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THE VALUE OF PERSONAL PSYCHOTHERAPY TO CLINICAL PRACTICE

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ABSTRACT

Practice wisdom as well as anecdotical evidence support the value of personal psychotherapy for clinical practitioners. Despite the apparent acceptance of that notion, little, if any, research has been done in clinical social work. Therefore, this study explored the significance of personal psychotherapy to the clinical work of advanced students and experienced practitioners. The paper focuses on the similarities and differences between these two groups.

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The Value of Personal Psychotherapy to Clinical Practice

Beginning in the formative years of psychoanalysis and extending into the present, personal treatment has been viewed as a valuable, *it* not indispensable qualification for clinical practice. In psychoanalytic training institutes, a personal analysis is required. Among many professionals engaged in the practice of psychotherapy, personal treatment is highly valued. However, personal psychotherapy is not generally required in the professional training of psychiatrists, psychologists, and social workers.

Although theory, experience and anecdotal evidence support the value of personal therapy for clinicians, relatively little research has been done on the subject. In reviewing the social and behavioral literature published in the 1980's, we found only a few studies, primarily in psychology, and none in social work. Among the studies reviewed (Buckley 1981; Grunebaum 1983; Guy 1988; Clark 1986; MacDevitt 1987; Norcross et al 1988; G; Guy et al 1988;) was a national survey of mental health professionals which included social workers from the 1985 NASW Register of Clinical Social Workers (Norcross et al 1988). Seventy- nine percent of female and fifty-eight percent of male social workers reported having been in personal treatment at some point in their careers. The most common form of treatment, identified by over half of all respondents, was psychoanalytic-psychodynamic therapy oriented to self awareness and insight Asked to identify how their experiences in personal treatment shaped their values about doing therapy, most respondents referred to the importance of non-specific factors such as empathy, warmth, patience and acceptance, as well as understanding transference-countertransference dynamics.

Findings of other studies (Buckley 1981;MacDevitt, 1987; Guy et al 1988) resonate with those of Nocross. Generally, professionals who have had therapy, regardless of its duration, value it as a critical, if not essential, component for practice. Most frequently, the value lies in developing insights into one's self which may enhance skill and functioning as a psychotherapist.

Other empirical studies suggest that the effects of personal treatment of psychologists and psychiatrists on their patients is inconclusive (Clark 1986.) No relationship was found between the personal treatment of therapists and outcomes for their patients in five out of seven studies. In one study, treatment may have been detrimental to clients. As with much research, these studies suffered from numerous defects in sampling, design or measurement and cannot be considered conclusive. At best they suggest no empirically verifiable connection between personal therapy of clinicians and outcome to their clients.

What emerges from these studies is the importance of understanding the topic within the context of several variables: the timing of therapy or when it occurs in one's life and career, the motivation of a person to pursue treatment, the mode(s) of intervention, the theoretical orientation(s) and competence of a therapist. These dynamics are difficult to control and become even more problematic when hidden contextual forces, life experiences, as well as imprecision in measuring instruments are considered.

This study explored the meaning of personal psychotherapy to advanced students and experienced practitioners in clinical social work. This was timely in view of the dearth of research in social work on the subject as well its potential significance to practice. By including both students and practitioners, the value of personal treatment was explored for those who were at the beginning of their careers as well as those in professional practice. The focal question was: Do social work students and practitioners see a connection between their personal psychotherapy and their practice and if so, how do they understand the nature of that connection?

METHODOLOGY

Personal interviews organized around the focal question were conducted with thirty respondents: 15 students in the second year of MSW graduate study and 15 MSW clinical social workers. A qualitative approach in which clinical interviewing skills were adapted for a research purpose was utilized for exploration of the topic, a methodology appropriate for studies which focus on relatively unexplored territory. We were interested

primarily in discovering what meaning personal therapy may have to individuals in their professional roles even though no one entered therapy to learn how to do clinical work. Essentially, this was a phenomenological question explored most effectively through focal Question interviews. Although previous studies offer some understanding of the empirical connection between one variable and another, they did not elicit the type of information which is possible to explore with qualitative techniques. That is. a qualitative mode of research provided room within structure to explore the significance of personal psychotherapy to professional practice.

