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The examined life: personal therapy and the social worker's ethical obligations to self

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THE EXAMINED LIFE:
PERSONAL THERAPY AND THE SOCIAL WORKER'S ETHICAL OBLIGATIONS TO SELF

by

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CERTIFICATE OF APPROVAL

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MASTER'S THESIS

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This is to certify that the Master's thesis of

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To Judy

When someone knocks on the door,
Think that he's about
To give you something large: tell you you're forgiven,
Or that it's not necessary to work all the time,
Or that it's been decided that if you lie down no one will die.

Robert Bly, *Things to Think*

A monk asked Chao-chou, “I have just entered the monastery:
please give me some guidance.”
Chao-chou said, “Have you eaten your rice gruel?”
The monk said, “Yes, I’ve eaten.”
Chao-chou said, “Then go wash your bowl.”

Zen Mondo

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But especially to Judy, who was there to help me save my life. It is true: the inner world *does* say much to those who choose to listen.

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CHAPTER I

LITERATURE REVIEW ON THE EFFICACY OF PSYCHOTHERAPY AND THE IMPACT OF PERSONAL THERAPY FOR MENTAL HEALTH PROFESSIONALS

Introduction

How people take care of themselves is the subject of much discussion and research (Mahoney, 1997). From reading and exercise to vacations, church, hobbies, and other leisure activities, self-care has been defined in a broad and expansive manner, often to the detriment of clarity or consistency. What exactly does self-care mean and what does it include? For the purposes of this examination, the value of self-care will be defined as purposive, intentional, and goal-oriented, with strategies that serve both preventive and remedial functions. In this way, self-care as a concept may include life-affirming pursuits that involve vacationing or hobbies, although its scope is more focused.

With self-care as the personal value, individuals devise different strategies to promote or enhance that value in their lives, utilizing various means of implementing those strategies. For instance, one may believe that separating work from family is essential for self-care, committing to rent a lakeside cabin every summer with her spouse and children. This example is three-fold: self-care is the individual's value, drawing a boundary between work and family is her self-care strategy, and vacationing with family is one of the means to achieve that end.

For many, the value of self-care is best promoted or enhanced by strategies that go beyond boundaries between work and family, such as self-awareness, the ability to tolerate emotional distress, mindfulness, or improved relationships. These strategies are

regularly called upon when life's difficulties become too overwhelming to manage with intimate and intense phone conversations between friends, or when the world seems to be exceedingly out of control for one to tolerate. In such situations, personal therapy is often used to navigate oneself back to a state of emotional contentment and equilibrium. Here the self-care strategy would be, for instance, personal betterment or a reduction in emotional distress, with personal therapy as the means to implement that self-care strategy.

This thesis aims to address the role that therapy plays in the self-care of mental health professionals, specifically social workers. In the first chapter, the efficacy of psychotherapy is addressed through a review of the existing literature on the subject, followed by a comprehensive literature review of personal therapy for therapists in the context of personal and professional development. Chapter Two presents the methodology used in my own research on social workers' attitudes toward and experiences with personal therapy. Results of the analysis of these data are presented in Chapter Three. There are several authors who have researched the intersection of personal and professional development vis-à-vis personal therapy for therapists, and I complement their findings with data from my own research. However, the ways in which care-for-clients and self-care (for therapists) interconnect is an area of research that is largely absent in the literature, and my thesis begins to bridge that gap.

Chapter Four provides a discussion of my findings with implications for practice, education, and the National Association of Social Workers (NASW) Code of Ethics. That is, are ethical obligations to clients, colleagues, and the profession sufficient for social workers? Many authors conclude their studies with the recommendation that more

research needs to be done in the area of codifying the value of self-care. Thus, one of the primary themes of this thesis is the ethical obligation to self. Finally, the experience of clinicians in rural practice has been insufficiently researched, particularly with respect to occurrences of burnout, vicarious traumatization, and the need for personal therapy or clinical supervision. How concerns surrounding confidentiality merge with issues of competence and self-care is at the heart of the debate about practitioners seeking personal therapy in rural areas. My thesis looks more carefully at these concerns through the qualitative data in Chapter Three and in the discussion and implications section of Chapter Four.

The Efficacy of Psychotherapy

Wampold (2001) provides the following criteria in his definition of psychotherapy:

- It is a primarily interpersonal treatment;
- Based on psychological principles;
- Involving a trained therapist and a client who has a mental disorder, problem or complaint;
- Intended by the therapist to be remedial for the client;
- Adapted or individualized for the particular client and his or her disorder, problem or complaint (p. 3)

According to Wampold, symptom relief is not the explicit pursuit of therapy; it is not why clients[1] seek psychotherapeutic assistance. Rather, "people seek psychotherapy [to obtain relief from] the demoralization that results from their symptoms" (Wampold, 2001, p. 24).

That psychotherapy is efficacious has been demonstrated through various analyses, meta-analyses, and meta-meta-analyses. Wampold (2001) examined the first

[1] Throughout this paper, the word "client" will be used, although many of the cited authors refer to "patients." The two terms are presumed to be interchangeable.

meta-analyses carried out by Smith, et al., in 1977 and 1980, the second of which reviewed 475 studies done on the efficacy of psychotherapy; 1766 effect sizes were produced by these studies, with an arithmetic average effect size of .85. Effect sizes are useful in meta-analyses because they "portray the strength of association [between variables] found in any study, no matter what outcome measure is used" (Rubin & Babbie, 2005, p. 609). In this way, the results of studies whose outcome measures differ can still be compared and contrasted. What the average effect size in this second meta-analysis shows about the efficacy of psychotherapy is that "the average client receiving therapy would be better off than 80% of untreated clients, that the treatment accounts for over 15% of the variance in outcomes, and that the success rate would change from 30% for the control group to 70% for the treatment group" (Wampold, 2001, p. 67).

Wampold (2001) reports on a meta-meta-analysis carried out by Grissom in 1996 on the 68 meta-analyses that produced "an aggregate effect size of .75 for the efficacy of psychotherapy" (p. 70). What these analyses demonstrate is that psychotherapy is very efficacious. Carrying out research on the outcomes of psychotherapy is complicated, to say the least. While the meta-analyses show the efficacy of psychotherapy, *how* that efficacy has taken place in therapeutic relationships does not come through in these researchers' data. In other words, was psychotherapy deemed successful if a client's symptoms were reduced for 6 months, or if a client experienced drastic personality change that lasted throughout the remainder of her lifetime? What does efficacious psychotherapy look like and how can this be comprehended in the context of each client's unique presenting disorder, problem, or complaint?

The ways in which this efficacy can best be understood are through the common factors inherent in all psychotherapeutic interventions. In his summary of the findings of The American Psychological Association's (APA) Division of Psychotherapy Task Force, Norcross (2002) notes that this task force's objective "was to identify empirically supported (therapy) relationships rather than empirically supported treatments – or ESR's rather than EST's" (p. 6). This objective stems from the debate surrounding evidence-supported, yet "personless" treatments. Norcross (2002), a prolific researcher in the areas of both psychotherapeutic efficacy and personal therapy for therapists, states that

> the EST lists and most other practice guidelines depict disembodied therapists performing procedures on Axis I disorders. This stands in marked contrast to the clinician's experience of psychotherapy as an intensely interpersonal and deeply emotional experience. Although efficacy research has gone to considerable lengths to eliminate the individual therapist as a variable that might account for patient improvement, the inescapable fact is that the therapist as a person is a central agent of change. The curative contribution of the therapist is, arguably, as empirically validated as manualized treatments or psychotherapy methods (p. 4).

What Norcross calls the therapist-as-a-person is further validated by the findings of Asay and Lambert (1999), that the therapeutic relationship accounts for 30% of improvement in psychotherapy patients; extratherapeutic change ("those factors that are a part of the client…and part of the environment…that aid in recovery regardless of participation in therapy" [p. 31]) accounts for 40% of improvement; techniques ("those factors unique to specific therapies" [p. 31]) make up 15% of improvement; and expectancy (placebo effects) ("that portion of improvement that results from the client's knowledge that he or she is being treated" [p. 31]) accounts for 15% of improvement in psychotherapy patients. Furthermore, it has been found "that patients who did not improve in therapy did not relate well to the therapist and kept the interaction superficial"

(Asay & Lambert, 1999, p. 32). In his summary of a questionnaire study of psychotherapists, Grunebaum (1983) shares that the majority of outcome studies pointed toward the influence of "mutual liking" between therapist and client, versus technique-driven aspects such as insight or interpretation.

Use of self as a means of evaluating practice has been found to be commonplace amongst psychotherapists, with those means varying based on a clinician's theoretical orientation (Ventimiglia, et al., 2000). "Professional use of self appears to be the comparison of a given client's unique presentation with the clinician's recalled images of the presentations of other clients with similar difficulties or needs…. [and] it proved to have a basis in particular empirical observations. Professional use of self was also a source of new questions to explore and to theorize from, in order to determine how to examine these reactions empirically" (Drisko. 2001, p. 424). Reconnecting the "examination of client" and "examination of self" is a theme that will emerge throughout this paper.

A therapist's ability to relate well to the client, "in a manner consistent with that of the client…[along with]…supportiveness, attentiveness, openness, and involvement are associated with [client] outcomes" (Miller, 2000, p. 212). The interactions between client and therapist have been shown to influence outcomes for clients, and "it is the client's early-in-treatment perception of the therapist-offered relationships that is the strongest predictor of outcome" (Miller, 2000, p. 212). This finding has been corroborated by Roseborough (2006), who shows that psychodynamic psychotherapy is effective over time, with considerable importance in the first 3 months.

What has been summarized about the therapist-as-a-person and the "critically important link between the therapist's personality and what he or she does in the therapy hour" (Edwards & Bess, 1998, p. 90) is that success or improvement in psychotherapy has more to do with the relationship between clinician and client, and whether or not that client *feels* that s/he has been helped, than with the evidence-based, "personless," techniques on which many have focused in the last few decades. There is some disagreement over this assertion. Reid (1997) reviewed meta-analyses that cite differences in treatment outcomes based on modality (e.g., cognitive-behavioral versus interpersonal). What he concluded is that several studies have demonstrated better outcomes with behavioral or cognitive-behavioral interventions than other modalities. This has been countered several times over, however, in that "all forms of psychotherapies do about equally well… [These results] come as a rude shock to efficacy researchers, since the main theme of efficacy studies has been the demonstration of the usefulness of specific techniques for specific disorders" (Seligman, 1995, p. 969).

In many of the studies reviewed by Reid (1997), the differences in outcomes "disappeared when 'investigator alliance' was used as a control variable" (p. 7). However, the allegiance of an investigator to one treatment modality over another does not necessarily suggest lack of substantiation for the effectiveness of that modality. Perhaps a clinician's confidence in her own treatment methods – much like the influence of the placebo effect on a client's success in therapy – contributes to the success of therapy because it allows her to form a thriving therapeutic alliance with her client aided by her own sense of usefulness. In this way, what might present as differences between

improvement in research subjects versus control group based on technique/interventions are actually attributable to the competence (i.e., person) of the therapist.

The debate over the effectiveness of one modality over another is muddied by clinically-disconnected methodology. What appears to be of greater concern in the research of evidence-based practices (done to prove the effectiveness of one treatment modality over another) is that they use

> structured, manualized treatments applied to people with a single psychiatric diagnosis. Although strong in design (i.e., providing strong internal validity), questions have been raised about the applicability of the findings from these efficacy studies to real-life clinical settings. This is a concern for many clinicians in that the majority of potential research subjects in such efficacy studies, especially those with more than one diagnosis, are often screened out up front (Roseborough, 2006, p. 166).

As Seligman (1995) states, "patients in psychotherapy in the field usually have *multiple problems* [author's emphasis], and psychotherapy is geared to relieving parallel and interacting difficulties. Patients in efficacy studies are selected to have but one diagnosis (except when two conditions are highly comorbid) by a long set of exclusion and inclusion criteria" (p. 967). Seligman's appraisal of psychotherapy is in keeping with the definition provided by Wampold (2001), that therapy is not about the symptoms, per se, but about the client's personal experience that emerges in the face of such symptoms.

The primary issue is less about whether or not one modality of psychotherapy is superior to another, but looks more at the clinical relevance of research that focuses on only one diagnosis or set of observable behaviors. These methods ignore the clinical reality of the overlapping symptoms, behaviors, thoughts, and emotions of complex clients with intricately constructed histories and experiences. In his thorough analysis of social workers' clinical practice evaluation, Drisko (2000) asserts that "variations in the

skills of the therapist and in the motivation and participation of the client are generally unexamined. This unitary view of therapy has been called the 'drug metaphor'…Drug metaphor studies fail to consider client motivation and participation ('compliance') over time, which may be an important omission in the views of practitioners" (p. 200).

