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## Therapists and Personal Therapy

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# Therapists and Personal Therapy

by

Samantha J. Lundgren, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
In Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

Committee Members  
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research a research problem, formulate a research implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### **Acknowledgements**

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### **Abstract**

Clinical social workers spend years in training and even more time ever refining their professional skill set as they work with clients. Personal therapy is another tool utilized by mental health professionals for personal and professional reasons. An array of research investigates the value of personal therapy for therapists. This study was designed for three reasons: 1) to examine the prevalence of personal therapy in the sample 2) to investigate the effect the practitioners experience of how therapy impacts their professional competence and 3) to evaluate perceptions of the role of personal therapy as a prerequisite to the profession. This researcher surveyed LICSW's registered to the Minnesota board of social work (N=51).

The findings indicate that personal therapy is prevalent and widely viewed as helpful amongst the participants. The results also show that that LICSW's found personal therapy to be beneficial for some professional factors as well, including increased self awareness, increased awareness/validation of the therapeutic process, and that it provided a form of self care. Lastly, the findings indicate that while participants overall felt personal therapy would be beneficial for therapists in training, they did not believe it should be required in training programs or for licensure.

**Table of Contents**

Introduction.....	5
Literature Review.....	7
Prevalence of Personal Therapy .....	7
Reasons for Seeking Personal Therapy .....	10
Outcomes of Personal Therapy.....	13
Personal Therapy as a Requirement .....	17
Methodology .....	21
Findings.....	25
Descriptive Statistics .....	25
Inferential Statistics .....	32
Discussion .....	40
References.....	48
Appendix A.....	52
Appendix B.....	53

### Introduction

The father of psychotherapy highlighted the importance of therapy for the practitioner. Freud himself asked in *Analysis Terminable and Interminable* (1937), “But where and how is the poor wretch to acquire the ideal qualifications which he will need to in his profession? The answer is an analysis of himself” (p. 246). Some of the most prominent figures in psychotherapy struggle with mental health issues in their own personal lives. Carl Jung, the founder of analytical psychology, was self-described as possessing a dual personality which he attributed to childhood trauma. His lifelong quest to “resolve his unconscious was motivated by his own pathology” (Smith, 1997, p. 2). Marsha Linehan, the founder of dialectical behavioral therapy (DBT), serves as a modern example. Recently, Linehan revealed that as a young adult she had psychiatric hospitalizations and underwent electroshock treatment (Carey, 2011, pp. 1A). Linehan also disclosed that she would make a self-diagnosis of Borderline Personality Disorder, the very disorder her DBT was designed to treat. If the founders and figureheads of psychotherapeutic techniques highlight their own emotional problems and the importance of their therapy, what does this suggest to the practicing therapist today?

Contemporary therapists appear to concur with Linehan and Jung’s emphasis on personal therapy; a majority of therapists have utilized mental health services (Norcross, 2005). The personal therapy of mental health professionals is widely accepted and regarded as valuable within the profession (Bike et al., 2009). While the ‘practicing what you preach’ vantage on personal therapy has benefits similar to those reported by any client, the professional implications are less widely articulated and encouraged. Personal

therapy and positive effects on professional practice competencies can be difficult to demonstrate and are widely debated amongst practicing therapists.

The topic of therapists' personal therapy has been well documented. Multiple studies have surveyed both large and small samples of therapists in regard to personal therapy (e.g., Macran, Stiles & Smith, 1999; Geller, 2011; Norcross, Schatz & Bike, 2009; Norcross, Bike, Evans & Schatz, 2008). Approximately 75% of mental health professionals have participated in at least one episode of personal therapy in their lives (Norcross, 2005).

It is necessary to know the benefits of personal therapy for therapists in order to define their role in professional development and competence. In a survey of over 1,000 mental health professionals, Gilroy, Carrol, and Murra (2002) found therapists reporting personal diagnoses, including but not limited to "depression, anxiety, substance abuse, and relationship dysfunction" (p. 402). Personal experiences with emotional issues and treatment increased therapist's empathy for clients; respondents also indicated that untreated mental health issues negatively impacted the quality of relationship with clients and colleagues (Norcross, 2005). Macran, Stiles, and Smith (1999) demonstrated a variety of professional benefits for personal therapy for therapists. The authors explain personal therapy "can improve awareness of own problems and areas of conflict, is essential for recognizing countertransference, facilitates empathy for the client, enhances understanding of therapeutic techniques, and increases confidence in power of therapeutic process and usefulness of underlying theories" (p. 419). Personal therapy has demonstrated a variety of benefits for practicing therapists related to therapist reliability, skill, and empathy (Bike, et al., 2008).

The purpose of this study is to seek a more detailed knowledge of the impact of psychotherapy on the therapists' professional competence. The research question will ask: does the therapist's personal therapy enhance their perception of their professional competence? Participants will be asked to respond to an online survey that was developed by the researcher. This study was designed for three reasons: 1) to examine the prevalence of personal therapy in the sample 2) to investigate the effect of therapy on professional competence 3) evaluate perceptions of the role of personal therapy as a prerequisite to the profession. This quantitative research will gather information on the effects of therapists' personal therapy; specifically its perceived effects on professional practice.

### **Literature Review**

This literature review will first examine the prevalence of personal therapy including factors that influence a psychotherapist to utilize personal therapy. Next this review will examine reasons for therapists to utilize personal therapy including personal reasons, professional reasons and as a graduate program requirement. Finally this review will examine the outcomes of seeking therapy as well as attitudes on therapy as a professional requirement.

### **Prevalence of Personal Therapy**

The prevalence of personal therapy has been well documented in previous research. In the 1987 survey of 710 therapists by Norcross, Strausser-Kirtland, and Missar (1988), 71% of respondents had obtained personal therapy at some point. A majority of therapists seeking therapy is a trend that continues into more recent research, as well. In a meta-analysis of 17 studies involving more than 8,000 participants Norcross



(2005) found that a majority of mental health professionals were seeking therapy at some point in their lives. After reviewing the studies Norcross (2005) “estimated the prevalence at approximately three quarters” (p. 841). Bike, Schatz, and Norcross (2009) replicated the Norcross, et al., (1988) survey and found that of the 727 psychotherapists who responded, 84% had participated in at least one episode of personal therapy. The prevalence amongst professionals is higher than the general population, which is estimated that 25% to 27% of American adults have received some form of mental health service (Norcross, 2005).

The prevalence of personal therapy in graduate students in psychology related masters programs was similar to their professional counterparts. In a survey of 1,047 students in clinical psychology programs Holzman, Searight, and Hughes (1996) found that 75% of respondents had received personal therapy. Correspondingly, Strozier and Stacey (2001) investigated the prevalence of personal therapy amongst graduate level social work students. In the survey of 139 Masters of Social Work (MSW) students 70% reported that they had received personal therapy in the past. Across the psychotherapy profession, a majority of professionals have sought personal therapy (Gilroy, Carroll, & Murra, 2002; Norcross, 2005; Bike, et al., 2009; Curtis, Knaan-Kostman, Mannix, 2004; Pope & Tabachnick, 1994). However, studies indicate that certain factors influence the rate of which psychotherapists utilize personal therapy including gender, career stage, and theoretical orientation.