Small theoretical samples are sufficient for this type of research. Contemporary thinking suggests that fewer than ten subjects are adequate when the sample is homogeneous and the research question is clearly formulated. (Carey 1984). Randomness is not critical since the focus of the inquiry is evocative and designed to generate ideas which emerge from and are grounded in the data (.Strauss 1987 & 1990).

Respondents were recruited through publicity which included an add in a professional newsletter. The goal of the study was stated briefly and individuals were invited to volunteer if they had been in personal psychotherapy. The criterion was simple: one had to be in the advanced clinical year of graduate training or be an MSW clinical practitioner. No attempts were made to control for other variables such as the mode(s) or type(s) of personal therapy. Of course, the way in which people were recruited for the study clearly implied a connection and very likely implied further that the connection was a positive one.

Interviews which lasted forty-five minutes were tape recorded. By listening to each recording, detailed process notes were prepared. Established procedures for coding and categorizing data as well as conceptualizing themes were followed (Strauss & Corbin 1990).

Transcriptions provided detailed examples of these themes as they were found in the responses of various interviewees. Working as a team, we checked, clarified, retained or discarded observations and inferences. The team approach enabled us to deal with biases and other subjective phenomena which may have contaminated the integrity of the findings.

SAMPLE

The mean age of students was 32 years and that of practitioners 42; median age of the former was 30 years and that of the latter 40. While only one practitioner was under 30 years of age, 40 percent of students were under 30; no students were over 50; 33 percent of practitioners were over 50. Practitioners had an average of 7 years of professional experience. Although no attempt was made to control for the number of men and women who volunteered for this study, the gender ratio of women to men (80% to 20%) approached that of the social work profession as a whole.

Reasons for entering personal therapy were similar for both groups. Fifty percent of all respondents identified something within themselves as precipitants. Frequently, this included personal reactions to some critical life event such as a developmental or career transition which triggered anxiety and/or a reactive depression. Twenty-three percent reported that interpersonal conflict within a significant relationship led them into treatment. Often, that involved the termination of an intimate relationship, such as marriage. This was different from the loss of a loved one by death and different from intrapersonal precipitants only in the way in which people talked about how they were troubled at the time of entering therapy.

Ten percent entered therapy as a consequence of stress associated with their MSW program and an equal percentage because of substance abuse, usually alcohol.

Except for two practitioners, respondents were currently in treatment. The two practitioners not in treatment at the time of the study were among the oldest respondents; they had extensive therapy in the recent past. Half of the sample were currently in treatment with clinical psychologists and 40 percent with social workers. The remaining 10 percent were seeing other professionals. Fifty-seven percent of therapists were women. The orientation of 67 percent of therapists was described as psychodynamic in which the goal was the development of self-awareness and insight through an exploratory and reflective modus operandi.

All respondents were in individual treatment with 23 percent of them also in another mode such as group or conjoint marital counselling. Two thirds of the sample were in treatment, for more than three years: 60 percent of students were in therapy less than three years and 93 percent of practitioners for more than three years.

In summary, students and practitioners were similar in the ratio of women to men in each group, their reasons for entering personal therapy, the profession of their therapists (although more students were treated by psychologists), the mode of treatment and the theoretical approach of their therapists. They differed in age and in the length of their personal therapy.

FINDINGS

After data for students and practitioners were coded and analyzed independently, the data, for the sample as a whole were analyzed again to determine if the significance of personal psychotherapy to each group was substantially different. Coding had produced five themes within each group which appeared to capture the significance of personal psychotherapy to their clinical work. Although themes were similar for both groups, differences became apparent as we examined the codes and resulting categories under each theme. For example, each group referred to their therapists as models for practice; most talked about therapy as an experience which enhanced empathy; all respondents talked of how personal therapy had helped them to understand the therapeutic process. However, students focused more on how personal therapy was a complement to their supervision and how therapy had helped them to integrate theoretical concepts in a personally meaningful way. Most practitioners focused on specific awarenesses of self that had emerged through their personal therapy. For them, integrating awarenesses of self into professional practice was central to their professional identities.

