifts of my analyst was the suggestion that I be in supervision with a brilliant female analyst. Against the backdrop of dreams that was part of my own analysis, this supervisor taught me to step into the unconscious with my patients in a way that was empowering and transforming to them and to me.

Historically, the place where supervision interfaced with personal therapy was in consideration of the supervisee's countertransference—that is, those unconscious reactions to the patient's transference that were viewed as a hindrance or obstacle, something to be analyzed away. The supervisor, from this perspective, would attempt to identify, confront, neutralize, or recommend personal therapy as a way to exclude such feelings and enhance the supervisee's effectiveness.

Evolved psychoanalytic thinking views countertransference in a more totalistic way as a function of the supervisee's person, personality, gender, history, and theoretical orientation. It is seen as inevitable, having both subjective and objective components, and is often a valuable lens for knowing oneself and one's patients (Kernberg, 1984).

While countertransference, seen as the total range of feelings toward a patient, is not automatically a reason to recommend therapy to a supervisee, it is valuable for the supervisor and supervisee to distinguish between those objective and subjective countertransference reactions that can be utilized in the service of the treatment and those that actually disrupt or compromise the care of the patient and the treatment goals. It is at these times that a supervisor who has developed a mutually respectful relationship with the supervisee can identify, clarify, and recommend personal therapy as a way to enhance personal and professional effectiveness. It is of great value for the supervisor to differentiate what personal therapy can offer that supervision cannot.

For example, a supervisee who became extremely negative and dismissive of any sexual issues brought up by a female patient revealed, when asked to consider possible reasons for her reaction, that she had been raped in her first year of college. The supervisor underscored the reality that working as a therapist very often trips the unhealed or unresolved issues in one's own history. The supervisor suggested that when personal triggers provide a reason for us to seek personal therapy, they offer an opportunity to change disruptive countertransference into therapeutic attunement.

In addition to countertransference, supervision interfaces with personal therapy because supervision is an interpersonal experience that occurs in the context of relationships—the supervisor and supervisee, and the supervisee and the patient (group, couple, family). Whatever is imparted or learned is both didactic and emotional and occurs in the context of intersecting relationships. There will be feelings, expectations, conflicts, and realities that will affect supervisor, supervisee, and patient in positive as well as negative ways.

In this regard, as a faculty member and supervisor in doctoral and post-doctoral programs for many years, I have seen students benefit from what

Fleming and Benedek (1966) termed a "learning alliance" with a supervisor—that is, one that parallels the working alliance in terms of the necessary trust, respect, and mutual goals to make the experience viable. As Rock (1997) explains, a supervisory experience is very meaningful when supervisees experience the supervisor as committed, focused, and expert as well as someone with whom they feel respect and mutuality.

On the other hand, I have been aware of students working with authoritative or rigid supervisors with whom they find "no fit" and with whom they become anxious, angry, or frozen. Often they begin to conceal the process, lose confidence, and in some way stop being authentic with self, supervisor, and patient.

Given the reality of differences in supervisors along one's training and career path, personal therapy for the supervisee may serve as a buffer, container, and support system. Whether personally chosen or suggested, personal therapy in concert with supervision offers an invaluable opportunity for integration of conscious and unconscious material, the continual opportunity to examine stirred countertransference and transference issues, and the experience of knowing what it is to be a patient and to have a therapist. What makes personal therapy different from supervision is that it is a reflective space that allows for work on the inevitable overlap of personal and professional issues without fear of judgment or professional evaluation.

As a supervisor, I have been keenly aware of the responsibility as well as the expectations of being the expert as well as the "intruder and the insider" with supervisee and patient (Phillips, 2006). Using a relational style, I have been moved by the mix of passion and humility of new therapists and have told them so. At other times, I have shared my anxiety and confusion on hearing a case and the anxiety or other feelings I may have felt with a former case of my own. Very often supervisees want to know "the right thing to do." It is difficult for them to value their silent presence or empathic listening with a patient. Some supervisees have tried to metaphorically "hand over" their patients, believing I must have all the answers. At those times, I have had to ask myself before I ask them: Did I invite this? Did I need this?

I believe that regardless of orientation, as supervisors we have to consider the value of self-reflection and some form of personal therapy. We have to consider our style and its impact. While there may be mutuality and collaboration, supervision is an asymmetrical relationship in that one is providing a service to the other and is "supposed" to have "super vision." How one uses the power in this relationship is central to what the supervisee will feel, learn, and pass forward. Generally, as supervisors, we may or may not know if we are making a supervisee feel anxious, inadequate, shamed, or blamed. It is crucial that we try to know, as these are feeling states incompatible with learning and growing. The self-reflection that we both overtly and implicitly model becomes the crucial factor of any technique we espouse as curative.