### **Factors that influence a psychotherapist to utilize personal therapy.**

#### ***Gender.***

Early research indicated that female practitioners were significantly more likely to seek personal therapy than men (e.g., Norcross, Stausser-Kirtland, & Missar, 1988; Pope & Tabachnick, 1994). More recent studies have suggested that gender is not a significant factor in seeking therapy. In Gilroy, Carroll and Murra (2002) random sampling of 1,000 psychologists “a chi-square analysis indicated a nonsignificant difference in the number of female and male psychologists who sought treatment” (p. 404). Similarly, the 2009 survey by Bike, Norcross and Schatz (2009) found that women (85%) and men (81%) were equally likely to have sought therapy.

### *Career stage.*

One suggested predictor of the frequency for personal therapy is stage of career in which therapy is first sought. Norcross, Bike, and Schatz (2009) surveyed 727 psychotherapists and found that the only predictor of frequency was career stage. Pre-career therapy seekers (61%) were “significantly more likely to seek therapy multiple times compared to those whose first therapy was early career (30%), midcareer (7%), late career (2%), or postretirement (<1%)”. The authors further elaborated that they had accounted for age as a factor, as well, which had no statistical significance in terms of seeking personal therapy.

### *Theoretical orientation.*

Another factor that may influence the rate at which psychotherapists utilize personal therapy is theoretical orientation. In a random sample and survey of 727 psychotherapists, Bike, Norcross, and Schatz (2009) found that theoretical orientation of the therapist was a significant factor in seeking therapy. Their data revealed, “those most

likely<sup>1</sup> to have sought personal therapy were self-identified as psychodynamic (98%), psychoanalytic (96%), interpersonal (92%), and humanistic (91%) therapists.

Multicultural, behavioral and cognitive therapists (72%, 74%, and 76%) were the least likely to have sought therapy” (p. 22).

These results were similar to the findings of Norcross, Bike, Evans and Schatz (2008). In a survey of 119 American mental health professionals, the authors found that therapy and non-therapy seekers differed significantly in theoretical orientation. These results found that 26% of all cognitive-behavioral therapists in the sample were non-therapy seekers. This percentage was significant<sup>2</sup> as compared to psychoanalytic/psychodynamic and humanistic therapists, “of whom only 3% and 15% did not seek therapy” (p. 1372). Both Norcross, et al., (2008) and Bike, et al., (2009) corroborate the synthesis of previous research on attending therapy by Norcross (2005). Norcross (2005) stated that of the theoretical orientations, “Psychoanalytic clinicians have the highest rates (82% to 100%) and behavior therapists the lowest (44% to 66%)” (p. 841).

### **Reasons for Seeking Personal Therapy**

Three primary reasons for psychotherapists to seek personal therapy have emerged in the research. Personal reasons, professional reasons, and a graduate program requirement have all been identified as reasons for psychotherapists to seek personal therapy. Past research has also identified reported reasons for therapists who do not seek therapy.

#### **Personal reasons.**

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<sup>1</sup> [X<sup>2</sup>(13,1722) = 33.39, p < .001]

<sup>2</sup> [X<sup>2</sup>(2, N=701) = 28.51, p < .001]

The primary reason most therapists seek personal therapy, is indeed personal in that they relate to the private non-professional person of the therapist. In Norcross (2005) synthesis of his past research it was reported that across the studies the reason therapists sited seeking therapy was personal (50% to 67%). The presenting personal problems for therapists are similar to most people pursuing mental health services (Gilroy, Carrol, & Murra, 2002).

In a random sample survey of 476 mental health professionals Pope and Tabachnick (1994) investigated the focus of therapy for therapists. The results revealed depression (25%) as the most common problem addressed in therapy, followed by marital problems or divorce (20%), relationship (general) (14%), self-esteem and self-confidence (12%), and anxiety (12%). A study by Bike, et al., (2009) produced similar findings. In a survey of 727 mental health professionals, the authors found the “two most common presenting problems were marital-couple distress (20%) and depression (13%)” (p. 24). Other commonly reported problems were a need for self-understanding (12%) and anxiety (10%). Additionally, respondents in Bike, et al., (2009) survey reported that 24% of therapists receiving psychotherapy had also been prescribed psychotropic medication.

Gilroy, Carrol and Murra (2002) found similar results to Pope and Tabachnick (1994). Gilroy, et al. (2002) surveyed a random sample of 1,000 psychologists to investigate therapists’ personal experiences with depression and treatment. A majority of respondents (62%) self-identified as depressed. A chi-square analysis of the data indicated that a significantly greater number of women therapists were reporting depression than male respondents<sup>3</sup>. The most commonly reported diagnosis was

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<sup>3</sup> [X<sup>2</sup>(1, N = 425) = 6.07, p < .01]

dysthymia (36%) followed by Adjustment disorder with depressed mood (33%). In the survey, 42% (78) respondents reported experiencing suicidal ideation or behavior. Furthermore, 31% (58) respondents had been prescribed psychotropic medication for depressive symptoms.

### **Professional reasons.**

Another reason psychotherapists seek psychotherapy are reported to be professional in that they relate directly to the professional work of the therapist. Bike, et al., (2009) asked respondents to indicate if they entered therapy for personal reasons, professional, or both. Five percent of participants indicated seeking therapy for professional reasons and 35% indicated “both”. The authors elaborated that participants who entered therapy for professional reasons “experienced the lowest number of treatment episodes as compared with those who entered for personal reasons or for both personal and professional reasons” (p. 24). Correspondingly, the authors included responses of “training purposes” and “career concerns” under personal reasons for seeking therapy. Men were twice as likely<sup>4</sup> to cite training purposes or career concerns (8%) as their presenting problem than were women (4.2%).

### **Graduate program requirement.**

Some graduate programs for mental health professionals require personal therapy as a program requirement. In their survey of mental health professionals Pope and Tabachnick (1994) found that of the 464 respondents who answered the question 13% (62) had been in graduate programs that required personal therapy in the curriculum. Norcross (2005) suggested that only psychoanalytic institutes and some graduate

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<sup>4</sup> [(N = 11,595) = 2.51, p < .01]

psychology training programs actually hold personal therapy as a requirement in their programming.

### **Therapists who do not seek therapy.**

Some therapists abstain from personal therapy. Norcross, Bike, Evan and Schatz (2008) sampled 2,100 randomly selected American psychotherapists and obtained a sample of 116 respondents who had never obtained personal therapy. Some of the highest rated reasons for not seeking therapy were “I dealt with my stress in other ways” and “I received sufficient support from friends, family, or coworkers”. Other reasons for not seeking therapy included: coping effectively with challenges, resolving problems before therapy was undertaken, and having no need for personal therapy. Cost was cited as a barrier for some; psychologists were significantly less concerned about the cost of therapy<sup>5</sup> than social workers or counselors.

### **Outcomes of Personal Therapy**

Across the literature, self-reported outcomes of personal therapy for the therapist as a client are positive. In a random sample of 476 psychologists by Pope and Tabachnick (1994), most of the participants found personal therapy helpful. Of the participants responding to the question, 85.7% reported their experience in therapy was very or exceptionally helpful. Only two respondents (.006%) reported the experience was not helpful. The therapy experience is sited as beneficial for the therapist personally, as well as professionally.