Differences appeared to be shaped principally by contextual variables; that is, the professional life space at the time of the study which individuals had occupied for a few years. Students were about to launch their professional careers in clinical social work. The significance of personal psychotherapy needs to be understood within the context of their role as learners and emerging clinical social workers. The practitioner sample had moved beyond that beginning stage of orientation to the profession. The significance of personal therapy reflected an investment at integrating

personal dimensions of themselves into their professional role. Although that theme was also found in the responses of students, they were more invested in connecting theory with skill within the context of searching for their identities as clinical social workers.

In thinking about context as it shapes the meaning of personal psychotherapy to practice, it is important to recall that there were no substantial differences between students or practitioners in their reasons for being in personal therapy. Because of the nature of the study and the definition of its parameters, we did not focus on the significance of psychotherapy to the personal lives of respondents. This was explored only if respondents mentioned it and, then, only if they indicated a connection between their personal lives and their practice as clinical social workers.

Three themes emerged from the data.. The first theme, therapist as model, included any references to identification with the modus operandi of therapists as well as adopting their skill in working with clients. The second theme, understanding the therapeutic process, included a wide range of responses which spoke to how personal therapy enabled respondents to comprehend and master elements of clinical practice. Frequent references were made to the dynamics of the therapeutic relationship, especially transference and counter transference. There were also references to understanding technique and to gaining an appreciation of what was therapeutic about therapy. The third theme, integration, included responses that addressed the inter-relationship of personal and professional dimensions in one's life.

Model

All practitioners and 14 out of 15 students talked about their therapists as objects of identification to be emulated in their clinical work. Perceptions of therapists' qualities such as genuineness, acceptance and empathy served as the foundation for the development of safe and trusting therapeutic relationships within which identifications and introjections developed. As a result, respondents found themselves internalizing many aspects of the modus operandi of therapists which included non-verbal mannerisms as well as verbal techniques. To many students and, to a considerable extent, the inexperienced practitioner, therapists represented the therapeutic ideal, whole objects of identification to be emulated. A student speaks to that aspect of modeling:

It's been a learning tool to sit with someone else who is a therapist; sometimes I even find myself responding to clients in a way that my therapist would respond, asking questions or phrasing certain things as he does; that's been very valuable.

A practitioner recalls:

When 1 began to practice, I made interpretations using his phrases, I could hear his tone of voice, it amazed me constantly and delighted me to hear it coming out of me just the way he said it.

That level of modeling was tempered by two factors: the length of time in therapy with the same therapist and the sense of competence which one had internalized as a result of success in practice. When these two factors were joined, respondents became selective about their identifications

and internalizations. Imitation and idealizing, more common among students and beginning practitioners, seemed to give way to differentiation of qualities, some of which fit and some of which did not fit with the individual style of a practitioner:

It's positive as well as negative, in terms of being a model. There are a lot of things that I think she handled really well that I have found myself sitting in a therapy relationship thinking: "How would she deal with this? Well, she has dealt with this with me and this is what she did." That was helpful to me so, I might do the same thing. Of course, going back and talking to her about that is interesting.

Changes in the nature of modeling were also connected to the observations among several respondents about their perceptions of therapists as treatment unfolded. Rather than ideal objects to be imitated, therapists became competent human beings with both good and not so good qualities (although none of them were experienced as bad). As that shift occurred in the relationship, respondents reflected about the fit of therapists characteristics with their own individuality as clinical practitioners. While this cannot be separated from a change in the transference, there is evidence that therapists respond differently to patients the longer the latter were in treatment. In other words, the shift was reciprocal in nature.

Despite variations in identifying with therapists as models for professional practice, there was a constancy to how therapists were experienced regardless of how long one had been in treatment. The basis of identifying therapists as models was in the experience of being accepted by

them as well as their empathic and patient modes of behaving within their therapeutic role Prominent themes of constancy, availability and belief in the patient especially when esteem for self was shaky were evident in responses. The mutual and collaborative nature of therapy was also important in understanding modeling. That is, the concept of the therapeutic alliance Was central to change even though there were many variations in specific behavior of therapists the longer one was in treatment.