The absence of "process" focused research is a concern of many clinicians; that is, the question is not "does psychotherapy work" but more importantly, "how does psychotherapy work?" Miller (2000) calls this outcome research versus process research. He says: "outcome research does not usually collect data on such promising process variables as transferential and countertransferential themes, on the vicissitudes of the therapeutic alliance, on the patients' mental representations of the therapist, and on his or her use of those representations as a referent. Process focused research can examine how such variables relate to outcome" (p. 214).

In addition to the concern about methodology, there is an overrepresentation of behavioral methods in efficacy research, due in part to the fact that behavioral interventions are more conducive to quantitative research, but also because behaviorists have the "strongest tradition of conducting research" (Miller, 2000, p. 209). The absence of long-term studies is another sizeable gap in the literature, with greater presence of short-term research that can avoid the array of threats to validity that are present in longer term research (Miller, 2000).

Seligman (1995) notes that

> hundreds of efficacy studies of both psychotherapy and drugs now exist – many of them well done. These studies show, among many other things, that cognitive therapy, interpersonal therapy, and medications all provide moderate relief from unipolar depressive disorder; that exposure and clomipramine both relieve the symptoms of obsessive-compulsive disorder moderately well but that exposure has more lasting benefits; that cognitive therapy works very

> well in panic disorder; that systematic desensitization relieves specific phobias; that 'applied tension' virtually cures blood and injury phobia; that transcendental meditation relieves anxiety; that aversion therapy produces only marginal improvement with sexual offenders…; that flooding plus medication does better in the treatment of agoraphobia than either alone; and that cognitive therapy provides significant relief of bulimia, outperforming medications alone (p. 965-966).

In their work with the Michigan State Psychotherapy Project, Karon and VandenBos (1971) demonstrated that psychoanalytic psychotherapy is very effective in the treatment of schizophrenia, further observing that "most patients did 'resolve' their acute psychotic reactions within four weeks" (p. 16). These authors go on to state that the personality and preparedness of the therapist was a factor in client improvement. Kingdon and Turkington (2005) have shown that individuals with schizophrenia or other psychoses respond well to cognitive therapy. Gottdiener and Haslam (2002) have also provided data on the effectiveness of individual psychotherapy for those diagnosed with schizophrenia.

Results from the NIMH study of depression showed that "medication lifted symptoms of depression rapidly and effectively, but that psychotherapy in combination with medication provided more general improvement. Both interpersonal and cognitive-behavioral therapies were useful. Even those in the control condition showed improvement [though much less so than the psychotherapies (Miller, 2000)], suggesting that relationship may be a powerful influence on this population" (Drisko, 2000, pp. 198-199).

The efficacy of psychotherapy has also been documented by brain research and neuroimaging. In a recent study on brain change in clients diagnosed with borderline personality disorder, (Schnella & Herpertz, 2007), the participants, after dialectical

behavioral therapy, showed changes in the areas of their brains ostensibly related to borderline personality disorder. Viinamäki, et al., (1998), have also demonstrated changes in serotonin levels following psychodynamic psychotherapy for borderline personality disorder. Baxter, et al., (2000) and Schwartz, et al., (1996) provided the most compelling evidence of brain change in the cognitive treatment of obsessive-compulsive disorder, indicating a decrease in the head of the right caudate nucleus and orbitofrontal cortex. Through PET scans, Brody, et al., (2001), verified that severely depressed patients exhibited improvements in neural metabolic abnormalities after 12 weeks of either an SSRI (Paxil) or interpersonal psychotherapy. The relationship between psychotherapy and brain functioning has been indicated throughout the literature, and brain research continues to grow in its range and reputation; indeed, its scope is too expansive to pursue further for the purposes of this study.

What is consistently confirmed in the research on efficacy and neurological change is that psychotherapy works. Studies on the effectiveness of psychotherapy – or, *how* psychotherapy works – continue to emphasize the importance of the therapeutic alliance between clinician and client.

Risks Facing Mental Health Professionals

Expanding on Norcross' assertion that for therapy to be effective it must be a mutual experience between two (or more) individuals, my examination seeks a further explanation of what takes place in the therapist. What constitutes an able psychotherapist, and how does she[2] ensure her own peace-of-mind, emotional well-being,

[2] Throughout this paper, references to therapist and client will alternate between female therapist/male client and male therapist/female client for the sake of both gender neutrality and clarity.

and personal identity in the face of otherwise stressful and potentially damaging experiences with clients?

Since social workers provide more psychotherapy services in this country than other mental health professionals (e.g., psychiatrists, psychologists, licensed professional counselors [LPC], marriage and family therapists [LMFT]) (Strozier & Stacey, 2001), this paper focuses research on social workers in clinical practice. Much of the existing literature, however, addresses mental health professionals from different backgrounds, primarily psychology and psychiatry. For the purposes of clarity, "social worker" will be used only when experiences unique to social work are being discussed; "psychotherapist" and "clinician" will be used to refer to any mental health professional engaged in psychotherapy, regardless of training or professional discipline. The remainder of this chapter will use the terms "psychotherapists" and "clinicians," although language found in the literature often references residents (psychiatry) and counselors (psychology).

Mental health professionals are at risk for many disturbances, including but not limited to "depression, anxiety, substance abuse, and relationship dysfunction" (Gilroy, Carroll, & Murra, 2002, p. 402). Numerous researchers have identified psychotherapy as a profession susceptible to increased stress when compared with other occupations (Deutsch, 1984; Farber & Heifetz, 1982; Rothschild, 2006). Additionally, the physical consequences of such emotional risks have been well documented (Rothschild, 2006).

Farber and Heifetz (1982) posit that the single greatest contributor to psychotherapists' stress is the "lack of therapeutic success…that is, the inability to promote positive change in patients" (p. 298). This potential source of strain on mental health professionals is identified in other areas of the research literature as well, although

rarely is it isolated as the primary stressor to therapists. Rather, there are other, more comprehensive components identified as risks to psychotherapists. Throughout the literature, four primary areas of impact emerge as summarized here by Rothschild (2006): "The therapist who is unable to distinguish her own feelings from those of her client, and who also feels at the mercy of her client's feelings, may increase her risk for" (p. 27) compassion fatigue, vicarious traumatization (VT), burnout, and unmanageable countertransference. A discussion of each follows.

Rothschild (2006) defines compassion fatigue as "a general term applied to anyone who suffers as a result of serving in a helping capacity" (p. 14). According to Fox (2003), vicarious traumatization is different from compassion fatigue in that it "refers to the effects which graphic and painful material (e.g., death, violence, injury, 9/11) presented to us by different individuals, produces *[sic]* in our own cognitive schemas or beliefs, expectations, and assumptions about ourselves and others" (p. 48). As Rothschild (2006) says, vicarious (or secondary) traumatization in therapists occurs as a result of the "direct experience of witnessing" (p. 14).

There are three characteristics of vicarious traumatization: first, it is "an individual phenomenon that affects each worker differently;" second, it is a "cumulative process; it affects workers across clients [versus simply with traumatized clients];" and third, it is "pervasive; it can affect all areas of workers' lives, including emotions, relationships and your view of the world" (Clemans, 2004, p. 65). Clemans further identifies three specific effects of vicarious traumatization: "(1) feelings of vulnerability and fear, (2) difficulty trusting in personal relationships, (3) a changed view of the world" (pp. 65-66).

Emotional exhaustion and fatigue have been described as two of the most commonly identified problems cited by psychotherapists (Mahoney, 1997). While many would describe these as signs of burnout, Rothschild (2006) clarifies that burnout is only recognized in situations where a clinician's workload has been wholly damaging to his ability to positively manage and cope with his life. Fox (2003) incorporates Mahoney's (1997) assertions when he distinguishes four experiences likely to be felt by the burned-out therapist: emotional exhaustion, feelings of being unable to help the severely distraught, cynicism due to minimal progress, and isolation or lack of support. The "nonreciprocated attentiveness and giving that are inherent within the therapeutic relationship," or "giving without the compensation of success" have also been said to lead to burnout (Farber & Heifetz, 1982, p. 298).

Finally, countertransference – what Freud (1910, 1915) described as the unresolved conflicts within the therapist that inform her own reactions to her client – is inextricably bound up with the previous three risks facing therapists. This is because countertransference is not simply related to the here-and-now of emotionally demanding work, but is also linked to the clinician's past experiences. Here, more than in any of the other areas, the therapist-as-a-person becomes distinctly felt, for he is not a disembodied automaton doing manual work with emotionally involving clients; he is, indeed, a person in his own right, with influences, burdens, and experiences that extend well beyond the clinical time and space.

When Freud first conceptualized countertransference he spoke of it as something to be "overcome" (1910) and kept "in check" (1915). Countertransference has since been recognized as a clinically relevant instrument that can inform a clinician's approach to

her client (Fox, 2003; Brenner, 2006). When one considers Freud's (1937) adage "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), it is surprising that he failed to recognize the value of using countertransference as a clinical indicator.

In the context of countertransference, the therapist-as-a-person is worthy of further scrutiny. Why is it that certain individuals opt for this profession? McCarley (1975) presents this examination:

> There are deep-seated, unconscious reasons, rooted in family dynamics, that motivate a person's choice of a caretaking career role such as that of psychotherapist. A significant number of psychotherapists are drawn to the role of caretaker because they were assigned this function early in life in their families. The role of caretaker allows for some symbolic gratification of one's own needs through identification with the client or patient to whom one is giving. And, over time, a fairly stable balance may be struck between giving care to others and receiving care. However, this balance is frequently precarious because the originally assigned role carries with it a proviso that the caretaker must be the 'strong one' who keeps out of consciousness *his* need to be cared for [author's emphasis]" (p. 223).

Given this observation about therapists' motivations for entering the profession, how does one guard against the overwhelming need for personal fulfillment at the expense of clients? That some individuals become therapists because of unresolved issues from their past, or for narcissistic yearnings to feel important and needed, or even because of their own positive experiences in personal therapy, may seem self-evident to some, as the idiosyncrasies or imperfections of mental health professionals are often popularly presented. But acknowledging these assumptions about therapists is not intended to negatively frame the process or benefits of therapy. Rather, it is to properly concentrate on the ways in which psychotherapists are able to put to use their own pasts to facilitate their clients' healing.

If countertransference can be used as a clinical tool to help deepen a clinician's understanding of the client, the question arises of whether that clinician necessarily requires his own personal therapy. Brenner (2006) argues that "personal treatment [therapy] may decrease the chances that the therapist will use the patient for his or her own gratification" (p. 270). Wheeler (1991) goes on to say:

> Unresolved issues with significant others in the counsellor's life may be present in the therapy session, with the client representing the part of the significant other. It is difficult to see how the counsellor can successfully cope with this situation to the benefit of the client, without personal therapy, to clear away the cobwebs and allow the client to be seen for themselves, rather than an echo of someone else (p. 199).

The role of personal therapy for therapists is a somewhat contentious topic, for it casts a light not simply on the effectiveness of psychotherapy – which has been demonstrated – nor the "woundedness" of mental health professionals, who are as human as any other clients. Rather, it raises in one's mind the relevance of personal therapy for new and experienced therapists alike. Indeed, preventing or addressing compassion fatigue, burnout, and/or vicarious traumatization are often seen as essential functions of group therapy, supervision, training, and other supportive networks within graduate programs and agency settings. One could argue, though, that in many cases supervision and training (within an agency) are insufficient self-care strategies, and the aid of support systems (coworkers, graduate school cohort, etc.) only extends so far. What personal therapy can provide goes much deeper than other means of self care and, according to much of the literature, the benefits of therapy for therapists are vast. The following section examines the ways in which personal therapy for mental health professionals has been shown to be effective.

Therapy for Therapists

In a review of the literature on the subject, Norcross (2005) verified that the majority of mental health professionals – regardless of the field in which they practice – have undertaken their own personal therapy. According to research that reviewed 17 studies with over 8,000 participants, around 72-75% of the research participants had received at least "one episode of personal therapy themselves" (p. 841).

These data have been corroborated by others, including Macran, Stiles, and Smith (1999). Many have contended that personal therapy for therapists serves multiple functions, which will be examined in detail throughout the remainder of this chapter. As one participant in Elman and Forrest's study (2004) asserts about the usefulness of one's own therapy, "It certainly doesn't indicate much confidence in our training if we don't think there is a potential for positive outcomes" (p. 126).

The greater part of the literature on personal therapy for therapists focuses on graduate students – primarily masters' or doctoral level counseling psychologists, with some research on MSW students and psychiatric residents – and their attitudes toward and experiences with personal therapy. The role that graduate programs play in mandating personal therapy will be discussed further at the end of this chapter. However, it is notable that in their research on clinical psychology graduate students, Holzman, Searight, and Hughes (1996) found that "of those respondents who had been in therapy prior to or during graduate school, the vast majority, 99%, reported that they were still in therapy or would consider seeking treatment again" (p. 99).