### **Outcomes in personal symptoms.**

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<sup>5</sup> [F(2, 109) = 5.33, p < .01]

Orlinsky and Ronnestad (2005) international survey of over 4,000 therapists produced data that indicated personal therapy produced positive outcomes for therapists. Eighty-eight percent of respondents indicated that they experienced positive personal benefit. Likewise, in a random sample of 727 psychotherapists, Bike, et al., (2009) demonstrated positive personal outcomes of personal therapy. Participants were asked on a five-point Likert scale to indicate the outcomes of therapy along three dimensions: behavioral-symptomatic, cognitive-insight and emotion-relief. Where 1 = *significant deterioration*, 3 = *no change* and 5= *significant improvement*. “The mean ratings were 4.30 (SD = 0.73) for behavioral-symptomatic, 4.40 (SD = 0.69) for cognitive-insight, and 4.46 (SD = 0.68) for emotion-relief change” (Bike et al., 2009, p. 26). The vast majority of respondents in the survey indicated significant improvement as the outcome of personal therapy. Overall, 86% of participants reported improvements in behavior-symptoms, 90% reported improvements in cognitive-insight, and 92% reported improvements in emotion-relief change.

Similarly, by utilizing a convenience sample of 75 psychoanalysts by Curtis, Field, Knaan-Kostman, and Mannix (2004) found positive personal outcomes of therapy. Twenty-nine percent of respondents indicated a high degree of positive overall change from therapy, 58% cited moderate improvement, 3% slight improvement and 1% (one respondent) indicated deterioration during their personal therapy. Some of the most frequently reported individual changes as a result of personal therapy were: capacity for emotional intimacy/closeness, ability to experience wide range of emotions, and ability to link past and present experiences.

Grimmer and Tribe's (2001) qualitative investigation of the impact of mandated personal therapy on professional development revealed positive personal outcomes in addition to professional ones. The results indicated that students who initially attended therapy without a presenting problem experienced personal growth. Participants reported personal gains including: "understanding when an issue is relevant to supervision and when it is more appropriately dealt with in personal therapy, being better able to tolerate ambivalence, and normalization" (Grimmer & Tribe, 2001, p. 295).

### **Outcomes in professional practice.**

#### ***Quantitative findings.***

Personal therapy was ranked among the top three sources of positive professional development (just following direct client contact and case consultation) in Orlinsky and Ronnestad's (2005) survey of over 4,000 psychotherapists (as cited in Norcross, 2005). "Across all nations, the appreciable positive benefit of personal therapy on career development was 94%" (Norcross, 2005, p. 843). Personal therapy exerted a strong impact on professional practice in Orlinsky and Ronnestad's (2005) sample. Similarly, Bike, et al., (2009) asked 727 respondents to survey to indicate the extent in which personal therapy taught or reminded them of lessons concerning the practice of psychotherapy. Respondents rated 14 lessons on a five-point Likert scale, the higher the score indicated greater importance. The four lessons that personal therapy reminded therapists of were: The therapist must be reliable and committed (M = 4.56), the therapist must be committed and skilled (M = 4.44), the personal relationship, warmth, and empathy are central (M = 4.42) and there is always a need for patience and tolerance (M = 4.16).



Strozier and Stacey (2001) survey of MSW students and social work faculty unveiled similar positive outcomes on professional implications of personal therapy. In a survey of 139 MSW students, the top three rated ways personal therapy was helpful in becoming a more effective practitioner were: Increase self awareness (30.8%), deal with own issues (23.8%), and increasing sensitivity to the client (12.8%).

*Qualitative findings.*

Macran, Stiles, and Smith (1999) conducted qualitative interviews with seven practicing therapists about personal therapy and how it affected their professional practice. The authors identified 12 common themes in the interviews, which were organized into three domains. The effects of personal therapy on professional practice were: orienting to the therapist, orienting to the client, and listening with the third ear. Orienting to the therapist referred to issues of humanity, power, and boundaries that psychotherapist's experience. Orienting to the client encompassed the notion of trust, respect and patience for the client to have their own experience in personal therapy. Listening with the third ear was defined as "how to distinguish between what was attributed to themselves and what was attributed to the client" (p. 427). Personal therapy helped professionals better understand the role of the therapist, the experience of the client, and to deepen the therapeutic work.

Bellows (2007) conducted semistructured interviews with 20 psychoanalytic therapists. The author's major finding was the acceptance of personal imperfections was one of the positive professional outcomes of personal therapy. Respondents indicated acceptance of personal imperfectability enhanced "clinical work by increasing empathy for how difficult change is, both for themselves and for their patients" (Bellows, 2007, p.

213). This fits with the Macran et al. (1999) finding that acceptance of personal imperfectability orients the therapist and the client in the therapeutic process.

Additionally, participants who experienced most self-reported psychological change from personal therapy were also more likely to report using their former therapist as a professional role model.

Similarly, a qualitative study by Grimmer and Tribe (2001) with 14 student or recently graduated psychotherapists investigated the professional effects of mandated personal therapy. The authors developed four categories of experience from the interviews: reflection on being a client, support as emerging professional, socialization experience, and interaction between personal and professional development. Similar to the findings of Macran, et al., (1999) participants reported orienting to the experience of a client. This aided in professional conceptualization of the therapeutic process. The category ‘socialization experience’ expressed personal therapy as a rite of passage into the professional identity. Furthermore, in the category ‘support for the emerging professional’ participants “described personal therapy as providing support in that it allowed them to make confidential disclosures in an environment where those disclosure would not rebound on their professional development... and was used as an explicit form of stress management”(Grimmer & Tribe, 2001, p. 289). Finally, in the category ‘interactions of personal therapy and professional development’ respondents indicated that personal therapy helped them distinguish whether issues were better discussed during supervision or personal therapy.

#### **Alternate explanations of outcomes.**

Two noteworthy studies (Rizq and Target (2010); Clark (1986)) make alternate explanations for the outcomes expressed in previous research.

In a unique mixed methods study, Rizq and Target (2010) investigate how psychotherapists' attachment status and levels of reflective functioning intersect with how therapists experience, describe and utilize personal therapy in their professional practice. Twelve psychotherapists participated in the qualitatively driven mixed methods study, which interviewed for participants attachment style using the Adult Attachment Interview (AAI), then coded for Reflective function (RF), and were finally interviewed for their narrative accounts of personal therapy as a psychotherapist. The results indicated that securely or earned securely attached participants with ordinary or high levels of RF used their personal therapy to manage feelings that came up in their work with difficult or challenging clients. Insecurely attached participants with lower levels of RF utilized personal therapy for professional behavior modeling, but not in managing complex process issues. The results of Rizq and Target (2010) study suggest that personal therapy will have different professional utilization depending on the attachment characteristics of the psychotherapist.

Alternately, in a review of previous empirical research, Clark (1986) questions the stress for therapists to undergo personal therapy. In an investigation of the previous research the author searches for evidence that personal therapy makes for a more efficacious practitioner. The author concludes, "in five of the studies no relation was found between patient outcome and whether the therapist had or had not experienced therapy" (p. 542). He expresses the need for future research to forgo the assumption that personal therapy is positive, and urges researchers to demonstrate an effect on client

outcomes. Norcross (2005) acknowledges this position stating, “randomized clinical trials of the efficacy of psychologists personal therapy have not been conducted and probably never will be” (p. 847).

### **Personal Therapy as a Requirement**

With many positive outcomes reported with personal therapy, some previous research has begun to investigate perceptions on requiring personal therapy as a professional standard. Strozier and Stacey (2001) asked 148 MSW faculty and 139 MSW students how important personal therapy is in their social work education. Respondents were asked to rate the importance on a Likert scale ranging from one to five; one = *essential*, two = *important*, three = *neutral*, four = *not important* and five = *harmful*. Students were significantly more likely to rate personal therapy as “essential” or “important” ( $X = 1.27$ ) than were faculty ( $X = 2.42$ ,  $p < .001$ ).