Finally, a difference was found in the nature of identifications and introjections depending on the discipline and gender of therapists. Among some women who were seeing female social workers, the gender and professional aspects of modeling were joined; specific references were made to identifying with qualities perceived in women therapists to which female practitioners aspired in their professional roles. This was similar for two males who were also seeing male therapists. Because the numbers were small, any potential patterns need to be treated with caution.

Understanding the Helping Process

All practitioners and 14 of 15 students reported that therapy had helped them to understand the therapeutic process. This theme included the enhancement of empathy, the learning of specific techniques, understanding dynamics such as transference and gaining confidence in being able to confront issues which had been intimidating to them.

Perhaps because of their closeness to formal learning about the helping process, students, more than practitioners, talked specifically of

gaining an intellectual appreciation of therapy as having a beginning, middle and end. Those in therapy a long time reflected on the importance of time in the beginning phase as a period in which they could gradually feel trusting and comfortable enough to explore very troubling inner conflicts. They recalled the beginnings of their treatment often extending over weeks or months, as a. time when they did most of the talking with therapists primarily adopting a listening mode. Most felt that this complementary relationship was appropriate to their needs at the time. All experienced their therapists as supportive, attentive and caring. Not infrequently, respondents talked of being in crisis during this period so that much of the beginning stage was focused on helping them to express their thoughts and feelings about recent events which had overwhelmed them. Once this initial period was negotiated, therapists were described as becoming more interactive, offering observations and actively engaging them in exploration, reflection and thinking about their conflicts. That shift was noted by a student when she observed:

The boundaries in my individual therapy have changed somewhat. It's not like he offers information but he's more likely to answer questions directly now then when I first started. That's probably because he knows me a lot better and knows what's behind my questions.

No one reported that therapists had acted inappropriately, nor did any feel that they were not seeing a professional person whose role was to help them. While it has been noted that these observations may reflect changes in the nature of transference and counter transference dynamics, they appeared to

reflect as well, a real shift in the subject's sense of relatedness to another human being who was also changing.

Students referred frequently to the value of therapy in helping them become more empathic with clients, especially to the meaning of the client role. They talked of their own vulnerability as patients, especially in the beginning phase of therapy, and how those experiences had enriched and deepened their appreciation of what it meant to apply for and accept help. Several references were made to how they used feelings associated with their experiences in working with clients:

Without therapy I wouldn't have been as attuned to my own feelings, to be able to use them in sitting with a client. Its an intuitive kind of thing to know where the client is by how I feel; without my therapy I wouldn't be able to do that

There were frequent references to identifying with the soothing and empathic functions of therapists which enabled students to be available to their clients in a similar way. To have been accepted and respected by their therapists was a vehicle for their treating clients in a similar manner:

I didn't realize it until now that one of the big things I've learned from this person who 1 idolize is just being very calm, taking things in a calm, cool and collected manner

Although similar themes were evident among practitioners, a different level of understanding was apparent in their responses. Often, therapy

helped to consolidate values about doing therapy. One practitioner comments on this gain as she describes how therapy had helped to enhance her listening skills;

I think the most important characteristic of being a good therapist is being able to listen. 1've been listened to and I can listen because of that. I've been encouraged to consider the depth of what I say and what I think about and to look beyond superficial meanings of things That came through his listening to me. I think that's what I do with my patients more than anything else.

An important aspect of understanding the therapeutic process was the new sense of discipline which respondents brought to their role as therapists. For students, this often involved new skills at being able to tolerate pain in clients without needing to do something about it. In that respect, a student talks of confidence in being able to tolerate silences which was linked to her reflection on the meaning of silence in her own therapy:

I was very uncomfortable with silences and would always jump in. It would raise so much anxiety for me that. I would try to ask a question or fill the silence in some way or another. In my own therapy I find that when there's a silence, I'm able to utilize that and really get some stuff from the gut. Sitting in my own therapy and being able to do that how useful it's been to me; now, when I'm working with clients, I remember that it is useful for them to sit with that silence and that it's OK.