Personal therapy is not simply an experience relevant for incoming therapists; as Norcross (2005) has shown, "the fact that psychotherapists seek personal treatment

repeatedly during their careers supports the conclusion that it is widely perceived as an essential part not only of the formative training phase but also of the practitioner's ongoing maturation and regenerative development" (p. 842). Freud (1937) postulated that "every analyst ought periodically…to enter analysis once more, at intervals of, say, five years, and without any feeling of shame in doing so" (pp. 248-249).

There has been less research done on the negative impact that personal therapy can have on therapists, although the research that does exist tends to point toward the risk that graduate students in training may become too immersed in the emotional struggles they are examining in therapy to be able to properly attend to their own clients (Clark, 1986; Brenner, 2006; Grimmer & Tribe, 2001). Moreover, Macaskill and Macaskill (1992) have noted that out of their respondents (N=27), 38% experienced negative effects during their therapy, including relationship strains, emotional withdrawal, and increased psychological distress. In this same study, however, 87% of respondents – including some of those who cited negative effects – stated that they experienced positive effects, such as greater self-awareness, self-esteem, and reduced symptoms. As therapy is "often expensive in both time and money, it can, in these respects, add to the stress experienced by…[students]…who may already feel overextended" (Brenner, 2006, p. 270). The role that financial cost plays in personal therapy for therapists will be explored in greater depth later in this chapter.

The most widely debated aspect of personal therapy for therapists is its impact on outcomes for clients; that is, do therapists who have engaged in their own personal therapy actually become better therapists, as evidenced by outcome measures of their own clients? Atkinson (2006) acknowledges the scarcity of "empirical evidence that

personal therapy for therapists has any measurable effect on client outcomes" (p. 408). The literature disagrees on the subject, and consistently points to difficulties in measuring such connections "in isolation from other variables" (Mackey & Mackey, 1994, p. 491). The debate on client outcomes is not the focus of this paper; however, a brief review of what the existing research shows on this subject is still worthwhile.

Wheeler (1991), in her study on the effects of counselor training in the establishment of a therapeutic alliance with clients who present with an eating disorder, notes that personal therapy for the therapist correlated negatively with the therapist's prediction of a therapeutic alliance. She postulates that this could be due to decreased confidence on the part of the therapist (in predicting an alliance); it could also suggest that "more personal therapy gives the therapist more confidence to allow the development and expression of a negative transference, a more reality based relationship, rather than one seen through rose colored spectacles" (p. 197).

Clark (1986) reports that psychiatric residents who had applied for therapy but did not receive it showed the least improvement during their training years. The analyses performed by Sandell, et al. (2006), of length of training therapy for the clinician as it affected patient outcome "did not show that shorter training therapies are better for the patients than longer training therapies… the rate of patient change on the GSIsqrt was at its highest (or best) among the 38 cases with training therapies of 7 or 8 years of duration…and at its lowest (or worst) among the 37 cases with durations of 13 or 14 years… Thus, the relation between training therapy duration and patient outcome seems to have been curvilinear" (p. 312).

It is difficult to account for all the variables at play in the outcome of therapy for a client; demonstrating a statistically significant relationship between the competence of a psychotherapist as influenced by her own therapy and its subsequent effect on client outcomes is tenuous at best. "What does seem to be related to client outcome," says Clark (1986), "is the experience of the therapist" (p. 542). Returning to the evidence for the efficacy of psychotherapy, approximately 30% of a client's success can be attributed to the therapeutic relationship (Asay & Lambert, 1999). Therefore, it could be argued that when the therapist is capable of attending to the relationship in a confident manner, and without unexamined countertransference, the relationship will be healthier and more effective. As Williams (1999) shows,

> if many practitioners enter this field because of their own unmet needs …there clearly are concerns about a therapist's own mental health and psychological functioning interfering with his or her responses to clients. Therefore, if the therapist's disturbance can be reduced by personal therapy, clients' treatment and outcome might be improved (p. 546).

Or as Patterson and Utesch (1991) note, "the person of the therapist is as important, if not more so, than the skill of the therapist" (p. 333). That is, the person (emotional well-being, ability to join with client using healthy boundaries and without unexamined countertransference) of the therapist has a greater impact on the likelihood of efficacious therapy than does her skill (technique) (Asay & Lambert, 1999).

The Personal and Professional Self

The ways in which personal therapy positively influence therapists' personal and professional development remain at the heart of most research in this area. Macran, Stiles, and Smith (1999) cite five areas of professional development: alleviating the stress of daily practice and aiding in emotional stability; improving self-awareness (and

personal problems/countertransference); experiencing the role of client; observing another therapist and her methods and interventions; and increased confidence in the usefulness of therapy.

As was discussed earlier in this paper, psychotherapists are at increased risk for struggles with depression, substance abuse, and relationship difficulties (Gilroy, Carroll, & Murra, 2002) when compared to the general population. Personal therapy as a means of resolving these issues is a self-evident response, as therapy is a common intervention for *anyone* wrestling with interpersonal or intrapsychic distress. Norman and Rosvall (1994) state: "With the stress that is inherent in the profession of psychotherapy, unwillingness to seek personal treatment may well place therapists at psychological risk" (p. 459). As maintained in the literature, personal therapy for therapists offers a unique opportunity for growth that, for many clinicians, exceeds the advantages offered by other professional and personal preparations for the career (e.g., graduate school, training programs, supervision, etc.) (Norcross, 2005).

The opportunity to complete "family-of-origin" work is one of the more evident personal benefits of therapy for therapists. Timm and Blow (1999) discuss the undue negative associations to family-of-origin vis-à-vis personal (and professional) development in what has been called "The Family of Origin Freeze" (p. 334). What these authors show is that most family-of-origin work for therapists dwells on subjects such as "What issues in therapy were 'too close to home?' How were issues 'getting in the way?' What were potential 'blind spots' in the therapy room" (p. 334)? In other words, working on one's own family-of-origin in therapy simply qualifies one to get in touch with how one's own clients stir up the negative experiences of one's childhood.

The distinction Timm and Blow draw, however, is between understanding the potential limitations certain unresolved family-of-origin based issues may pose, and the strengths and prospective advantages these so-called "blind spots" can present. "There are many events, some of which are even painful or traumatic, which help therapists to be better therapists" (p. 334).

What these authors seem to be saying is that even the "painful or traumatic" events from a therapist's past should not necessarily be conflated with blind spots in work with clients. Perhaps a therapist's negative experiences make her more attuned to the nuances of the client's experience. Moreover, a therapist's positive memories or experiences can have just as much of a "blinding" effect on his work with clients. So it is inadequate to reduce family-of-origin work to the exclusive focus of dredging up the painful in order to keep the therapist on-guard.

Self-awareness is one of the key benefits of personal therapy, as cited by numerous authors (Mackey & Mackey, 1994; Norcross, 2005; Murphy, 2005; Grimmer & Tribe, 2001; Mackey & Mackey, 1993; Macran, Stiles, & Smith, 1999; Wiseman & Shefler, 2001). The ability to recognize key dynamics in one's own personality and family-of-origin and the ways in which these dynamics continue to play out in one's life – indeed, in one's practice – are invaluable for the development of a cohesive sense of self. A participant in the research of Mackey and Mackey (1994) shares this perspective: "As a therapist I'm my tool, but if I'm not aware of my strengths, my weaknesses, my buttons, I'm not going to be of any service to my client" (p. 496). Here the intersection of personal and professional self is illuminated.

Trying to distinguish between personal and professional growth with respect to the benefits of personal therapy is somewhat artificial (Mackey & Mackey, 1994), since both of these dimensions of self are so fundamental to the practicing therapist. To better understand how therapy provides the developing (or seasoned) therapist a superior opportunity for personal/professional growth, Brenner (2006) offers this important distillation of psychotherapy:

> There is a great difference between intellectually knowing about something unsettling (e.g., infantile dependency yearnings, sadomasochism, murderous envy) and coming into live, affective contact with it during one's own personal therapy… As a patient the resident learns the feeling of being on the receiving end of such interventions and can begin to calibrate his or her own instrument for modulating the intensity of the dialogue" (p. 270)

The opportunity to "be the client" is one of the most frequently cited advantages of personal therapy (Grimmer & Tribe, 2001; Mackey & Mackey, 1993; Macran, Stiles, & Smith, 1999; Norcross, Strausser, & Faltus, 1988; Wiseman & Shefler, 2001; Brenner, 2006; Mackey & Mackey, 1994; Gilroy, Carroll, & Murra, 2002; Pope & Tabachnick, 1994; Patterson & Utesch, 1991). Unique to the profession of social work is the shared value of recognizing the forces of oppression on the clients being served. The adage of "walking in someone's shoes" suggests that one cannot properly appreciate the tumult faced by one's client if one has not faced such hardships oneself. However, what the literature suggests is that "sitting in the client's chair" can itself provide for therapists an encounter unlike other learning experiences.

The role of "client" can be very frightening for many therapists, as it represents the "struggle with patienthood where therapists fear that feelings emerging in one's own psychotherapy would erode the carefully honed sense of self-as-healer/patient-as-wounded paradigm, rendering therapists exactly like the patients they are supposed to

help" (Gilroy, Carroll, & Murra, 2002, p. 402). Engaging in this experience requires a paradigm shift that includes valuing "the dignity and worth of the person" as discussed in the National Association of Social Workers (NASW) Code of Ethics (NASW, 1999).

Being able to blur the line between helper and helped aids in the therapist's humility and compassion. Moreover, research on the efficacy of psychotherapy would lend itself to the psychotherapist's humility as it deemphasizes technique when compared with the value of the therapeutic relationship (Asay & Lambert, 1999). As Danieli (1994) notes, "our work calls on us to confront with our clients and within ourselves, extraordinary human experiences. This confrontation is profoundly humbling in that at all times these experiences try our view of the world we live in or challenge the limits of our humanity" (p. 368). In this way, personal therapy can provide a space in which empathy for clients becomes deeper and more personally felt, allowing the therapist to more wholeheartedly meet the needs of her client (Macran, Stiles, & Smith, 1999; Sandell, et al., 2006).

Returning to psychotherapy's efficacy as evidenced by the therapeutic relationship (Norcross, 2002; Asay & Lambert, 1999), the role of a therapist's own therapy to make possible a truly empathic relationship becomes a meaningful point of discussion. In the context of the relationality of therapy, Fromm-Reichmann (1950) went so far as to assert that "any attempt at intensive psychotherapy is fraught with danger, hence unacceptable, where not preceded by the future psychiatrist's personal analysis" (p. 42).

There are differences, says Murphy (2005), between personal growth and professional development, although he is in the minority with respect to these facets of

therapist growth. Murphy delineates four primary processes or phases emerging from his research on personal therapy for therapists: reflexivity (unresolved personal issues; issues rising due to training/education), growth (empathic understanding; expanding awareness), authentication (validation of self; validation of approach), and prolongation (establishing self in profession; positive experience; more personal therapy). His observations, while separating personal from professional, are in keeping with the themes that emerge in other authors' research.

Macran, Stiles, and Smith (1999) created three domains[3] in which they grouped the themes of their research: orienting to the therapist; orienting to the client; and listening with the third ear. One of the fundamental themes (domain 1: orienting to the client) that emerged was "knowing one's boundaries and limitations" (p. 422) or, as a participant in the interviews of Grimmer and Tribe (2001) put it, "…what is my stuff and what is…theirs" (p. 294)?

Another key theme (domain 2: orienting to the therapist) expressed in the research of Macran, Stiles, and Smith (1999) is "holding back from jumping in to help" (p. 422). In allowing a client to experience the discomfort and potential distress often accompanying personal therapy, one of the necessary caveats to this claim is that therapists must discriminate between "doing no harm" and "causing no pain" (Fromm, 2004). That is, an additional function of "being the client" is recalling times when the most growth in one's own therapy came from tension and uneasiness, for both client *and* therapist. This helps to produce the understanding that, as a therapist, one's role is more complex than simply making the client feel better. If a therapist feels compelled to gloss

[3] The domains of Macran, Stiles, and Smith (1999) served as a point of reference for my own survey design, found in the appendix. The methods and results of my research will be presented in Chapters Two and Three of this paper.

over his client's painful emotions in a session, this says more about the therapist than his client. One participant in the research of Mackey and Mackey (1993) illustrates the lesson she learned from having to sift through the tensions in therapy rather than engaging in what might be called "avoidant therapy":

> 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 (p. 105).