Pope and Tabachnick (1994) surveyed 476 psychotherapists investigating participants experience with personal therapy. Respondents were asked five-point Likert scale questions about the need for personal therapy. The rating scale was: 1 = *absolutely yes*, 2 = *probably*, 3 = *don't know*, 4 = *probably not*, and 5 = *absolutely not*. Most of respondents (70%) believed that personal therapy should “probably” or “absolutely” be required as part of the training during graduate school for psychotherapists in training. Another 54% of respondents believed state licensing boards should “probably” or “absolutely” require personal therapy in licensure requirements. The authors described these results as surprising, as only 13% of the participants had ever been required to have therapy in their graduate programming.

Similarly, Bike et al. (2009) asked their 727 respondents to rate the importance of personal therapy along a five point Likert scale. On the scale 1 = *very unimportant*, 3 = *neutral/undecided*, and 5 = *very important*. Generally, respondents believed personal therapy was an important (M = 4.00, SD = 1.71) prerequisite for clinicians. Of the sample, psychodynamic (M = 4.52, SD = 1.02) and therapy seeking (M = 4.23, SD = 1.04) therapists were significantly more likely to view personal therapy as an important or very important prerequisite to practice. Overall, the sample viewed personal therapy as a moderately important (M = 3.66, SD = 1.07) for ongoing professional development. In the sample, women (M = 3.77, SD = 1.04), psychodynamic (M = 4.07, SD = 1.00) and therapy seeking (M = 3.84, SD = 1.00) were more likely to rate therapy as important or very important for ongoing development.

The aim of this study is to add to the body of knowledge on the effects of personal therapy on psychotherapists, further define the effects of therapy on professional competence, and finally to investigate therapists attitudes and beliefs on the role of personal therapy as a professional standard.

## **Methodology**

### **Purpose and Design**

The purpose of this study was to gather information on the effects of a therapist's personal therapy; specifically its perceived effects on professional social work practice. This project used descriptive, quantitative analysis. The participants were asked to respond to an online survey that was developed by the researcher. This study was designed for three reasons: 1) to examine the prevalence of personal therapy in the sample 2) to investigate the effect the practitioners experience of how therapy impacts their professional competence and 3) to evaluate perceptions of the role of personal therapy as a prerequisite to the profession. A quantitative survey was chosen as it allows for the researcher to gather the opinions of a larger sample of social workers.

### **Sample**

The target population for this study was social workers working in the mental health profession. A non-probability sample was obtained by purchasing the current list of Licensed Independent Clinical Social Workers (LICSW) in Minnesota. Non-probability samples are preferred in research studies such as this, where the aim is to see whether a relationship exists between independent and dependent variables and not to make a generalization to the larger population (Monette, Sullivan, & DeJong, 2011). Inclusion criteria for respondents were LICSWs in Minnesota. Exclusion criteria for respondents were: non-English speaking, non-Minnesotan social workers, and not registered to the Board of Social Work. Of the 250 surveys distributed, 51 were completed. One survey was completed after the data analysis began and was not included in the data. Eighty eight percent of respondents were female (n=45) and 12% were male

(n = 6). Sixty one percent of respondents were 30-50 years old (n=31) and 39% were older than 50 (n = 20).

### **Data Collection**

Data for the study was collected using a survey (See Appendix B) designed by the researcher. Questions for the survey were developed based on the literature review. A cover letter (See Appendix A) explaining the purpose of the study was mailed via the Qualtrics Survey distribution software in January 2013. In the cover letter participants were asked to respond to a quantitative online survey at [www.qualtrics.com](http://www.qualtrics.com) or via a link included in the cover.

### **Instrument**

The survey collected demographic data and questions about the therapists' personal experience with therapy, their perception of therapy's effect on their practice, and their view of personal therapy in professional development. The researcher estimates the survey takes 15 minutes to complete.

### **Data Analysis**

The researcher utilized SPSS, a software used for statistical analysis, to analyze the data using descriptive and inferential statistical analysis. The researcher used frequency distributions, measures of central tendency, and chi-square tests.

### **Measures for protection of human subjects.**

The researcher obtained approval from the Institutional Review Board at the University of Saint Thomas prior to recruiting participants and collecting data. The participants were mailed a cover letter/letter of invitation explaining the nature of the survey and why they were selected to be participants (Appendix A). This letter

explained: the risks and benefits associated with participating in the survey, the anonymous and confidential nature of the survey, and that choosing to participate or not participate would have no effect on their relationship with College of Saint Catherine or the University of Saint Thomas. The cover letter also explained that participation is voluntary and that respondents do not need to answer any questions they feel are uncomfortable. And finally, it described whom to contact with questions and concerns. This letter of invitation constitutes the consent form in this study. If participants choose to partake in the online survey following the letter, consent will be implied.

Data was collected anonymously via [www.qualtrics.com](http://www.qualtrics.com). The researcher has no way of identifying any of the participating respondents. There was no identifying information stored in regards to completed surveys and identifying information. Due to the anonymity associated with the data collection, the data will not be subject to any other unique methods of confidentiality. The final research paper is public information. After July 2013, the data set will be destroyed.

### **Risks and benefits.**

There were three possible risks identified for participants in the survey. Participants were informed that they could feel vulnerable revealing personal information about past personal therapy, that participating may evoke difficult emotions associated with past or current therapy and that participation could bring up material that would make participant feel a need to seek therapy. It is considered unlikely that participating in the survey would evoke any amount of great personal duress. There are no direct benefits from participating in the survey. Indirect benefits include contributing to the professional body of knowledge concerning the role of personal therapy for psychotherapists.



**Operationalizing of Definitions**

Within the study, it is important for the purpose of clarity, understanding and consistency to define several key terms. Defining these terms increases the reliability and validity of the study. The term “therapist” in this research project refers to mental health professionals in the social work field. The term “personal therapy” is used meaning the utilization of a therapeutic relationship with a licensed professional in dealing with a personal mental health issue. The mode of therapy can be group, couples, family, or individual.

## Findings

The introduction email (see Appendix A) and survey (Appendix B) were sent out to 250 LICSW's in Minnesota. The intended participants were given a month (30 days) to return the survey. Of the 250 surveys distributed, 51 were completed (a return rate of 20.4%).

### Descriptive Findings

#### Frequency distribution.

Table 1 shows the descriptive statistics of the frequency, which respondents identified with a specific theoretical orientation. The most popular response to this question was Cognitive/Behavioral, which was selected by 43% of respondents. Twenty percent of respondents indicated Eclectic or Integrative as their primary theoretical orientation. Eighteen percent of participants indicated Psychodynamic/Psychoanalytic/Attachment.

Table 1 Frequency of respondents' primary theoretical orientation

#	Answer		Response	%
1	Psychodynamic/Psychoanalytic/Attachment		9	18%
2	Cognitive/Behavioral		22	43%
3	Humanistic/Person-centered		4	8%
4	Systems		3	6%
5	Eclectic/Integrative		10	20%
6	Other (please specify)		3	6%
	Total		51	100%

Respondents were also asked if they had ever sought personal therapy in the past.

Table 2 shows the participant's response to this question. A majority of respondents (84%) indicated they had sought personal therapy in the past. Only eight participants (16%) had not sought therapy in the past.

Table 2 Frequency with which respondents had sought personal therapy in the past.

#	Answer	Response	%
1	Yes	43	84%
2	No	8	16%
	Total	51	100%

Participants were also asked the degree to which their graduate training programs required therapists in training to enter therapy. Most participants indicated their graduate training programs were “Neutral”. Two respondents indicated their graduate training program required students to enter therapy.