Practitioners often talked about the significance of therapy in clarifying and reinforcing fundamental therapeutic principles. For one practitioner, this underscored professional discipline:

I wanted to be gratified as a patient and didn't get gratified What growth came from that! It taught me that gratifying the client out of my needs is not a good thing to do; it might feel nice for both of us and we might leave today with smiles on our faces, but it isn't going to change anything. This person is here for change, whether they are fully aware of it or not. Otherwise, they wouldn't have come here; that's hard work and it's not always fun sticking to the business. That's something I learned in my own therapy

Another practitioner expressed similar thoughts in the following way:

An important impact on my work is what it feels like to sit on the other side; to me that is so important 1 know how it feels to have somebody really listen and really care and also how anxiety provoking the whole experience can be. You come to know real resistance and how important it is for a therapist to respect somebody; to understand that you can't push people too much but you have to push them somewhat. I know now that being a nice person is not enough to make a therapeutic relationship move. No matter how many books I read, sitting in that other seat is what made that alive to me.

One area which students talked about more than practitioners was how personal therapy served as a valuable complement to supervision in their field internships. Interestingly, little ambiguity was reported among

students about the boundary between these two modes of practice. In their minds, therapy was differentiated from supervision in its attention to personal dynamics while supervision focused more on learning how to do clinical work. Therapy often served as **a** vehicle for exploring issues that had been identified in supervision as counter transference problems. A student speaks to that differentiation in the following:

> *In therapy, I'm able to talk about my past and what's making me think like this now or respond in this way. In supervision that's touched on but not nearly as much as in my therapy where 1 spend a lot of time talking about counter-transference issues that come up in my placement. That's very important in the work that I'm doing. I need a third hour, therapy, to be able to connect that to my own developmental and family issues.*

Finally, respondents from both groups talked about personal therapy as an anecdote to burn out. Often, this involved understanding their caregiving histories and how elements of that history were played out in clinical practice. Frequent references were made to establishing and maintaining appropriate boundaries with clients based on understanding themselves. Since students were not confronted with as long a professional history as practitioners in working with very needy clients who often made extraordinary demands on their sense of narcissistic integrity, they did not talk as much about this aspect of the therapeutic process as did practitioners. A practitioner speaks to that theme:

Therapy has been very helpful, especially when people relapse and not to take it personally. 1 call it the Messiah complex: you have to go out and save all these alcoholics; you're not that powerful. You're an aid that they can use to help them get sober or help them sort through their issues. You're not going to be the person saving them; they're going to save themselves. Therapy 1 think, has been helpful in terms of preventing burn-out. Just knowing what you can and can't do as a therapist, as a human being.

Integration

Although everyone spoke of the integrative value of personal therapy, practitioners focused more on the inseparability of one's identity as a human being with how one is in professional roles with clients. Many practitioners spoke of how therapy had helped them to find and to preserve a central part of themselves that remained constant despite different roles which were adopted in practice. Students talked somewhat differently about integration although they were equally concerned about its importance to their professional identity. They focused more on finding a professional identity which included how to behave in professional relationships with clients whose needs differed, how to tolerate and sit with pain and how to respond in ways that would be truly helpful.

Professional and personal integration may become a nodal issue once one reaches a plateau of adult development, which may occur several years after receiving the professional degree and entering practice. Not

uncommonly, the developmental shift of moving from one plateau to another was often fueled by new awarenesses of self achieved in personal therapy. Often, these breakthroughs acted as a catalyst to spur professional/personal development as in the following:

For a *long period of time, 1 never realized anyone else was depressed. Nobody was ever depressed that I saw and then 1 realized through treatment that 1 had a real hard time recognizing my own depression. 1 was more comfortable being anxious and so half my clients were anxious; I was not realizing what 1 was doing; I had a real blind spot to see other people's depression. My therapist really helped me see that as we talked about my work.*

Students referred to similar connections but the foci of insights and the specific value of self awareness in shaping professional responses were quite different. An important aspect of integration among students was in being able to understand concepts which had eluded them in the past. Feelings associated with ideas, which had been in conflict with cognitive understanding, no longer undermined the process of learning. Thus, therapy became a framework for integrating thoughts with feelings as well as theory with practice. Ideas which had been tinged with conflict were experienced differently in the context of empathic, psychotherapeutic relationships. As a result, students talked of being more free to think about theory, evaluate its significance to their emerging role as clinical social workers and to be less intimidated by the process of intellectual discovery.