Increased confidence in the usefulness of therapy is an important recurring theme in the literature. It has been speculated that "if therapists did not believe that they themselves can benefit from the therapeutic tools of their profession, they have no business practicing them on others" (Williams, Coyle, & Lyons, 1999, p. 554). As Gilroy, Carroll, and Murra (2002) found in their study of female psychologists who have dealt with depression, "greater faith in the therapeutic process" (p. 403) ranked among enhanced empathy, more patience and tolerance when progress is slow, and increased sensitivity to the hard work of therapy, as the ways personal therapy had a positive professional impact on them.

Grimmer and Tribe (2001) cite similar justifications for therapy, adding professional socialization to the other rationales and benefits found throughout the existing research on the subject. This experience of having therapy "modeled" for the therapist-client by his own therapist is one of the benefits about which research participants felt the strongest, as presented in the literature. What Wiseman and Shefler (2001) call the "imitation and identification with the personal therapist" (p. 133), others

have spoken of as "passing the torch" (Norcross, Geller, & Kurzawa, 2000, p. 204) from the perspective of those mental health professionals who have done therapy with therapist-clients. One participant, as quoted by Mackey and Mackey (1994), recalls that "I have found myself sitting in a therapy relationship as the therapist thinking: 'How would she deal with this? Well, she has dealt with this with me and this is what she did'" (p. 494). Returning to the issue of motivations to become a therapist, Patterson and Utesch (1991) note that many graduate students entering the mental health disciplines identify their previous or current experiences in therapy – and the admiration they have for their therapist – as an important inspiration to becoming therapists themselves.

It is nonetheless vital to note that overemphasizing the techniques, skills, or methods of one's own therapist – especially given the likelihood that an aspiring therapist may idealize her own therapist – can be professionally harmful for a psychotherapist. Therapist-clients who experienced harmful effects during their own therapy might inadvertently reenact similar interventions with their own clients, which could be considered a risk of personal therapy for therapists (over-identification with therapist). Conversely, if an intervention did not work on a therapist-client during her own personal therapy, she may be reluctant to engage in certain approaches with her clients, even if such methods could prove highly beneficial (Grimmer & Tribe, 2001). The self-aware psychotherapist needs to remain cognizant of this fact.

Personal psychotherapy is considered by therapists "the most important contributor to their professional development…second only to practical experience" according to Norcross, Strausser, and Faltus (1988, p. 53). In their study of over 4,000 psychotherapists, Orlinsky and Rønnestad (2005, in Norcross, 2005) found that personal

therapy was placed among the top three sources of positive development alongside direct practice and clinical supervision.

Ethical Obligations to Self and Client

Looking at the abundance of research communicating the benefits of personal therapy for therapists, both personally and professionally, the possibility arises of making therapy mandatory in graduate schools, training institutes, or as a licensing requirement. While the empirical evidence supporting or refuting the positive impact that therapists' personal therapy has on their clients' outcome is scant (Norcross, 2005), a case could be made for the ethical dimensions of making personal therapy mandatory for new therapists. That is, a clinician is ethically bound to serve his client to the best of his ability, and if his personal therapy strengthens that capacity by enhancing his own emotional functioning, it would seem clear that this is as central a form of preparation as graduate work or other licensing requirements.

Likewise, when confronted with the risks inherent in the mental health profession (i.e., compassion fatigue, vicarious traumatization, burnout, etc.), what are a therapist's ethical obligations to herself? Are these obligations necessarily restricted to examination in individual personal therapy, or might other treatment approaches such as group therapy, supervision, etc., be equally (if not more) effective (Williams, Coyle, & Lyons, 1999)? Implications for the different professional organizations' codes of ethics will be presented more thoroughly in Chapter Four. What the literature suggests concerning mandating personal therapy will be addressed here. Strong opinions exist on both sides of this argument.

In the United States there are few licensing bodies or graduate programs that require personal therapy for all students studying to become psychotherapists. In many cases, therapy is required of graduate students whose performance or behavior is in question, and personal therapy is used as a corrective measure. However, mandating personal therapy as a tool for development remains most frequently seen in certain psychology graduate programs and nearly all psychoanalytic training institutes (Norcross, 2005), although even within this latter community there is a small – but present – discussion about making it optional.

Many European countries require a certain number of hours of personal therapy for accreditation and licensure as a psychotherapist; the British Association for Counselling and Psychotherapy (BACP) "had until recently set 40 hours of personal therapy as a requirement for practitioners to become registered or accredited. This is also the case with the British Psychological Society which proposes that 40 hours of personal therapy is an essential requirement for counselling psychologists aiming to achieve chartered status" (Murphy, 2005, p. 27). This is reflected in the literature from the United Kingdom, most of which studies the experiences of masters' or doctoral level students in counseling psychology programs that mandate personal therapy.

The relationship between attitude toward and participation in therapy has been shown to be statistically significant (Dearing, Maddux, & Tangney, 2005; Gilroy, Carroll, & Murra, 2002; Weintraub, et al., 1999; Daly, 1998), with students whose attitudes are positive having higher levels of commitment to receiving their own therapy. Additionally, the attitudes of faculty toward personal therapy have been demonstrated to affect students' participation in – but not necessarily attitudes toward – personal therapy

(Dearing, Maddux, & Tangney, 2005). Interestingly, there is a sharp divide in attitudes of students toward personal therapy and those of faculty. Eighty-five percent (85%) of MSW students surveyed by Strozier and Stacey (2001) believe that personal therapy is important or even essential to social work education, while only 58% of faculty believe it is important. Even fewer faculty members, 16%, believe that personal therapy is essential to social work education.

What might account for this discrepancy in the data? Strozier and Stacey go on to state that the enduring debate in social work education regarding a "return" to social work's "heritage of working with the poor versus…the practice of clinical social work," has lent itself to a decreased emphasis on clinical skills or preparedness (vis-à-vis personal therapy). Put another way, "some of the faculty's negative feelings toward therapy for students may stem from philosophical beliefs about the importance of social work's commitment to social justice and populations at risk versus private practice" (pp. 191-192). Additionally, there has been a shift away from psychodynamic/analytic models of clinical practice, models that historically have mandated personal therapy for the aspiring psychotherapist as necessary for ethical practice. This can be seen in social work education, with its "increased emphasis on empowerment models" (Strozier & Stacey, 2001, p 192), although one must be careful not to pit models of psychotherapy against empowerment models, for they are not mutually exclusive. Similar trends in education have occurred, and continue to occur, in graduate programs of psychology as well as in psychiatric education.

Weintraub, et al. (1999), assert a comparable explanation for the reduction in personal therapy for the mental health professional, in this case, the psychiatric resident.

"[T]he recent shift in psychiatry toward a biological focus and away from a psychodynamic approach…may have led to the recruitment of residents with a decreased interest in psychodynamic therapy" (p. 18). These authors go on to state that non-insight oriented therapies – indeed, many of the manual-based approaches being used due to the push for evidence-based practice and under pressure from managed care – may partly be to blame for the reduced interest in or requirement of personal therapy for therapists. However, it is not this paper's aim to declare the primacy of one theoretical model over another.

Within the broader mental health community, the principal argument against mandating personal therapy for therapists, whether within graduate schools or for purposes of licensure, comes down to choice (Norcross, 2005; Greenberg & Staller, 1981; Brenner, 2006). As Grunebaum (1983) succinctly notes: "It is clear that the experience of having a genuine choice makes effective psychotherapy more likely" (p. 1338). Furthermore, one could argue that removing an individual's "strongly felt need for change" (Greenberg & Staller, 1981, p. 1468) by making personal therapy mandatory is tantamount to sidestepping the therapeutic relationship for automated, personless interventions.

Reasons why therapists do *not* seek personal therapy are varied. The literature tends to suggest these common deterrents to therapists pursuing personal therapy: cost (Weintraub, et al., 1999; Daly, 1998; Deutsch, 1985), concern about what others (e.g., colleagues, faculty) will think (Gilroy, Carroll, & Murra, 2002; Deutsch, 1985), concerns about confidentiality/availability (e.g., in rural practice settings) (Gilroy, Carroll, & Murra, 2002; Dearing, Maddux, & Tangney, 2005; Deutsch, 1985) and concern about

time/energy required (Gilroy, Carroll, & Murra, 2002; Dearing & Maddux, 2005; Deutsch, 1985).

This chapter has summarized the literature on personal therapy for therapists. What is clear in the research literature is that most mental health professionals have engaged in their own personal therapy at one time or another, have found it to be both personally and professional beneficial, and would consider seeking personal therapy for themselves again in the future. The evidence for therapists' own personal therapy having a positive impact on the outcomes of their own clients is scant as of this writing, and further research in that area would be useful, albeit difficult to perform. Additionally, the negative experiences that therapist-clients have encountered in their own therapy are scarcely mentioned in the literature, a problem that can perhaps be attributed to research methodology. Unfortunately, the ways in which such negative experiences in personal therapy influence therapists' interventions with their clients has not been satisfactorily presented in the existing research literature on the subject.

This examination turns to my own research on social workers' attitudes toward and experiences with personal therapy. Chapter Two presents the population studied and methods used in the data collection and analysis process. Chapter Three focuses on the results of this study interpreted in the context of the literature discussed above.

CHAPTER II

SAMPLE AND METHODOLOGY

The research questions for my study are:

- What is the association between attitudes toward personal therapy for social workers and participation in personal therapy for oneself?
- What is the association between one's theoretical orientation toward practice and participation in personal therapy for oneself?
- What role does personal therapy play in the potential betterment of social workers' personal lives and the development of a professional identity?
- In what ways do personal and professional benefits of personal therapy intersect?

A 20-question survey was constructed using questions and findings adapted from Gilroy, Carroll, and Murra (2002) and Dearing, Maddux, and Tangney (2005). As neither of the surveys were included in their respective published articles, they were used with permission of the authors. Additionally, Macran, Stiles, and Smith (1999), in their qualitative analysis of seven structured interviews with therapists in their own personal therapy, identified 12 themes that emerged, subsequently categorizing those themes into three domains. The results of these authors' research shaped the construction of my own survey; certain items (Question I: ways in which therapy was professionally beneficial) were included in my survey. The survey as it was distributed to research participants is included in the Appendix.

This questionnaire sought to ascertain respondents' practice settings; theoretical orientations toward practice; attitudes toward personal therapy for social workers; experiences with personal therapy, if any; and attitudes toward and experiences with

personal therapy as a useful component of professional development. Basic demographics (gender, age, race/ethnicity, relationship status, highest level of education completed, and year in which highest degree was obtained) were also collected.

One hundred and fifty four (N=154) surveys were distributed to members of the South Dakota chapter of NASW with a Master of Social Work or higher degree (DSW or PhD). The Board of Directors of NASW-SD, who provided the names and contact information for the participants, approved this study, as did the Institutional Review Board (IRB) of the University of Iowa. Consideration was given to the potential risks and benefits of participation based on the federally mandated regulations for research with human subjects as required by the University of Iowa's IRB. This population is not considered "at risk" by IRB standards, and the anonymity of the participants protected what might be deemed sensitive personal questions that could label or stigmatize an individual.

Ninety-two surveys were returned (N=92), a response rate of 59.7%. A data set and code book were established before distribution of the surveys for the sake of consistency and accuracy in data collection and to prevent any confusion or error in data entry. Upon its receipt, the completed survey was numbered and its quantitative data were entered into a spreadsheet and analyzed using SPSS Version 13. The final question on the survey provided space for respondents to address the ways in which they believe that NASW could/should provide resources or education regarding self-care for social workers (Question T1). Participants were also asked to provide any additional comments, concerns, or issues they would like to raise regarding personal therapy for social workers (Question T2). Fifty of the 92 participants provided responses to these

questions; 21 of the 50 supplied responses specifically to the NASW-related question (Question T1), 29 respondents replied to the second question (Question T2) or both.

Qualitative data in respondents' comments were transcribed along with the survey number and the gender and age of the respondent. The process used in my qualitative analysis of putting the various categories under larger, more conclusive headings was informed by the research of Macran, Stiles, and Smith (1999). While transcribing the comments I noted recurring themes (e.g., self-care, rural practice/confidentiality, professional development, etc.) and created a list of these themes. After the comments were transcribed a key was developed to color code the different themes that emerged from the data. Seven codes were used to analyze the NASW-relevant comments (Question T1) and 15 codes were used for the personal therapy-related comments (Question T2). Comments from respondents were color coded and these coded comments were then sorted into their respective categories. In cases where themes overlapped (e.g., personal benefits of therapy and professional benefits of therapy) both color codes were used; for instance, "countertransference" could be considered germane to both themes and was therefore included in each of these sorted categories.

After consulting with a colleague, it was determined that many of the categories could be further collapsed to better analyze the ways in which themes (e.g., personal and professional development) were similar and different. The frequency of this occurrence led me to group the 22 categories under 4 headings; these categories will be detailed further in the next chapter.