Table 3 Frequency in which respondents graduate training programs required therapists in training to enter therapy

#	Question	Discourage	Neutral	Encourage	Require	Mean
1	Response:	1	31	6	2	40

Additionally, participants who had indicated they participated in therapy in the past were asked to indicate when they first entered therapy. Table 4 displays the response to this question. A majority (62%) of participants first entered therapy prior to graduate school. Eight participants began therapy during graduate school and eight respondents began therapy after graduate school.

Table 4 Frequency in which respondents first entered therapy

#	Answer	Response	%
1	Prior to graduate school	26	62%
2	During graduate school	8	19%
3	After graduate school	8	19%
	Total	42	100%

Participants were asked to indicate the approximate total length of time they had participated in therapy. Table 5 displays participant’s response to this question. The most popular response to this question was “More than two years”, was selected by 30.9% of respondents (N=42). However, a majority of participants (69%) responded that their total length of time in therapy was less than two years.

Table 5 Frequency in which respondents indicated approximate total length of time in therapy

#	Answer	Response	%
1	Less than 3 months	9	21%
2	6 months to 1 year	9	21%
3	1 - 2 years	11	26%
4	More than 2 years	13	31%
	Total	42	100%

Participants who indicated they had sought personal therapy in the past were asked the theoretical orientation of their most recent therapist. Table 6 displays the response to this question. The most popular response to this question was “Psychodynamic/Psychoanalytic/Attachment”, which was selected by 26% of respondents (N=41).

Table 6. Frequency of orientation of most recent therapists theoretical orientation.

#	Answer	Response	%
1	Psychodynamic/Psychoanalytic/Attachment	11	26%
2	Cognitive/Behavioral	8	19%
3	Humanistic/Person-centered	8	19%
4	Systems	1	2%
5	Eclectic/Integrative	7	17%
6	Other (please specify)	1	2%
7	Unknown	6	14%
	Total	42	100%

Participants who indicated they had sought personal therapy in the past were asked to indicate the degree to which they found therapy helpful. As Table 7 displays, no participants indicated they found the therapy experience harmful. A majority (greater than 97%) found therapy “helpful” or “extremely helpful”.

Table 7 Frequency of helpfulness of therapy experience.

#	Question	Harmful	Neutral	Helpful	Extremely helpful		Mean
1	Response:	0	1	21	20	42	3.45

Participants who indicated they had sought personal therapy in the past were asked to indicate if professional factors were influenced by personal therapy. Table 8 displays the response to this question. The professional factor most cited by participants as impacted by personal therapy was “Increased self awareness”, which 93% of participants indicated. Ninety percent of respondents indicated that the professional factor “Increased awareness/validation of the therapeutic process” was impacted by personal therapy. Approximately 85% of respondents indicated that personal therapy was a form of the professional factor “self care”. Sixty-four percent of participants indicated that personal therapy *did not* impact their professional sense of “what not to do as a therapist”. Additionally, respondents who indicated “other” were allowed a qualitative explanation. Responses included “somatic awareness”, “I have hope if they don’t. You can overcome great pain and find purpose.”, and “Recovery/hope is possible”.

Table 8 Frequency of professional factors impacted by personal therapy.

#	Question	Yes	No		Mean
1	Increased self awareness	39	3	42	1.07
2	Dealt with own issues	41	1	42	1.02
3	Increased sensitivity to the client	30	11	41	1.27
4	Increased awareness/validation of the therapeutic process	38	4	42	1.10
5	Reduced countertransference	20	19	39	1.49
6	Better understanding of personal boundaries	27	14	41	1.34
7	Reduced professional stress/burnout	25	14	39	1.36
8	A form of self care	35	6	41	1.15
9	Former therapist serves as a professional model	20	21	41	1.51
10	Learned what not to do as a therapist	13	27	40	1.68
11	Hold back from jumping in to help clients	15	24	39	1.62
12	Work at a deeper level with clients	21	20	41	1.49
13	Other:	4	4	8	1.50

**Other:**

Recovery is possible/hope

I have hope if they dont. I know you can over come deep pain and find purpose.

somatic awareness

Participants who responded that they had sought personal therapy in the past were asked several questions about the professional value of personal therapy. Table 9 displays the responses to these questions. The mean score of “Therapy helped me develop personal insight that has helped me as a therapist” was 3.93, which indicates that

on average respondents agreed with the statement. The mean score of “My personal therapy has improved my client outcomes” was 3.36, which indicates respondents on average felt neutral about the statement. Approximately one third of participants (33%) indicated they would be uncomfortable with colleagues knowing they have engaged in personal therapy in the past. “I work differently with my clients because I have had personal therapy” had a mean score of 3.67, which indicates respondents on average agreed with the statement. Finally, “Personal therapy has helped my growth and development as a professional” had a mean score of 3.95, which indicates that on average respondents agreed with the statement.

Table 9 Frequency of degree to which respondents felt personal therapy affected professional factors.

#	Question	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree		Mean
1	Therapy helped me develop personal insight that has helped me as a therapist.	2	0	7	23	10	42	3.93
2	My personal therapy has improved my client outcomes.	2	4	17	15	4	42	3.36
3	I would be comfortable with my colleagues knowing I have engaged in personal therapy.	2	4	8	15	13	42	3.79
4	I work differently with my clients because I have had personal therapy.	2	2	13	16	9	42	3.67
5	Personal therapy has helped my growth and development as a professional.	2	1	4	25	10	42	3.95

Finally, all participants were asked to what degree they agree or disagree with the statements regarding personal therapy as a requirement. Table 10 displays the response to these questions. “Personal therapy would be beneficial to therapists in training” had a



mean score of 3.96, which indicates respondents, on average, agreed with the statement.

The mean score of “Personal therapy should be required in graduate training schools” was 3.02, which indicates that respondents, on average, felt neutral about the statement.

“Personal therapy should be required by licensing boards” had a mean score of 2.45, which indicates respondents, on average, disagreed with the statement.

Table 10 Frequency in which respondents indicated they believe with personal therapy requirements.

#	Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree		Mean
1	Personal therapy would be beneficial to therapists-in-training	1	1	13	17	16	48	3.96
2	Personal therapy should be required in graduate psychology training schools	6	11	17	6	9	49	3.02
3	Personal therapy should be required by licensing boards	10	15	18	4	2	49	2.45

### Inferential Statistics

#### Association.

Table 11 demonstrates that there is no significant relationship between a participant’s primary theoretical orientation and the degree to which they found personal therapy helpful ( $X = 2.043$  ;  $p = .728$ ). The responses to the question about primary

theoretical orientation were recoded into three groups:

Psychoanalytic/Psychodynamic/Attachment, Cognitive/Behavioral, and Other. The

responses to the question how helpful has your experience in therapy been were recoded

into three groups: Harmful/Neutral, Helpful, and Extremely Helpful.

Table 11

**How helpful has your experience in therapy been RECODED \* What is your primary theoretical orientation RECODED Crosstabulation**

			What is your primary theoretical orientation RECODED			Total
			1.00	2.00	3.00	
How helpful has your experience in therapy been RECODED	1.00	Count	0	1	0	1
		Expected	.2	.4	.4	1.0
	2.00	Count	4	10	7	21
		Expected	4.5	9.0	7.5	21.0
	3.00	Count	5	7	8	20
		Expected	4.3	8.6	7.1	20.0
Total	Count	9	18	15	42	
	Expected	9.0	18.0	15.0	42.0	
	Count					

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.043 <sup>a</sup>	4	.728
Likelihood Ratio	2.413	4	.660
Linear-by-Linear Association	.012	1	.914
N of Valid Cases	42		

a. 5 cells (55.6%) have expected count less than 5. The minimum expected count is .21.