A student comments on being able to process learning in ways that were previously unavailable to her:

I couldn't tolerate ambiguity before. That's been a major change in my life and it's affected me emotionally and intellectually. My writing is much better because I used to feel like 1 had to know what the right way to do something or say something was. Now, I can think in more complex ways. Complex ideas are ambiguous.

An important aspect of integration for students was in being able to understand theory in the context of their therapeutic experiences, a theme reflected in the following:

Being in therapy has helped me to understand object relations theory and self psychology in a very personal way I know what that feels like to have somebody containing your feelings and performing functions that you can't do for yourself, like when you're depressed, distorting things and not able to soothe yourself; the therapist does that for you. For a while, 1 couldn't do it for myself 1 would wait every week to see the therapist to do it for me and now I do it for myself.

Among practitioners, integration was often a matter of bringing together personal development with professional identity. As a catalyst for personal development, therapy became a central resource in the journey toward professional competence. Metaphorically, that theme was captured by a practitioner when she said:

My analyst used to leave the window open all the time, and 1 would lay there, a brand new patient my legs outstretched and the wind blowing on my legs, freezing. 1 wanted to be a good girl, put up with it but the bottom line was 1 wanted the window dosed and I was afraid to ask. There's something about that memory: how a patient feels, their fear not so much that they'll be disappointed but how will they handle the rage and deal with the therapist? 1 feel that so profoundly. 1 know when a patient is going through that and 1 know not to help them, not to get up and close the window. It's not because I delight in watching them squirm, but I know that until they ask me, "Is it OK to close the window?," they will not have confronted that central issue

CONCLUSIONS

This study explored an important, yet little understood, dimension of social work: the meaning of personal treatment to the clinical work of graduate students and experienced practitioners. Building on to previous studies of clinical psychologists, the findings supported the hypothesis that personal therapy may be a valuable resource in becoming a competent clinical social worker.

The mode of research, in which clinical interviewing skills were adapted to the needs of the study, enabled us to explore the unique meanings which personal therapy had to respondents. This included contextual aspects such as the life space of students who were about to launch their careers and of professional clinical social workers with several years of clinical experience.

Indeed context seemed to account for most of the qualitative differences found between the two groups.

The findings provide the profession with some important indicators of how personal treatment may enhance practice. For these respondents, therapy helped to nurture knowledge, values and skills by way of identification with psychotherapists who became models of professional practice. No doubt, the good-enough fit between patients and therapists explains the quality of these highly positive results although previous treatment with other therapists were not always experienced as positively. What these therapists seemed to have in common was a talent for integrating paradoxical themes into their therapeutic roles. They were experienced by respondents as supportive yet confrontational, connected yet separate, and empathic yet sticking to the business of therapy. Identification with and introjection of these characteristics led to a progressive sense of competence within respondents.

The experience of personal treatment also was a vehicle for understanding, cognitively and emotionally, the helping process and the dynamics of psychotherapy. However, this so-called secondary gain never compromised the primary motivation for and focus of therapy, the amelioration of personal conflict. Rather, the treatment experience appeared to be reframed as an opportunity for continued development in adulthood which included the practice of clinical social work. Respondents talked of therapy as an indispensable resource for integration of their therapeutic selves, something not possible through other means such as reading,

supervision and education. Their therapists were valuable allies and catalysts in that process.

In the grounded theory perspective of qualitative research, these findings help us to understand how personal treatment may be helpful to clinical social work practice. They do not resolve a major question. Should all clinicians be required to be in personal treatment? Respondents were split on the subject. About half thought that such a requirement would undermine essential pre-conditions for successful treatment, motivation and readiness. The other half pointed to other pre-requisites for professional practice, including the graduate degree and a license, which they felt were no more important than personal treatment. All were in agreement about the value of personal psychotherapy to their roles as clinical social workers.

This research may stimulate discussion and further study of this important subject, especially in graduate schools of social work and in centers where training for clinical practice is an important mission.

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