There are many benefits to including data derived from qualitative research methods alongside data garnered from survey-based quantitative methods.

Counterbalancing the limitations of quantitative data by providing a deeper context, flexibility, and more authentic representation of the points of view of the surveyed population is an asset that qualitative data provide (Rubin & Babbie, 2005). Coding and analyzing qualitative data necessitate an appreciation of concept and not just frequency. As I looked at the comments provided by respondents, the *meanings* of professional and personal vis-à-vis benefits of therapy began to blur; likewise, the function of their coded categories had to be adapted to make sense of these overlapping concepts.

One of this study's research questions aims to more fully understand the role that personal therapy can play in the potential betterment of social workers' personal lives and the development of a professional identity. Therefore, the ways in which these two concepts intersect and influence each other are best seen in the emergence of qualitatively documented patterns or themes (Rubin & Babbie, 2005).

The next chapter reports on the categories derived from the qualitative data, as well as the findings resulting from analyses of the quantitative data from my research on social workers' attitudes toward and experiences with personal therapy.

CHAPTER III

RESULTS

There were 92 surveys returned, a response rate of 59.7%, although one of these was not viable due to an error in completion. Thus, data were analyzed from the 91 usable surveys. This chapter will address the quantitative findings first, presenting the qualitative results in the second part of the chapter.

Quantitative Results

The ages of respondents ranged from 25 years of age to 72 years of age, with a mean of 50.25 years of age and a median of 52 years of age (SD=12.080). The gender and race/ethnicity of respondents are shown in Tables 1 and 2, respectively.

Table 1. Gender of respondents

Gender of Respondent	Totals (N=91)	Percentage
Female	65	71.4%
Male	26	28.6%

Table 2. Race/ethnicity of respondents

Race/Ethnicity of Respondents	Totals (N=91)
European American (Caucasian)	82
Native American/First Nation/American Indian	5
Asian American	1
Hispanic/Latino/a	1
Other	2

All respondents completed a Master of Social Work, as this was a requirement to participate in the study. Eighty-six percent of respondents (N=79) identified their Master

of Social Work (MSW) as the highest level of education completed; ten respondents selected PhD/DSW as their highest level of education completed, and two respondents selected "other," which may have meant a graduate degree in another related field (e.g., LPC, LMFT, MDiv). Respondents were also asked to share the year in which they obtained their highest degree: the graduation dates ranged from 1966 to 2006, with a mean result of 1989. At the time they completed their survey, 31 of the 91 respondents (34.1%) had not participated in their own personal therapy, whereas 60 respondents (65.9%) had. Fifteen percent (N=14) of respondents attended personal therapy for 1-6 weeks, 16% percent (N=15) for 2-6 months, and 18.5% (N=17) for more than 2 years.

Table 3 shows the attitudes toward personal therapy for social workers by respondents' participation in personal therapy. Of the 60 respondents who participated in their own personal therapy, only one stated that s/he did not believe personal therapy was important for social workers. Thirty-seven (N=37) of those who participated in personal therapy believed that personal therapy is important for personal growth, 26 believed that it is important for professional growth, and 26 stated that it should be mandatory in social work education. The majority of those who had not participated in personal therapy (N=23) believed that personal therapy is important only if an individual has emotional struggles.

Table 3. Attitudes toward personal therapy by participation in personal therapy

Attitude	Participation – Yes	Participation – No	Totals*
Not Important	1	2	3
Important – Personal growth	37	6	43
Only if emotional struggles	18	23	41
Important – Professional growth	26	4	30
Should be mandatory in SW programs	26	1	27
Should occur in agencies	8	0	8

*Respondents were asked to select all that apply, so totals will not add up to 91.

Of the 60 respondents that participated in personal therapy, 47% found it beneficial and 42% found it very beneficial. While none of the respondents indicated that therapy was harmful, these data cannot necessarily be generalized to the larger population, since there were 62 social workers (more than those respondents that participated in personal therapy) that did not participate in this research and whose experiences in personal therapy may or may not have been beneficial. Table 4 shows the results of this question.

Table 4. Extent to which respondents who participated in personal therapy found it personally beneficial

	Total (N=60)	Percentage
Very Beneficial	25	41.7%
Beneficial	28	46.7%
Neutral	3	5%
Not Beneficial	4	6.7%
Harmful	0	-----

Table 5 presents the relationship between gender and participation in personal therapy. Seventy-two percent (N=47) of the 65 females participated in personal therapy, compared with 50% (N=13) of the male respondents who stated that they had participated in their own personal therapy. The relationship between gender and participation in personal therapy was statistically significant based on a Chi-Square analysis**.** There was a significant association ($p<.05$) between gender and whether or not the respondent had participated in therapy ($\chi^2(1)=4.115$, $p=.043$).

Table 5. Gender of respondents by participation in personal therapy

Gender	Participation – Yes	Participation – No	Total (N=91)
Female	47	18	65
Male	13	13	26

According to the 60 respondents who participated in personal therapy, the primary reasons for seeking therapy were depression (N=30), marital problems (N=25), and stress (N=25); it should be noted that respondents were asked to answer all that applied, so the responses are not mutually exclusive. Reasons why the 31 respondents had not participated in personal therapy are detailed in Table 7. The most common were: not needing therapy (61%), concerns about confidentiality (26%), and cost (23%).

Table 6. Reasons for participating in personal therapy

	Total* **
Depression	30
Marital Problems	25
Stress	25
Anxiety	16
Other	15
Grief	11
Adjustment Disorder	11
Bipolar Disorder	0

* Total out of 60 respondents who answered "yes" to question D "Are you now or have you ever attended therapy?"

** Will not add up to 60 because respondents were asked to answer "yes" to all that apply.

Table 7. Reasons for not participating in personal therapy

	Total*	Percentage**
Don't feel I need therapy	19	61.3%
Concern about confidentiality	8	25.8%
Cost	7	22.6%
Concern about what others would think	3	9.7%
Concern that being in therapy would affect how colleagues view me	3	9.7%
Concern about dual relationships or conflicts of interest	3	9.7%
Uncertainty about availability of services	1	3.2%
Concern about what I would find out about self	0	-----
Lack of transportation	0	-----

* Will not add up to 31 because respondents were asked to answer "yes" to all that apply.

** Percent out of 31 respondents who answered "no" to question D "Are you now or have you ever attended therapy?"

Respondents were asked to select their two principal theoretical orientations from the list provided (see Table 8). Thirty-two (N=32) of the respondents identified

themselves as using a cognitive behavioral orientation, with the second most common orientation being solution-focused (N=23). There was no statistically significant relationship found between a respondent's theoretical orientation and either her attitude toward or participation in personal therapy based on a Chi-Square analysis of the data. The theoretical orientation of respondents' therapists (for those that have participated in therapy) was also gathered. There was no statistically significant relationship between the theoretical orientation of one's therapist and either the respondent's own theoretical orientation or her attitude toward/participation in personal therapy, based on Chi-Square analyses.

Table 8. Theoretical orientation of respondents

Theoretical Orientation	Total*
Cognitive-Behavioral	32
Solution-Focused	23
Systems	15
Eclectic	11
Psychoanalytic/Psychodynamic	6
Other	6
Behavioral	4
Existential	0
Feminist	0
Humanistic	0
Gestalt	0

* Respondents were asked to select two theoretical orientations, so total will not add up to 91.

Table 9 shows the different ways in which respondents reported that their therapy was professionally useful. The areas of professional benefit are grouped according to the domains distinguished by Macran, Stiles, and Smith (1999). They are: orienting to

therapist, orienting to client, and listening with third ear. Of the 54 respondents who found therapy professionally useful (see Question H from the survey in Appendix), 82% (N=44) believed that it was useful because it provided the knowledge of how it feels to have therapy. Also substantial were the respondents who believed that taking care of self is a professionally useful benefit of one's own personal therapy (74%); knowing one's boundaries/limits (54%); and increased confidence in the usefulness of therapy (52%). The least frequently selected areas of professional benefit for respondents were: holding back from jumping in to help (22%), judging the pace of therapy (18.5%), and giving clients space (15%).

Table 9. Areas of professional benefit for respondents who believed therapy was professionally useful (N=54)

Domain	Theme/Areas of Professional Benefit	Total	Percentage*
1. Orienting to therapist	Knowing how it feels to have therapy	44	81.5%
	Taking care of self	40	74.1%
	Therapists can be clients	24	44.4%
	Providing a role model	22	40.7%
	Learning to be one's real self	21	38.9%
	Knowing one's boundaries/limits	29	53.7%
	Knowing what not to do	15	27.8%
	Increased confidence in usefulness of therapy	28	51.9%
2. Orienting to client	Giving clients space	8	14.8%
	Holding back from jumping in to help	12	22.2%
3. Listening with third ear	Separating own feelings and clients feelings	18	33.3%
	Working at deeper level	22	40.7%
	Judging pace of therapy	10	18.5%

* Percentage out of 54 "yes" responses to question H on survey, "Did you find therapy professionally useful?"

Qualitative Results

As discussed in Chapter Two, qualitative data came from the final survey question soliciting suggestions for NASW to address the need for self-care resources for its members (Question T1), as well as from additional comments on the subject of personal therapy for social workers (Question T2). Fifty respondents provided qualitative data. The eight categories of responses under the heading "Responses to NASW" are summarized in Table 10. The most frequently mentioned category that emerged from respondents' suggestions for NASW were "Seminars, Webinars, Training, Workshops, and Conferences" (N=16).

Table 10. Categories under heading "Responses to NASW"

	Totals*
Social Workers-as-People/Destigmatization	3
EAP/Provision of Therapy/Advocate for MH Parity	7
Seminars/Webinars/Training/Workshops/Conferences	16
Support Idea of Personal Therapy	4
Newsletters/Articles	6
Awareness of Resources/Networking	3
Support Groups/Discussion Groups	3
Not NASW's Role/Adequate Resources Available/Personal Responsibility	8

* Total number of occurrences in Question T1: "In what ways do you believe that NASW could/should provide resources or education regarding self-care for social workers?"

Data taken from respondents' additional comments on the subject of personal therapy for social workers (Question T2) were also put into their appropriate categories. Because there were certain similarities amongst categories, it was decided that grouping these analogous categories together would help to make their similarities more recognizable. Self-care/wellness (N=15), burnout (N=5), stress (N=2), and trauma (N=2)

were grouped under the heading of "Self-Care." Only one respondent suggested that "social workers are already pretty patched into self-care." Most respondents, on the other hand, believed that self-care is insufficiently undertaken in the field of social work: "self-care wasn't even addressed in graduate school" [respondent graduated in 1999]. The general consensus among the respondents who mentioned self-care in Question T is that "self-care is critical" and more needs to be done at the graduate level and by NASW (conferences, publications, etc.) to meet this need. Additionally, "emphasizing how personal therapy could be an effective way to prevent or deal with burn out would be good."

There was a great deal of overlap between personal and professional (many of these data were double coded), with the intersection of the two being "therapist-as-client," or as Macran, Stiles, and Smith (1999) present it: "knowing how it feels to have therapy" and "therapists can be clients" (p. 422) (see Table 9). Thus, I have labeled this overlap "self-as-therapist-as-client" to encapsulate the connection between professional socialization (self-as-therapist), self-awareness (self-as-client), and humility/empathy (therapist-as-client). As one respondent said, "Your first and last client is ultimately yourself."

The heading of "Self-as-Therapist-as-Client" includes 5 categories, detailed in Table 11.

Table 11. Categories under heading
"Self-as-Therapist-as-Client"

	Totals*
Knowing self/issues	15
Professional development/qualification	14
Being a client	3
Family-of-origin	2
Limitations of therapy	1

* Total number of occurrences in responses to Question T2 regarding personal therapy for therapists

One respondent stated "I have at times had decreased [underlined by respondent] confidence in the usefulness of therapy." This respondent did not elaborate on his reasons for having decreased confidence in the usefulness of therapy, which is unfortunately in keeping with the lack of research on negative experiences in therapy, save for the work on student therapists whose personal therapy infringes on their ability to attend to their clients.

The majority of respondents who provided these data to Question T2 found therapy to be both personally and professionally useful. As another respondent noted, "I think that one of the [two underlines] most important things for professionals who provide psychotherapy is to experience what it's like to 'sit in the other chair' and to explore their own issues before they suggest to someone else to explore their own."

With respect to professional development, similar themes emerged as first identified by Macran, Stiles, and Smith (1999), such as working at a deeper level and recognizing boundaries and limitations. "It is very important for social workers to work on their own issues for increased self awareness and boundary issues. Blind spots can be dangerous." In this quote, the gap between personal and professional is shown to be a

small, if not nonexistent one: blind spots lead to ineffective or even damaging work with clients and these blind spots emerge because one has not "worked on [one's] own issues," according to this respondent.