Table 12 demonstrates that there is no significant relationship between a participant’s primary theoretical orientation and seeking personal therapy ( $X = 2.059$  ;  $p = .357$ ). A total of 51 participants answered this question in a way that allowed for their responses to be cross-tabulated. The responses to the question about primary theoretical orientation were recoded into three groups: Psychoanalytic/Psychodynamic/Attachment, Cognitive/Behavioral, and Other.

Table 12

**What is your primary theoretical orientation RECODED \* I have sought personal therapy in the past: Crosstabulation**

			I have sought personal therapy in the past:		Total
			Yes	No	
What is your primary theoretical orientation RECODED	1.00	Count	9	0	9
		Expected Count	7.6	1.4	9.0
	2.00	Count	18	4	22
		Expected Count	18.5	3.5	22.0
	3.00	Count	16	4	20
		Expected Count	16.9	3.1	20.0
Total		Count	43	8	51
		Expected Count	43.0	8.0	51.0

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.059 <sup>a</sup>	2	.357
Likelihood Ratio	3.434	2	.180
Linear-by-Linear Association	1.440	1	.230
N of Valid Cases	51		

a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is 1.41.

Table 13 demonstrates that there is a significant relationship between the degree to which participants believe personal therapy should be required in graduate school and seeking personal therapy in the past ( $X = 11.449$ ;  $p = .022$ ).

Table 13

**I have sought personal therapy in the past: \* To what degree do you believe...-Personal therapy should be required in graduate psychology training schools Crosstabulation**

			To what degree do you believe...-Personal therapy should be required in graduate psychology training schools					Total
			Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
I have sought personal therapy in the past:	Yes	Count	4	11	15	3	9	42
		Expected	5.1	9.4	14.6	5.1	7.7	42.0
		Count						
	No	Count	2	0	2	3	0	7
		Expected	.9	1.6	2.4	.9	1.3	7.0
		Count						
Total	Count	6	11	17	6	9	49	
	Expected	6.0	11.0	17.0	6.0	9.0	49.0	
	Count							

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.449 <sup>a</sup>	4	.022
Likelihood Ratio	11.920	4	.018
Linear-by-Linear Association	.136	1	.713
N of Valid Cases	49		

a. 5 cells (50.0%) have expected count less than 5. The minimum expected count is .86.

Table 14 demonstrates that there is a statistically significant relationship between the length of time in personal therapy and the professional factor “Increased self awareness” ( $X = 11.846 ; p = .008$ ).

Table 14

**What is the approximate length of time you have been in therapy (total)? \* Please indicate if the following have been affected in your practice due to personal therapy:-Increased self awareness**

**Crosstabulation**

			Please indicate if the following have been affected in your practice due to personal therapy:-Increased self awareness		Total
			Yes	No	
What is the approximate length of time you have been in therapy (total)?	Less than 3 months	Count	6	3	9
		Expected	8.4	.6	9.0
	6 months to 1 year	Count	9	0	9
		Expected	8.4	.6	9.0
	1 - 2 years	Count	11	0	11
		Expected	10.2	.8	11.0
	More than 2 years	Count	13	0	13
		Expected	12.1	.9	13.0
	Total	Count	39	3	42
		Expected	39.0	3.0	42.0
		Count			

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.846 <sup>a</sup>	3	.008
Likelihood Ratio	10.158	3	.017
Linear-by-Linear Association	6.899	1	.009
N of Valid Cases	42		

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.846 <sup>a</sup>	3	.008
Likelihood Ratio	10.158	3	.017
Linear-by-Linear Association	6.899	1	.009
N of Valid Cases	42		

a. 4 cells (50.0%) have expected count less than 5. The minimum expected count is .64.

Table 15 demonstrates that there is a significant relationship between the length of time in personal therapy and the professional factor “Increased awareness/validation of the therapeutic process” ( $X = 8.239$  ;  $p = .041$ ).

Table 15

**What is the approximate length of time you have been in therapy (total)? \* Please indicate if the following have been affected in your practice due to personal therapy:-Increased awareness/validation of the therapeutic process Crosstabulation**

			Please indicate if the following have been affected in your practice due to personal therapy:-Increased awareness/validation of the therapeutic process		Total
			Yes	No	
What is the approximate length of time you have been in therapy (total)?	Less than 3 months	Count	6	3	9
		Expected	8.1	.9	9.0
		Count			
	6 months to 1 year	Count	9	0	9
		Expected	8.1	.9	9.0
		Count			
	1 - 2 years	Count	10	1	11
		Expected	10.0	1.0	11.0
		Count			
	More than 2 years	Count	13	0	13
		Expected	11.8	1.2	13.0
		Count			
Total	Count	38	4	42	
	Expected	38.0	4.0	42.0	
	Count				

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.239 <sup>a</sup>	3	.041
Likelihood Ratio	8.258	3	.041
Linear-by-Linear Association	4.626	1	.031
N of Valid Cases	42		

Table 16 demonstrates that there is a statistically significant relationship between the length of time in personal therapy and the professional factor “A form of self care” ( $X = 8.707 ; p = .033$ ).

Table 16

**What is the approximate length of time you have been in therapy (total)? \* Please indicate if the following have been affected in your practice due to personal therapy:-A form of self care**

**Crosstabulation**

			Please indicate if the following have been affected in your practice due to personal therapy:-A form of self care		Total
			Yes	No	
What is the approximate length of time you have been in therapy (total)?	Less than 3 months	Count	5	4	9
		Expected	7.7	1.3	9.0
		Count			
	6 months to 1 year	Count	8	1	9
		Expected	7.7	1.3	9.0
		Count			
	1 - 2 years	Count	10	0	10
		Expected	8.5	1.5	10.0
		Count			
	More than 2 years	Count	12	1	13
		Expected	11.1	1.9	13.0
		Count			
Total	Count	35	6	41	
	Expected	35.0	6.0	41.0	
	Count				

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.707 <sup>a</sup>	3	.033
Likelihood Ratio	8.442	3	.038
Linear-by-Linear Association	5.197	1	.023
N of Valid Cases	41		

a. 4 cells (50.0%) have expected count less than 5. The minimum expected count is 1.32.



## **Discussion**

The findings indicate that personal therapy is prevalent and widely viewed as helpful amongst the participants. The results also show that that LICSW's found personal therapy to be beneficial for a variety of professional factors as well, including increased self awareness, increased awareness/validation of the therapeutic process, and that it provided a form of self care. Lastly, the findings indicate that while participants overall felt personal therapy would be beneficial for therapists in training, they did not believe it should be required in training programs or for licensure.

### **Comparison with Previous Research**

#### **Prevalence of personal therapy.**

This study found that a majority of respondents (84%) indicated they had sought personal therapy in the past. Only eight participants (16%) had not sought therapy. These results align with the findings of most recent research on the prevalence of personal therapy. In a meta-analysis of 17 studies involving more than 8,000 participants Norcross (2005) "estimated the prevalence at approximately three quarters" (p. 841). Furthermore, Bike, Schatz, and Norcross (2009) found that of the 727 psychotherapists who responded, 84% had participated in at least one episode of personal therapy. While this researcher had a much smaller sample size (N=51), it is encouraging that the sample reflected prevalence rates from much larger studies. This may indicate that the sample in this survey reflects more accurate results despite its smaller size.