Just as it may be necessary to encourage a supervisee to seek personal therapy, it may be necessary for a supervisor to seek personal therapy because

he or she recognizes that his or her functioning as a supervisor is being compromised by personal life events, historical triggers, or the emotional configuration of a particular supervisee or his or her patient. In the interface with supervision, personal therapy should be considered as an important option on a continuum of self-reflection, self-care, and self-development.

Cultural Competence and Personal Therapy

Cultural competence addresses the therapist's worldview and the personal and professional capacity to work effectively with patients from diverse cultural, socioeconomic, and racial populations and sexual orientations. Competence in this regard requires humility, the acquisition of information, and the ability to consider assumptions about self and other, to recognize cognitive and emotional rigidity, and to challenge inherent bias and perspective. To do this, a process of self-reflection, in the form of group process, group therapy, and/or personal therapy, becomes the essential complement to didactic opportunities.

Traditionally, the acquisition of cultural competence involved didactic experience from an "etic" perspective—that is, learning about the aspects of a particular minority group by becoming intellectually aware as an objective outsider of the norms, customs, language, histories, and traditions of the group (Brown, 2009, p. 12). This approach leaves out two essential components of cultural competence: the recognition of the multiple identities owned by anyone identified with any minority group, and the inclusion of the multiple identities of the person of the therapist as an object of self-study relevant to understanding the person, group, couple, or family with whom he or she is working.

An example of the limitations of this perspective is reflected in the situation in one training institute noted for the racial, ethnic, and sexual diversity of its candidates. An unexpected complaint voiced by candidates to faculty was the singularity of definition experienced by members of certain minorities, who felt they were turned to as "the spokesperson" whenever a patient from their minority group was discussed. The surprise and concern on the part of the faculty on hearing this underscored the complexity of cultural understanding and the need for alternative models to address diversity awareness.

Toward this end, Laura Brown (2009) recommends that therapists consider themselves and their clients through Hays' (2008) epistemic model of social identifiers captured in the acronym ADDRESSING, standing for age, disability (acquired and/or developmental), religion, ethnicity, social class, sexual orientation, indigenous heritage, national origin, and gender/sex. This consideration of self and other expands the nature and viability of the therapeutic exchange. To some degree, however, it is only part of the process for developing cultural competence.

Cultural competence requires heightened awareness of what we represent to patients and what they represent to us on a conscious and unconscious basis. To truly facilitate self-consideration of social identifiers, didactic information about another culture, clinical experience, and cross-cultural involvement requires the addition of group process or therapy experience to afford opportunities for both increased feedback and self-reflection.

For example, given the educational and professional background of most therapists, it is likely that they have had “dominant group privilege” as a function of their race, ethnicity, social class, education, and even gender orientation (Brown, 2009). Given that privilege tends to be invisible to those benefiting from it, but very visible to those who do not have it, some opportunity to develop self-awareness is needed to understand what we represent to patients and what they represent to us.

Research has demonstrated the value of multicultural competence programs that include learning through reflection; teams that afford a venue for consistent open dialogues about identities and biases; and group team meetings that include ongoing multicultural supervision (Park-Taylor et al., 2009). Multicultural competency requires an orientation that is didactic, self-reflective, interpersonal, and continuous.

Mandated Personal Therapy

When we think about mandated personal therapy for mental health professionals who have completed their training, we are referring to those cases where professionals are pressured to seek treatment from professional ethics committees, licensing boards, or programs for impaired professionals. According to Norcross and Connor (2005), the most common reasons are sexual misconduct with patients, substance abuse, or nonsexual boundary violations.

Many variables factor into the viability of mandated personal therapy to address personal and professional issues. In her book *Sexual Boundary Violations*, Celenza (2007), for example, makes a crucial distinction between the majority of one-time offenders and the few psychopathic predators, and the amenability of the former to rehabilitation as compared with the latter. Central to the vulnerability associated with professionals who face problems that require mandated treatment is a lack of self-reflection, an inability to recognize warning signs, and discomfort in seeking help in the face of emotional pain and unresolved issues.

In their comparison of multiple studies, Norcross and Connor (2005) report that, regardless of stage of career, those mental health professionals who do not seek personal therapy report similar reasons for their decisions. These include confidentiality concerns, financial expenses, exposure fears, self-sufficiency desires, time constraints, and difficulty finding a good enough therapist outside of their social and professional networks. A number also report using other effective means of dealing with burdens in life.