Another respondent expressed this concern: "I have met individuals who are counselors and social workers who have never been in therapy and refuse to acknowledge they themselves ever needed help, which demonstrates an inherent lack of insight that is required to have empathy for those we serve. From my experience these are usually the individuals, though not always, who believe their role is to impart their knowledge on those they are supposedly helping, instead of empowering clients in generating their (clients') own solutions."

"When I was in graduate school I did some psychotherapy to 'clean up my own backyard' so to speak. I always felt that if we were going to help others 'clean up' their own lives, we should do that like wise." In this statement the connection between personal development/self-awareness and professional competence/being-the-client emerges as well. What this respondent articulated is the obligation to self ("clean up my own backyard") and client ("help others 'clean up' their own lives"). But the two are inextricably linked, as the comment demonstrates. Another respondent suggested that "we as social workers cannot take others any further than we ourselves have come."

Respondents mentioned that the functions personal therapy can play in self-care (obligations to self) and competence (obligations to clients) are not mutually exclusive. "We owe it to the people we serve to know what is our stuff – and what is their stuff. We should not ask of others what we are not willing to do ourselves." In this way, personal therapy for the therapist could be seen as modeling, as in the theme that Macran, Stiles,

and Smith (1999) term "increased confidence in the usefulness of therapy" (p. 422). As one respondent says, it is "helpful for therapists to model the usefulness of therapy." Modeling the "usefulness of therapy" is an extension of professional development as well. Note that in the quantitative data, 41% (N=22) of respondents indicated that having their therapist provide a role model was one of the professional benefits of their own personal therapy (see Table 9).

Finally, numerous data emerged from responses to Question T2 regarding concerns about confidentiality and/or the judgment or opinions of others, particularly with respect to rural practice settings. These categories were included under the heading of Rural Practice/Concerns of Confidentiality, and the comments made by respondents speak for themselves. "The social work community is a small community in South Dakota and finding a therapist you don't already know through professional circles is difficult;" "it is difficult to find a therapist when you are in a rural area. You know or work with every therapist within 100 miles;" "in a predominantly rural area the options are limited or non-existent."

The frequency of such concerns in respondents' surveys is small when compared with those of other categories. Yet in the context of the dearth of research on the effects of rural practice on self-care and burnout, the impact of their message is immense. The following respondent speaks to the dual issues of rural practice and privacy/confidentiality.

> The difficulty with social workers receiving therapy is professional pride and confidentiality… There is always the thought that if others know I'm in therapy or I have marital problems, etc., it will negatively affect their opinion of me professionally and in turn negatively affect my practice. However, I do know intellectually just how beneficial therapy could be for a therapist's personal and therefore professional growth. If I practiced in a more

> metropolitan area where I could be assured more privacy when seeking therapy, I'd be more likely to seek therapy. It's not that I don't believe any therapist I see wouldn't keep my information private, it's more just knowing that they'd know about my personal struggles and make their own personal judgments; not to mention in a small rural community always wondering who is going to see you entering that therapy office.

Interestingly, this same respondent suggests that a function of NASW could be "contracting with therapists that could specialize in therapy for the helping professions and making that known to members."

One respondent in particular supplied a rich contribution related to her concerns about confidentiality and competence. While she was one of few to illuminate such concerns, it is likely that these are shared fears inhibiting many social workers from participating in their own therapy. "I've wondered if you go your therapist could say you are not fit to continue to practice and this would ruin your clinical career. Could they report you to the Board? What if you're just under a lot of stress but you can still provide quality care/services to clients but your therapist does not agree. What then? If you do follow therapist advice how do you return back to work after stressor/crisis has passed? How, what do other therapists think of you?" One of the notable suggestions for NASW, as included in Table 10, is to "continue working to destigmatize therapy for professionals," perhaps even "making it available and at low cost and encouraging participation…[which]…may be of benefit in having healthier MSW's."

The importance of personal therapy for therapists – as a strategy to promote self-care – was stressed by those respondents who had participated in personal therapy and found it personally and/or professionally beneficial; this was expressed both in the quantitative and qualitative data. With respect to my first research question, it is clear that most of the respondents who participated in their own personal therapy also believed

that personal therapy is important for personal and professional development. There was not a correlation between one's theoretical orientation and participation in personal therapy, however, which suggests that a positive attitude toward personal therapy is not the exclusive domain of certain theoretical orientations (e.g., psychoanalytic). In fact, most of the respondents were cognitive-behavioral and/or solution-focused in their theoretical orientation.

In answer to the third research question, "what role does personal therapy play in the potential betterment of social workers' personal lives and the development of a professional identity," most of the respondents who participated in personal therapy agreed that their own therapy was not only personally beneficial but professionally valuable as well. Again, this is only accounting for the experiences of the 60 respondents who had participated in personal therapy. There were 62 social workers that did not complete the survey, a noticeable absence of potentially useful data, particularly on those whose experiences in personal therapy may have been unhelpful or even harmful. Additionally, there was an outlier in the data, which came from the respondent who stated "I have at times had <u>decreased</u> [underlined by respondent] confidence in the usefulness of therapy."

Finally, the qualitative data show that for many therapists, the value of personal improvement/well-being and the role of being a therapist are congruous. That is, to be a competent clinician one must also take seriously one's own emotional needs. In this way, the personal benefits of therapy, such as maintaining healthy boundaries in relationships, increased self-awareness, mindfulness, ability to tolerate distress, etc., are inextricably linked with the skills needed to be a competent psychotherapist.

This examination turns now to a discussion of the implications for practice and education and how these results can be more meaningfully absorbed into the culture of social work.

CHAPTER IV

DISCUSSION AND IMPLICATIONS FOR EDUCATION AND PRACTICE

Summary

This paper has focused on personal therapy as a means of implementing self-care strategies for therapists, with an emphasis on social workers. The research shows that psychotherapy is efficacious, although the way in which researchers carry out their studies continues to be a contentious issue. Of particular concern is the disconnect between researchers and clinicians – between theory and praxis. Many have proposed a shift in the research gaze from *whether* psychotherapy works to *how* psychotherapy works. In this way, a more process-oriented paradigm may help to bridge the gap between the aspirations of researchers to locate and disseminate evidence-based practice according to specific diagnostic criteria, and those of clinicians to evaluate practice-based evidence with their own clients, whose experiences are more authentic when looked at contextually than diagnostically.

The effectiveness of psychotherapy has been shown to be heavily rooted in the therapeutic alliance between client and clinician, with some evidence that specific interventions or modalities work better than others according to the population they aim to treat. However, much of the literature points to what has been called the “dodo bird” verdict: therapy works less because of technique – which levels the playing field of theoretical orientations – and more because of clients’ extratherapeutic experiences, expectations from therapy, and sense of relationship with their therapist. This concept comes from *Alice in Wonderland*; after a vigorous race, where participants began to run at their leisure, the dodo bird declared: "Everyone has won and all must have prizes"

(Carroll, 1988, p. 22). In other words, psychotherapy works regardless of modality. In addition to this "dodo bird" verdict, the efficacy research often underestimates the weight that a client's motivation and commitment can have on outcomes. Accordingly, the client-as-a-person proves truer than his quantifiable symptoms.

Based on this evidence supporting the value of a mutually experienced therapeutic relationship, the therapist-as-a-person has become a prominent area of investigation. The risks facing mental health professionals include compassion fatigue, vicarious traumatization, burnout, and unchecked countertransference, placing the value of self-care squarely at the center of the discussion on these risks. To what extent do social workers in particular value self-care, and in what ways do they implement self-care strategies such as personal development, in light of the emotionally taxing work that they have chosen for themselves?

The literature suggests that personal therapy is a highly valued activity for therapists new and seasoned alike. Moreover, many therapists assert that their own personal therapy was more important than coursework or supervision for their development of a professional identity. Here, personal and professional growth become inextricably linked; the common strand that connects these two facets of therapists seems to be the value of self-care. The data from my own research supports the literature's findings that personal therapy is a meaningful contribution to personal and professional development – concepts that have more in common than they differ.

Discussion

Some of the most telling data that emerged from my study have to do with a social worker's experience of being a client. Self-as-therapist-as-client is a model of

mutuality, for it connects three unique realities: self-as-therapist, self-as-client, and therapist-as-client. How these three fuse is in the overlap between the personal value of self-care and the professional value of care-for-clients; again, the personal and professional are not mutually exclusive. Thus, the strategies a clinician would use to promote or sustain her own self-care, such as healthy boundaries in relationships, insight, self-reflection, mindfulness, distress tolerance, etc., and the strategies she would use to promote her value of care-for-clients are analogous The means to achieve these strategies (e.g., personal therapy) are often one-and-the-same as well.

What distinguishes professional values from personal values in the field of social work is the issue of competence. That is, competence is to be achieved and advanced according to one's ethical obligations to clients, colleagues, and the profession. The NASW Code of Ethics says this about competence and colleagues:

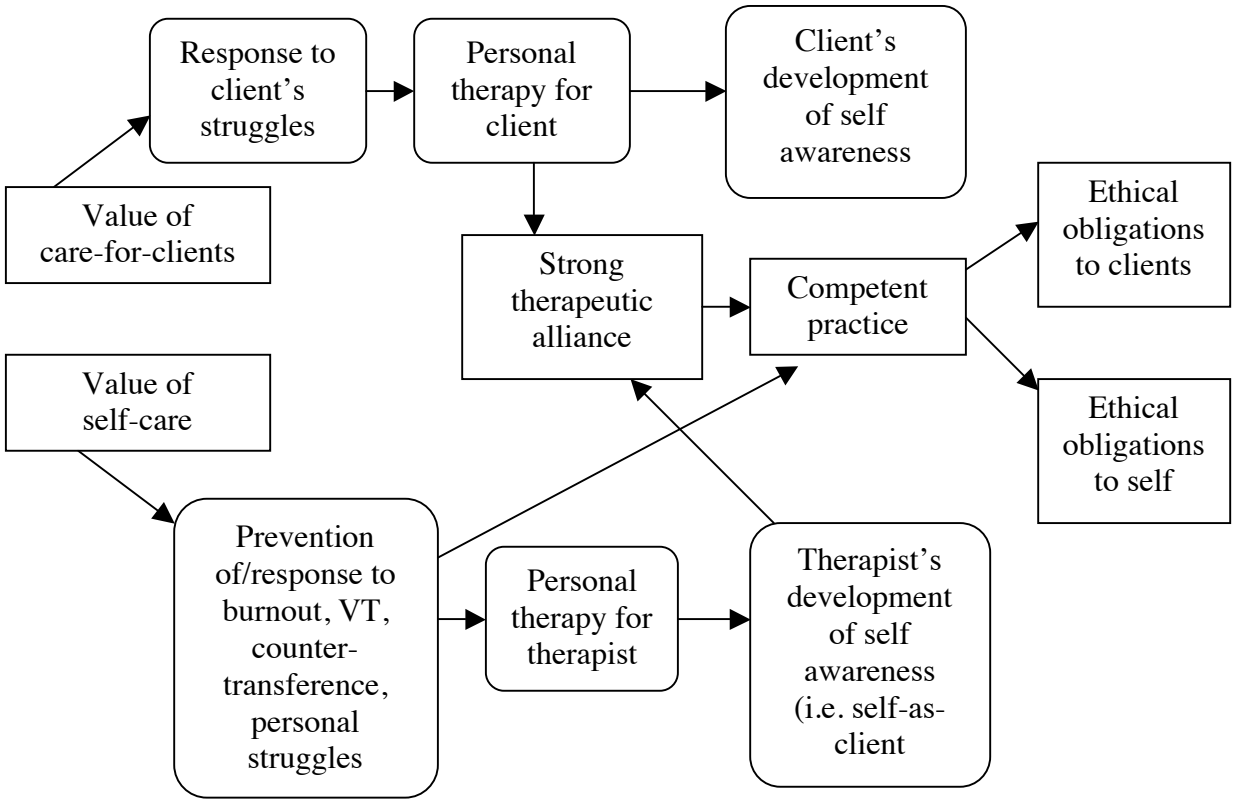
> Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action (NASW, 1999, retrieved March 6, 2008 from http://www.socialworkers.org/pubs/code/code.asp).

This raises an important question about ethical obligations to colleagues in the context of self-care. Often the therapists claiming not to need personal therapy are those that need it the most. How then does one teach the value of self-care to others, or, if not the value itself, specific strategies like those mentioned above?