#### **Personal therapy characterized.**

The overwhelming identification of personal therapy as helpful was an interesting finding of this survey. No participants report finding their therapy experience as harmful.

The majority of participants (greater than 97%) indicated they found therapy “helpful” or “extremely helpful”. This matches the findings of Pope and Tabachnick (1994). Of the participants in Pope and Tabachnick’s (1994) survey, 85.7% reported their experience in therapy was very or exceptionally helpful. Only two respondents (.006%) reported the experience was not helpful. Personal therapy appears to have extremely positive regard both in previous research and in this sample.

The researcher in this study examined if there was a relationship between a participant’s primary theoretical orientation and participation in personal therapy. Analysis indicated that there was not a statistically significant variance in the rates of Psychoanalytic/Psychodynamic/Attachment, Cognitive/Behavioral, and Other orientations seeking therapy in this sample. This differs from previous research. Bike, Norcross, and Schatz (2009) found that theoretical orientation of the therapist was a significant factor in seeking therapy. One explanation for this difference could be the sample. This research focused on LICSW’s where as Bike, Norcross, and Schatz (2009) surveyed a variety of mental health professionals. Furthermore, this researcher also examined the relationship between a participant’s primary theoretical orientation and the degree to which they found personal therapy helpful. Between Psychoanalytic/Psychodynamic/Attachment, Cognitive/Behavioral, and Other, the association between primary theoretical orientation and the degree to which therapy helpful was not shown to be statistically significant. This association could not be found in previous research.

Interestingly, in this survey approximately one third of participants (33%) indicated they would be uncomfortable with colleagues knowing they have engaged in personal

therapy in the past. This substantial section of the sample is thought-provoking knowing the prevalence (84%) of personal therapy and being highly regarded as being helpful (97%) and may be indicative that a stigma is still present.

### **Professional development and personal therapy.**

Previous research indicated that professionals widely viewed personal therapy as beneficial to professional development. Personal therapy was ranked among the top three sources of positive professional development (just following direct client contact and case consultation) in Orlinsky and Ronnestad's (2005) survey of over 4,000 mental health professionals. "Across all nations, the appreciable positive benefit of personal therapy on career development was 94%" (Norcross, 2005, p. 843). However, data from this survey did not yield equally strong regard for personal therapy's positive impact professionally. While approximately 78% of participants in this research indicated that they "agree" or "strongly agree" with the statement "Therapy helped me develop personal insight that has helped me as a therapist"- only 59% participants (59%) indicated they "agree" with the statement "Personal therapy has helped my growth and development as a professional". Additionally, the most common response to the statement "My personal therapy has improved my client outcomes" was "neutral" and only 16 of 42 respondents indicated they "agree" with the statement "I work differently with my clients because I have had personal therapy". One explanation for this might be that a clinician's orientation may influence the degree to which they view personal therapy as professionally beneficial. Respondents in this survey did not appear to feel that personal therapy was as directly beneficial to their professional practice as participants in previous research.

This study found a variety of professional factors that were influenced by personal therapy. Respondents in this survey indicated: “Increased self awareness”, “Increased awareness/validation of the therapeutic process”, and “self care” were influenced by the therapeutic experience. These findings are similar to those of Strozier and Stacey (2001) who found the top three rated ways personal therapy was helpful in becoming a more effective practitioner were: Increase self awareness (30.8%), deal with own issues (23.8%), and increasing sensitivity to the client (12.8%). Additionally, this research examined the relationship between length of time in therapy and professional factors. Inferential statistics indicated a statistically significant relationship between “length of time in therapy” and “professional factors” (Increased self awareness, dealt with own issues, and a form of self care) by respondents. One explanation for this relationship could be that the longer a therapist was in therapy the more they experienced an improvement in their professional development. Another explanation may be that the longer a therapist is in personal therapy the more able they are to identify professional factors impacted by the therapy.

#### **Personal therapy as a requirement.**

With many positive outcomes reported from personal therapy, this research also investigated perceptions on requiring personal therapy as a professional standard. In this survey, only two respondents (3%) indicated their graduate training program had required students to enter therapy. This is fewer than 13% of participants who indicated they had been required in Pope and Tabachnick’s (1994) of 476 psychotherapists. This discrepancy could be explained by a difference in the survey sample or perhaps less training programs are requiring personal therapy recently or in the area of the sample.

However a majority (68%) of participants in this research indicated they “Agree” or “Strongly agree” with the statement “Personal therapy would be beneficial to therapists in training”. This is similar to the findings of Bike et al. (2009) who found that amongst their 727 participants personal therapy was generally regarded as an “important” prerequisite for clinicians.

Participants in the survey felt less strongly that personal therapy should be a requirement in the profession. Only 30% of participants indicated that they agree or strongly agree with the statement “Personal therapy should be required in graduate training schools”. Even fewer, just 12%, indicated they “agree” or “strongly agree” that “Personal therapy should be required by licensing boards”. These findings were in contrast to those of Pope and Tabachnick (1994). Most (70%) of the 476 respondents in Pope and Tabachnick (1994) survey believed that personal therapy should “probably” or “absolutely” be required as part of the training during graduate school for psychotherapists in training. Another 54% of respondents believed state licensing boards should “probably” or “absolutely” require personal therapy in licensure requirements. There is a stark lack of support for requirement by respondents in this survey.

### **Strengths and Limitations**

There are strengths in this study’s design. The anonymity of the survey will increase participation and likely led to more truthful responses that can produce more accurate data. This survey did not require participants to return surveys in the mail. Eliminating this step increases the likelihood of participation. The nature of this design also has limitations. Participation in the survey requires that respondents are comfortable with the internet. This research also has a sampling bias; the homogenous sample of

social workers means the sample may have had similar training or orientation to the role of personal therapy, which could skew the data. Finally, therapists with shame associated to seeking therapy and therapists who have never had therapy will likely be less inclined to participate.

### **Contributions to Social Work Practice**

It is evident based on past research and these survey results that social workers tend to utilize and find personal therapy helpful. The findings of this survey add to the body of knowledge on the prevalence of therapy and the professional factors impacted by the therapeutic process. This information could be helpful for current and future social workers as they consider therapy as a tool for personal and professional development. Additionally, this research may be valuable for those who assess social work education to consider the professional value of personal therapy and attitudes regarding its requirement in the profession.

### **Implications for Future Research**

It is evident, that based on the previous research and findings of this survey, that therapists utilize and support utilizing personal therapy. Surprisingly, the results of this research may indicate the concerns presented by Clark (1986) are still valid today. Clark (1986) questions the stress for therapists to undergo personal therapy, emphasizing the lack of evidence that personal therapy actually makes for a more efficacious practitioner. The author concludes, “in five of the studies no relation was found between patient outcome and whether the therapist had or had not experienced therapy” (p. 542). Clark (1986) asserts the need for future research to forgo the assumption that personal therapy is positive, and urges researchers to demonstrate an effect on client outcomes. Similarly,

the respondents in this research indicated that therapy was common and beneficial for therapists personally, but less widely recognized or able to be substantiated professionally.

Previous research acknowledges the difficulty of distinguishing professional efficacy from personal and professional benefits from therapy. Norcross (2005), recognizes this position stating “randomized clinical trials of the efficacy of psychologists personal therapy have not been conducted and probably never will be” (p. 847). Future research should continue to expand on and distinguish the ways personal therapy benefits the mental health professional. As further research refines what we know, perhaps someday it can be established if and exactly how personal therapy impacts professional efficacy.