One wonders if more knowledge about the prevalence of seeking personal therapy by mental health professionals and perhaps more "colleague care" in terms of attention to warning signs and encouragement in seeking help would serve both professionals and those they treat.

While personal therapy is not required in most training programs or graduate programs, the requirement to seek personal therapy is often made by faculty to a student or trainee who demonstrates problem performance or behavior (Huprich & Rudd, 2003). Underscoring this is the program's ethical and legal responsibility to maintain quality assurance in the professional services of trainees seeing clients as well as the professional capacities of their program's graduates.

One of the problems associated with required treatment is the identification of personal therapy with failure, inadequacy, or exposed difficulties. I would suggest that if personal therapy is openly recommended for all candidates as part of professional development, along with didactic training, clinical experience, and supervision, students might avail themselves of personal therapy as a choice that reduces the need for required treatment. In such an atmosphere, the requirement of treatment, if needed, might be experienced differently—that is, with less shame and more effectiveness.

Required treatment often involves treatment progress reporting. For example, the Psychology Code of Ethics states conditions under which a faculty member may require student disclosure of personal information and personal therapy so long as issues of privacy and confidentiality are addressed in advance. In view of these newer regulations designed to protect both the public and practitioners, there must be clear guidelines for confidentiality of material reported to the training committee of an institute or graduate department.

With respect to the issue of communication between the trainee's therapist and the faculty who mandate personal therapy, Elman and Forrest (2004) reviewed the plan of 14 training programs and identified them as using either a "hands-off approach" or an "active involvement" approach. Reporting that the "hands-off approach" was found to be unclear and ineffective, they recommend an active involvement plan with a nuanced and sensitive model of trainee privacy and confidentiality that has real merit.

The plan, which would be spelled out as department policy known by trainees and faculty, includes the trainee's choice of a therapist from an approved list; meeting with the treating therapist and trainee to establish goals of therapy relevant to the professional functioning concerns of the faculty; and agreement by the therapist and trainee that attendance and progress will be reported to the training program. Crucial to this reporting is the clear differentiation between information revealed in therapy like dreams, fears, and personal history, which should remain private and protected, and information pertinent to a trainee's professional competencies and capacity to address issues that might compromise or interfere with treatment, such as boundary violations, excessive use of anger, excessive anxiety, substance abuse,

and so forth. It would seem a plan of this type might serve the needs of both trainee and faculty in a professional way.

A crucial aspect of this plan or any required treatment is choice of therapist. Recommended therapists not only need expertise and empathy, but also should have the ability to recognize the needs of the student within the framework and concerns of the department. As with any culture, the therapist also needs to make himself or herself aware of the particular discipline, orientation, and faculty recommending the student. From a systems perspective it is always valid to consider the context of identified problems.

Conclusion: The Legacy of Personal Therapy

An overwhelming majority of therapists of all disciplines across different orientations, both nationally and internationally, seek personal therapy, often more than once, during and after training. They have done so by choice. Licensure in psychology, psychiatry, social work, marriage and family counseling, and psychiatric nursing does not require personal therapy. The reasons that therapists give for seeking therapy are more personal than professional and are consistent with those of the general population. What is different is the prevalence with which they choose therapy and the consistent report by the majority of positive professional gains and career development growth.

Personal therapy is integral to a therapist's formative training and ongoing development across disciplines and orientations because there is an inextricable mix of personal and professional dimensions in the functioning of therapists. Clinical experience, care of the caregiver, supervision, and cultural competence all hinge on the integration of expertise and training with the person of the therapist and the personal qualities and awareness he or she brings to this work.

When asked, most mental health professionals across disciplines and orientations feel that personal therapy in some form should be recommended but not required. As one group therapist working from a cognitive behavioral perspective said, "The model is not critical. It is the act of being in therapy that is significant" (G. Crosby, January 15, 2009).

Personal therapy cannot guarantee the effectiveness of a therapist. This is a rewarding and often stressful profession. It is one that demands and invites a continual awareness of self while one is responsible for another. It is one for which personal and professional dimensions overlap, fostering growth and development or creating stress and disruption. As such, therapists need to do more than recommend personal therapy. As colleagues, faculty, and supervisors, we need to discuss, disclose, and model the personal therapy journey so many of us have taken. Passing on a legacy of personal therapy validates its crucial role in professional development and invites the recognition that our effectiveness as professionals depends on our connection as people.

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