The link between ethics and values is an important one. An ethic is defined as a set of moral principles that guides one's conduct; a value, on the other hand, is one's principles or standards of behavior, or one's judgment of what is important in life. There is a unifying thread between a social worker's value of care-for-clients and his ethical

obligations to clients vis-à-vis competent practice. Returning to the effectiveness research, it would appear that this connection is the power of relationship. Figure 1 presents a working conceptual model of the ways in which personal and professional are related vis-à-vis values and competence.

Figure 1. Relationship between value of self-care and ethical obligations to clients through strategy of self awareness



As Figure 1 shows, a relationship is not one-sided; rather, and particularly in the context of the therapeutic alliance, it involves at least two people, each with distinct personalities, needs, and frailties. What is striking in the NASW Code of Ethics, as well as the codes from other professional organizations, is the minimal recognition of this fact.

Naturally the bulk of these codes is spent placing the practitioner in a professional context of service to others, which is reasonable. But based on the recognition of relationship as one of the core attributes in therapy that leads to positive outcomes, the well-being of *both* individuals in that relationship seems self-evident. An ethical obligation to self is different than self-care because it goes further than values. It places one's commitment to self in the domain of professional competence and not simply in the realm of one's judgments about what is important in life.

The Code of Ethics for the American Association for Marriage and Family Therapy (AAMFT) says this about personal impairment and competence: "Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment" (AAMFT, 2001, retrieved March 6, 2008, from http://www.aamft.org/Resources/lrmplan/Ethics/Ethicscode2001.asp). The American Psychological Association makes a similar decree in its Ethics Code:

> (a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
> (b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties (APA, 2002, retrieved March 6, 2008, from http://www.apa.org/ethics/code2002.pdf).

Finally, NASW's Code states:

> (a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

> (b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others (NASW, 1999, retrieved March 6, 2008, from http://www.socialworkers.org/pubs/code/code.asp).

These documents are consistent in what they have codified, but the question remains: how are "impaired" clinicians supposed to seek help when they have limited time or resources?

Implications for Practice, Education, and Advocacy

One of the key findings that emerged from my own data relates to confidentiality and rural practice. The impact that rural practice settings have on the availability of therapy, concern about confidentiality/dual relationships, and the intersection of these types of concerns with the risks of burnout, compassion fatigue, and vicarious traumatization (increased when one works/lives in an isolated community) cannot be overstated. How these issues relate back to the obligations of professional organizations and their codes of ethics (e.g., ethical obligations to colleagues) are truly germane. In South Dakota, similar to many other states where rural areas predominate, the number of persons per square mile in 2000, the most recent year for which these data are available, were 9.9 according to federal data (retrieved March 11, 2008, from http://www.fedstats.gov/qf/states/46000.html). To put this in perspective, the persons per square mile in New York were 401.9, in California they were 217.2, and in Illinois this statistic came to 223.4. These numbers are relevant to a state like South Dakota because rural social workers are not simply practicing in agencies that reside in small communities. Many social workers are lone workers, practicing in isolation or having to

travel great distances to meet with their clients. Therefore, these practitioners often receive minimal supervision, clinical *or* administrative.

The literature has been silent on the implications of this reality for clinical practice and therapists' development and self-care. Moreover, when the ethic of professional competence is brought into the discussion, the necessity for more resources and an improved dialogue becomes paramount.

What is the responsibility of an organization like NASW to advocate for its members by expanding the provision of services to clinicians practicing in rural settings? I attempted to contact various leadership figures in NASW to ask about the organization's response to members' self-care concerns, but was met with minimal success. The only information I was able to garner from NASW leadership had to do with social workers' obligations to confront their risk for burnout or vicarious traumatization. With respect to personal therapy, NASW does have a document addressing business expense deductions for psychotherapy (Morgan & Polowy, 2004). Citing several court cases, most notably *Porter v. C.I.R.*, this memorandum speaks to social workers' abilities to claim the cost of their individual psychotherapy as an ordinary and necessary business expense. According to several U.S. Tax Court decisions, psychotherapists are able to argue that their own psychotherapy has been useful in their professional development/practice and subsequently claim a portion of those expenses (Morgan & Polowy, 2004).

NASW has also published an article entitled, "Burned Out – *and at Risk*" that seeks to engage the subject of burnout in the context of the Code of Ethics. It states:

> social workers who suspect they might be undergoing a process of burnout are advised to undertake preventive measures – measures to safeguard themselves

and their clients, among them:

- Listen to concerns of colleagues, family, and friends
- Conduct periodic self-assessments
- Reduce isolation by maintaining regular supervision and network with colleagues
- Take needed "mental health days" and use stress-reduction techniques
- Arrange for reassignment at work, take leave, and seek appropriate professional help, as needed (Robb, 2004, retrieved March 6, 2008, from http://www.naswassurance.org/understanding_risk_management/pointers/PP%20Burnout%20Final.pdf).

The use of euphemisms for personal therapy ("professional help," "professional consultation," "professional assistance") are found throughout organizations like NASW's dictums. What message do organizations of and for mental health professionals send when they so glaringly avoid the word "therapy?" Perhaps they use vague language in an effort not to be imposing, which is understandable. So too is the assumption that professional help, consultation, or assistance might be referring to clinical supervision, and not just personal therapy. Nevertheless, it seems to speak to a presumption of some mental health professionals: therapy is for clients, not for therapists. Robb (2004) goes on to say that:

> It is important to seek out needed resources to help deal with this insidious phenomenon [burnout]. This might include making use of a host of NASW chapter programs and special programs of state professional regulatory boards. The good news? Help is available for social workers experiencing burnout. The first steps require us to recognize that a problem exists—and then to seek appropriate help. In short, social workers should heed the age-old maxim: know thyself (retrieved March 6, 2008, from http://www.naswassurance.org/understanding_risk_management/pointers/PP%20Burnout%20Final.pdf).

Help is *not* available for social workers experiencing burnout when every practicing therapist in a 200 mile radius is a colleague and/or friend. What, then, are rural practitioners to do? Given new media and technology, the question arises of whether or not therapy needs to be face-to-face. Many clinicians do phone-therapy with clients,

particularly if one of them has moved away but they both agree to continue therapy with each other. Might there be more savvy ways that rural practitioners with legitimate concerns about confidentiality and dual relationships can access needed services? Many graduate programs in social work are now utilizing distance education methods to educate social work students. While a traditional classroom environment continues to be the preferred means of teaching social work, supplementing this with other forms of education (via webcam, Internet discussions, etc.) can prove invaluable. One could argue that a traditional therapy environment is more sacred and inflexible than the classroom of the 21st century, and that the therapeutic alliance would be compromised outside of this face-to-face space. But this is not necessarily true; moreover, when faced with burnout or trauma, therapy via the Internet is better than no therapy at all.

Limitations of Study

The limitations of my study deserve attention because they point not just to my own methodological drawbacks but also to weaknesses in the literature on psychotherapists' attitudes toward and participation in personal therapy. The sample from which I drew included 92 of the 154 practicing MSW's who are members of NASW-SD. Of these respondents, 66% had participated in personal therapy. Out of those who participated, the majority experienced their personal therapy as being personally beneficial or highly beneficial. This does not necessarily mean that such results are generalizable to a larger group, since 62 MSW's did not respond. One might conclude that individuals who have participated in personal therapy and experienced positive benefits from that therapy are more likely to respond to a survey like this one. Furthermore, the study neglects to consider the ways in which negative experiences in

one's personal therapy can enhance professional skill.

A weakness of my survey is that, presumably, it only asks about a single experience in therapy. For many respondents this may have left them with the choice of answering questions about the most beneficial experience in therapy, overlooking the comparisons and contrasts between therapies. Also, were the 31 respondents who had not participated in personal therapy free of psychological distress? Did they have other means of implementing self-care strategies and, if so, what were they? These questions were not accounted for in my study but would be useful to explore in future research. Finally, the shortage of available therapy for those in rural practice may have influenced individuals' willingness to respond as well.

Recommendations

Future research addressing solely negative experiences in personal therapy would be greatly beneficial to the field. Much of the research that does address negative experiences – including my own – asks these questions in the context of positive experiences, often to the exclusion of richer, more developed questions about those individuals who have undergone unhelpful or even harmful therapy. Data that answer some of these queries might provide fruitful information about the potential risks of personal therapy for therapists. Another line of questioning that is noticeably absent in the literature is that which asks "Why not therapy?" What are the means of implementing self-care strategies being used by those, like the 31 respondents in my research, who have not sought personal therapy. Indeed, the majority of the 31 in my research stated it was because they did not believe they needed therapy. What are some of the variables that account for this stance? Again, questions like those in my survey

that seek out such reasons not to attend personal therapy (e.g. cost, confidentiality, etc.) are comparatively shallow or incomplete when placed alongside the more frequent and comprehensive questions inquiring about positive experiences in personal therapy. This is seen in many other research designs found in the literature.

It is clear that further research on the dilemmas facing rural practitioners is sorely needed. Hopefully, future researchers may begin to offer solutions and alternatives for those who do not have feasible access to therapy (or proper clinical supervision for that matter). This is true not just for rural practitioners either. The cost of psychotherapy in the United States greatly exceeds that of other countries, which points to needed changes in legislation. Furthermore, increased attention needs to be given to the role that graduate schools of social work and advocacy-oriented organizations like NASW can play in helping to remove barriers to services, such as linking up students or new therapists to reduced-rate therapy. As previously discussed, the accessibility of therapy is a concern for many social workers. There are also psychological barriers to services for many mental health professionals, not the least of which is the academic and professional culture that neglects to adequately recognize self-care and the needs of the therapist-as-a-person.

Many are concerned that NASW is growing less accepting of clinical social work, despite the predominance of this area of practice. Additionally, graduate schools of social work are growing more diagnostic and evidence-based in their orientation, rather than training students to evaluate their practice-based evidence on a client-by-client basis while competently employing well-researched modalities. Ideally, such well-researched modalities would incorporate self-care strategies for the therapist, since the therapeutic

alliance rests on her own well-being. One of the key ways in which graduate schools of social work can prepare future generations of social workers (clinical, organizational, and community-based) is by infusing their curricula with the ethic that the personal value of self-care and the professional value of care-for-clients are fundamentally related.

BIBLIOGRAPHY

American Association for Marriage and Family Therapy (2001). *AAMFT code of ethics*. Alexandria: Author. Retrieved January 8, 2008, from http://www.aamft.org/Resources/lrmplan/Ethics/Ethicscode2001.asp.

American Psychological Association (2002). *Ethical principles of psychologists and code of conduct*. Washington, D.C.: Author. Retrieved January 8, 2008, from http://www.apa.org/ethics/code2002.pdf.

Asay, T.P. & Lambert, M.J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23-55). Washington, D.C.: American Psychological Association.

Atkinson, P. (2006). Personal therapy in the training of therapists. *European Journal of Psychotherapy and Counselling, 8*(4), 407-410.

Baxter, L.R. Jr., Ackermann, R. F., Swerdlow, N., Brody, A., Saxena, S., Schwartz, J. M., Gregortich, J. M,. Stoessel, P., & Phelps, M.E. (2000). Specific brain system mediation of obsessive-compulsive disorder responsive to either medication or behavior therapy. In W. K. Goodman, M. V. Rudorfer, & J. D. Maser, (Eds.), *Obsessive-compulsive disorder: Contemporary issues in treatment. Personality and clinical psychology series* (pp. 573-609). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Bly, R. (1998). *Morning poems*. New York: Harper Perennial.

Brenner, A.M. (2006). The role of personal psychodynamic psychotherapy in becoming a competent psychiatrist. *Harvard Review of Psychiatry, 14*(5), 268-272.

Brody, A.L., Saxena, S., Stoessel, P., Gillies, L.A., Fairbanks, L.A., Alborzian, S., Phelps, M.E., Huang, S.-C., Wu, H.-M., Ho, M.L., Ho, M.K., Au, S.C., Maidment, K., & Baxter, L.R. Jr. (2001). Regional brain metabolic changes in patients with major depression treated with either paroxetine or interpersonal therapy: Preliminary findings. *Archives of General Psychiatry, 58*(7), 631-640.

Carroll, L. (1988). *Alice's adventures in wonderland*. New York: Alfred A. Knopf.

Clark, M.M. (1986). Personal therapy: A review of empirical research. *Professional Psychology: Research and Practice, 17*(6), 541-543.

Clemans, S.E. (2004). Recognizing vicarious traumatization: A single session group model for trauma workers. *Social Work with Groups, 27*(2/3), 55-74.

Daly, K.A. (1998). Attitudes of U.S. psychiatry residencies about personal psychotherapy for psychiatry residents. *Academic Psychiatry, 22*(4), 223-228).

Dane, B. (2002). Duty to inform: Preparing social work students to understand vicarious traumatization. *Journal of Teaching in Social Work, 22*(3/4), 3-19.