This study could be helpful for future social workers and current mental health professionals as they contemplate the general helpfulness of therapy in their personal and professional lives. Past research and this data set continue to highlight personal therapy as beneficial to therapists in training and current professionals. However, conclusions that personal therapy improves professional efficaciousness cannot be made. This is reflected in the lack on consensus and underwhelming regard that personal therapy should be a requirement in training or licensure.

This research ultimately reiterated an early recommendation is psychotherapy. As Freud asked in *Analysis Terminable and Interminable* (1937), “But where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession? The answer is an analysis of himself” (p. 246). Personal therapy as beneficial to the

professional psychotherapist is a recommendation (not requirement) that is widely supported today.



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## Appendix A

Hello!

I am a graduate student at the University of St. Thomas. I am completing a research project for graduation and am requesting your participation. This study is being conducted by: Samantha Lundgren, MSW student with the supervision of Colin Hollidge, Ph.D., LICSW.

The purpose of this study is to explore clinical social workers' value and view of personal therapy. Results of this survey will not only add to the body of knowledge on how clinical social workers' view personal therapy, but will also serve as a valuable tool in understanding how personal therapy impacts professional competence.

This survey is 25 questions long should take less than 15 minutes to complete. All survey responses are completely anonymous. There were three possible risks identified for participants in the survey: you could feel vulnerable revealing personal information about past personal therapy, participation may evoke difficult emotions associated with past or current therapy and that participation could bring up material that would make participant feel a need to seek therapy. These risks are not considered likely to occur. Participation is voluntary and you should only answer questions with which you are comfortable.

If you consent to participate, the survey is available by clicking the following link: \_\_\_\_\_ or by visiting [www.qualtrics.com](http://www.qualtrics.com).

If you have any questions you may contact me at (612) 834-6885. If you desire you may also contact the supervisor of this study, Colin Hollidge, Ph.D., at (651) 962-5819. You may also contact the University of St. Thomas Institutional Review Board at (651) 962-5341 with any questions or concerns.

Your participation is greatly appreciated.

Sincerely,

Samantha Lundgren, MSW student

**Appendix B****Survey**

1. I am an LICSW:
  - a. True
  - b. False
2. I am:
  - a. Male
  - b. Female
  - c. Transgender
  - d. Other: \_\_\_\_\_
3. How old are you?
  - a. Younger than 30
  - b. 30-50
  - c. Older than 50
4. Number of years in practice?
  - a. Less than 10
  - b. 10-20
  - c. More than 20
5. What is your theoretical orientation?
  - a. Psychodynamic/Psychoanalytic/Attachment
  - b. Cognitive/Behavioral
  - c. Humanistic/Person-centered
  - d. Systems
  - e. Eclectic/Integrative
  - f. Other
6. I have sought personal therapy in the past:
  - a. Yes
  - b. No
7. If you did not seek personal therapy, the main reason was: (Norcross, 2008)
  - a. I received sufficient support from friends, family, coworkers
  - b. I dealt with stress in ways other than therapy
  - c. I did not need therapy.
  - d. I did not have time for therapy.
  - e. I knew all the therapists in my locale.
  - f. Cost
  - g. Other: \_\_\_\_\_
8. If you did seek personal therapy, the main reason for seeking personal therapy was: (Strozier, Stacey, 2001)
  - a. Personal Crisis/Change
  - b. Anxiety
  - c. Depression
  - d. Family of Origin problem
  - e. Interpersonal difficulties
  - f. Substance abuse issues
  - g. Training requirement

- h. Professional growth
  - i. Professional distress
  - j. Marital/Couples counseling
  - k. Family counseling
  - l. Other: \_\_\_\_\_
9. Did your graduate training program require you as a therapist-in-training to enter personal therapy while in graduate school? (Pope, Tabachnik, 1994)
    - a. Discourage – Neutral -- Recommend -- Require
  10. At what point in life did you first enter personal therapy? (Pope, Tabachnik, 1994).
    - a. Prior to graduate school
    - b. During graduate school
    - c. While a professional
  11. What type of personal therapy have you participated in?
 

a. Individual	yes	no
b. Group	yes	no
c. Couples	yes	no
d. Family	yes	no
  12. Approximate length on time in therapy
    - a. < 3 months
    - b. 6 months to 1 year
    - c. 1 – 2 years
    - d. More than two years
  13. What was your most recent therapist’s theoretical orientation? (Curtis, Field, Kostmann)
    - a. Psychodynamic/Psychoanalytic
    - b. Cognitive/Behavioral
    - c. Humanistic/Person-centered
    - d. Systems
    - e. Eclectic/Integrative
    - f. Other
    - g. Unknown
  14. How much time has passed since your last experience in personal therapy? (Pope, Tabachnik, 1994)
    - a. Currently in personal therapy
    - b. Less than 6 months
    - c. 6 months to 1 year
    - d. 1-2 years
    - e. 2- 5 years
    - f. 5+ years
  15. How helpful has your experience in personal therapy been?
    - a. Harmful—Neutral --Helpful – Extremely Helpful
  16. Please rank up to four ways personal therapy has been beneficial to your practice as a social worker: (Strozier, Stacey, 2001)(Grimmer and Tribe, 2001) (Macran Stiles Smith, 1999)
 

a. Increased self-awareness	yes	no
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b. Dealt with own issues	yes	no
c. Increased sensitivity to client	yes	no
d. Increased awareness/validation of therapeutic process	yes	no
e. Reduced countertransference	yes	no
f. Better understanding of personal boundaries	yes	no
g. Reduced professional stress/burnout	yes	no
h. A form of self care	yes	no
i. Therapist serves as a professional model	yes	no
j. Know what not to do as a therapist	yes	no
k. Hold back from jumping in to help client	yes	no
l. Work at a deeper level with client	yes	no
m. Other: (Please Explain)		

To what degree do you agree or disagree with the following statements:

17. Personal therapy helped me develop personal insight that has helped in my practice as a therapist. (Bellows, 2007)
18. I would be comfortable with my colleagues knowing I have engaged in personal therapy.
19. I work differently with my clients because I have had personal therapy. (Bellows, 2007)
20. Personal therapy has helped my growth and development as a professional.
  - a. Strongly disagree – Disagree – Neutral -- Agree -- Strongly Agree
21. How has your therapist's style informed your practice?
  - a. I think of my therapist and use as model to act similarly.
  - b. I think of my therapist and use as model of what not to do.
  - c. Both
  - d. None of the above
22. Do images or thoughts of your therapist come to mind while you're conducting psychotherapy? (Bellows, 2007)
  - a. Yes
  - b. No
23. Personal therapy has helped my growth and development as a therapist.
  - a. Strongly disagree – Disagree-- Agree – Strongly Agree
24. Do you have thoughts of returning to therapy? (Pope, Tabachnik, 1994)
  - a. Yes, in the immediate future
  - b. Someday, if needed
  - c. No
  - d. Never, therapy was not helpful or was harmful.
  - e. I do not know.

To what degree do you believe:

25. Personal therapy would be beneficial to therapists-in training. (Pope, Tabachnik, 1994) (Strozier, Stacey, 2001).
26. Personal therapy should be required in psychology graduate school. (Pope, Tabachnik, 1994).
27. Licensing boards should require personal therapy. (Pope Tabachnik, 1994)
  - a. Strongly disagree—Disagree--Neutral—Agree--Strongly Agree