Danieli, Y. (1994). Countertransference, trauma and training. In J. Wilson, & J.D. Lindy Eds.), *Countertransference in the treatment of PTSD*, (pp. 368-388). New York: Guilford.

Dearing, R.L., Maddux, J.E., & Tangney, J.P. (2005). Predictors of psychological help seeking in clinical and counseling psychology graduate students. *Professional Psychology: Research and Practice, 36*(3), 323-329.

Deutsch, C. (1984). Self-reported sources of stress among psychotherapists. *Professional Psychology: Research and Practice, 15*(6), 833-845.

_____. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16*(2), 305-315.

Drisko, J.W. (2000). Conceptualizing clinical practice evaluation: Historical trends and current issues. *Smith College Studies in Social Work, 70*(2), 185-205.

_____. (2001). How clinical social workers evaluate practice. *Smith College Studies in Social Work, 71*(3), 419-439.

Edwards, J.K., & Bess, J.M. (1998). Developing effectiveness in the therapeutic use of self. *Clinical Social Work Journal, 26*(1), 89-105.

Elman, N.S., & Forrest, L. (2004). Psychotherapy in the remediation of psychology trainees: Exploratory interviews with training directors. *Professional Psychology: Research and Practice, 35*(2), 123-130.

Farber, B.A., & Heifetz, L.J. (1982). The process and dimensions of burnout in psychotherapists. *Professional Psychology, 13*(2), 293-301.

Fleischer, J.A., & Wissler, A. (1985). The therapist as patient: Special problems and considerations. *Psychotherapy, 22,* 587-594.

Fox, R. (2003). Traumaphobia: Confronting personal and professional anxiety. *Psychoanalytic Social Work, 10*(1), 43-55.

Freud, S. (1910). The future prospects of psycho-analytic therapy. *Standard Edition* 11: 141-151.

_____. (1915). Observations on transference-love. *Standard Edition* 12: 159-171.

_____. (1937). Analysis terminable and interminable. In J. Strachey (Ed.), *Complete Psychological Works of Sigmund Freud* (pp. 209-253). London: Hogarth Press.

Fromm, M.G. (2004). On being the other person: Clare Winnicott, psychoanalyst and social worker. *Beyond the Couch: The Online Journal of the American Association for Psychoanalysis in Clinical Social Work, 1.* Retrieved November 11, 2007, from http://www.beyondthecouch.org/0307/winnicott_0307.htm.

Fromm-Reichmann, F. (1950). *Principles of intensive psychotherapy*. Chicago: University of Chicago Press.

Geller, J.D., Norcross, J.C., & Orlinsky, D.E., (Eds.). (2005). *The psychotherapist's own psychotherapy: Patient and clinician perspectives*. Oxford: Oxford University Press.

Gilroy, P.J., Carroll, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice, 33*(4), 402-407.

Gottdiener, W.H., & Haslam, N. (2002). The benefits of individual psychotherapy for people diagnosed with schizophrenia: A meta-analytic review. *Ethical Human Sciences and Services, 4*(3), 163-187.

Greenberg, R.P., & Staller, J. (1981). Personal therapy for therapists. *American Journal of Psychiatry, 138*(11), 1467-1471.

Grimmer, A., & Tribe, R. (2001). Counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development – an exploratory study. *Counselling Psychology Quarterly, 14*(4), 287-301.

Grunebaum, H. (1983). A study of therapists' choice of a therapist. *American Journal of Psychiatry, 140*(10), 1336-1339.

Guy, J.D., Stark, M.J., & Poelstra, P.L. (1988). Personal therapy for psychotherapists before and after entering professional practice. *Professional Psychology: Research and Practice, 19*(4), 474-476.

Holzman, L.A., Searight, H.R., & Hughes, H.M. (1996). Clinical psychology graduate students in personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice, 27*(1), 98-101.

Hubble, M.A., Duncan, B.L., & Miller, S.D., (Eds.). (1999). *The heart and soul of change: what works in therapy*. Washington, D.C.: American Psychological Association.

Karon, B.P., & VandenBos, G.R. (1971). The Michigan State Psychotherapy Project study. Retrieved March 5, 2008, from http://psychrights.org/Research/Digest/Effective/MIPsychProj.pdf.

Kaslow, F.W. (Ed.). 1984). *Psychotherapy with psychotherapists*. New York: Haworth Press.

Kingdon, D.G., & Turkington, D. (2005). *Cognitive therapy of schizophrenia: Guides to individualized evidence-based treatment*. New York: Guilford Press.

Macaskill, N.D. & Macaskill, A. (1992). Psychotherapists-in-training evaluate their personal therapy: Results of a UK survey. *British Journal of Psychotherapy,* 9, 133-138.

Mackey, R.A., & Mackey, E.F. (1993). The value of personal psychotherapy to clinical practice. *Clinical Social Work Journal, 21*(1), 97-110.

_____. (1994). Personal psychotherapy and the development of a professional self. *Families in Society: The Journal of Contemporary Human Services*, 490-498.

Macran, S., Stiles, W.B., & Smith, J.A. (1999). How does personal therapy affect therapists' practice? *Journal of Counseling Psychology, 46*(4), 419-431.

Mahoney, M.J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28*(1), 14-16.

McCarley, T. (1975). The psychotherapist's search for self-renewal. *American Journal of Psychiatry, 132*(3), 221-224.

Miller, R.R. (2000). Perspectives on the efficacy of psychotherapy. *Smith College Studies in Social Work, 70*(2), 207-216.

Morgan, S., & Polowy, C.I. (2004). Business expense deductions for psychotherapy. Washington, D.C.: National Association of Social Workers.

Murphy, D. (2005). A qualitative study into the experience of mandatory personal therapy during training. *Counselling and Psychotherapy Research, 5*(1), 27-32.

National Association of Social Workers (1999). *Code of ethics of the National Association of Social Workers*. Washington, D.C.: Author. Retrieved January 8, 2008, from http://www.socialworkers.org/pubs/code/code.asp.

Norcross, J.C., (Ed.). (2002). *Psychotherapy relationships that work: therapist contributions and responsiveness to patients*. Oxford: Oxford University Press.

Norcross, J.C. (2005). The psychotherapist's own psychotherapy: Educating and developing psychologists. *American Psychologist, 60*(8), 840-850.

Norcross, J.C., Strausser, D.J., & Faltus, F.J. (1988). The therapist's therapist. *American Journal of Psychotherapy, 42*(1), 53-66.

Norcross, J.C., Geller, J.D., & Kurzawa, E.K. (2000). Conducting psychotherapy with psychotherapists: I. Prevalence, patients, and problems. *Psychotherapy, 37*(3), 199-205.

Norcross, J.C., Geller, J.D., & Kurzawa, E.K. (2001). Conducting psychotherapy with psychotherapists II: Clinical and collegial advice. *Journal of Psychotherapy Practice and Research, 10*(1), 37-45.

Norman, J., & Rosvall, S.B. (1994). Help-seeking behavior among mental health practitioners. *Clinical Social Work Journal, 22*(4), 449-460.

Patterson, J.E., & Utesch, W.E. (1991). Personal therapy for family therapy graduate students. *Contemporary Family Therapy, 13*(4), 333-343.

Pope, K.S., & Tabachnick, B.G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice, 25*(3), 247-258.

Reid, W.J. (1997). Evaluating the dodo's verdict: Do all interventions have equivalent outcomes? *Social Work Research, 21*(1), 5-16.

Robb, M. (2004). Burned out – and at risk. Washington, D.C.: National Association of Social Workers. Retrieved March 4, 2008, from http://www.naswassurance.org/understanding_risk_management/pointers/PP%20Burnout%20Final.pdf.

Roseborough, D.J. (2006). Psychodynamic psychotherapy: An effectiveness study. *Research on Social Work Practice, 16*, 166-175.

Rothschild, B. (2006). *Help for the helper: Self-care strategies for managing burnout and stress*. New York: W.W. Norton & Company.

Rubin, A., & Babbie, E.R. (2005). *Research methods for social work, 5th edition*. Belmont, CA: Thomson Learning, Inc.

Sandell, R., Carlsson, J., Schubert, J., Grant, J., Lazar, A., & Broberg, J. (2006). Therapists' therapies: The relation between training therapy and patient change in long-term psychotherapy and psychoanalysis. *Psychotherapy Research, 16*(3), 306-316.

Schiller, D., (Ed.). (1994). *The little Zen companion*. New York: Workman Publishing.

Schnella, K., & Herpertz, S.C. (2007). Effects of dialectic-behavioral-therapy on the neural correlates of affective hyperarousal in borderline personality disorder. *Journal of Psychiatric Research, 41*(10), 837-847.

Schwartz, J. M., Gulliford, E. Z., Stier, J., & Thienemann, M. (2005). Mindful awareness and self-directed neuroplasticity: Integrating psychospiritual and biological approaches to mental health with a focus on obsessive-compulsive disorder. In S.G. Mijares, & G. S. Khalsa, (Eds.), *The psychospiritual clinician's handbook: Alternative methods for understanding and treating mental disorders* (pp. 281-300). New York: Haworth Press.

Seligman, M.E.P. (1995). The effectiveness of psychotherapy. *American Psychologist, 50*(12), 965-974.

Strozier, A.L., & Stacey, L. (2001). The relevance of personal therapy in the education of MSW students. *Clinical Social Work Journal, 29*(2), 181-195.

Timm, T.M., & Blow, A.J. (1999). Self-of-the-therapist work: A balance between removing restraints and identifying resources. *Contemporary Family Therapy, 21*(3), 331-351.

Ventimiglia, J.A., Marschke, J., Carmichael, P., & Loew, R. (2000). How do clinicians evaluate their practice effectiveness? A survey of clinical social workers. *Smith College Studies in Social Work, 70*(2), 287-306.

Viinamäki, H., Kuikka, J., Tiihonen, J., & Lehtonen, J. (1998). Change in monoamine transporter density related to clinical recovery: A case-control study. *Nordic Journal of Psychiatry, 52*(1), 39-44.

Wampold, B.E. (2001). *The great psychotherapy debate: models, methods, and findings*. Mahwah, N.J.: Lawrence Erlbaum Associates, Inc.

Weintraub, D., Dixon, L., Kohlhepp, E., & Woolery, J. (1999). Residents in personal psychotherapy: A longitudinal and cross-sectional perspective. *Academic Psychiatry, 23*(1), 14-19.

Wheeler, S. (1991). Personal therapy: An essential aspect of counsellor training, or a distraction from focusing on the client? *International Journal for the Advancement of Counselling, 14*, 193-202.

Williams, F., Coyle, A., & Lyons, E. (1999). How counselling psychologists view their personal therapy. *British Journal of Medical Psychology, 72*, 545-555.

Wiseman, H., & Shefler, G. (2001). Experienced psychoanalytically oriented therapists' narrative accounts of their personal therapy: Impacts on professional and personal development. *Psychotherapy, 38*(2), 129-141.

APPENDIX

Questionnaire on Personal Therapy[4]

Please answer the following questions by circling or checking the appropriate answer, or by filling in the blank, as indicated. This survey is anonymous and no information in it will be used to identify any of its respondents. Thank you for your participation. (Questions are indicated with capital letters; all numbers are for data entry purposes only). **Questionnaire printed on both sides.**

A. What is currently your primary social work practice setting? (check one)

1. _____Hospital
2. _____School (non-university setting)
3. _____University (social work education)
4. _____Private Practice
5. _____Community Clinic
6. _____State Agency (i.e., Department of Social Services)
7. _____Not-for-profit Organization
8. _____Other (specify): _____

B. If you practice in a clinical setting, to which theory/theories do you primarily adhere? (check no more than **two**) (**If you do not practice in a clinical setting, skip to question C**)

1. _____Does not apply to my setting
2. _____Behavioral
3. _____Cognitive-Behavioral
4. _____Eclectic
5. _____Existential
6. _____Feminist
7. _____Gestalt
8. _____Humanistic
9. _____Psychoanalytic/Psychodynamic
10. _____Solutions-Focused
11. _____Systems
12. _____Other (specify): _____
13. _____Don't know

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[4] Certain items in this questionnaire were adapted from the surveys of Gilroy, Carroll, and Murra (2002) and Dearing, Maddux, and Tangney (2005). As neither of the surveys were included in their published articles, they are used with permission of the authors, respectively. Additionally, Question I was taken from the research of Macran, Stiles, and Smith (1999) and is given due credit when appropriate.

C. How do you view personal therapy for social workers? (check all that apply)

1. _____Not important
2. _____Important for personal growth
3. _____Important only if individual has emotional struggles
4. _____Important for professional growth/socialization
5. _____Should be mandatory in social work programs
6. _____Should occur within agencies
7. _____Other (specify): _____

D. Are you now attending, or have you ever attended personal therapy for yourself?

_____ Yes
_____ No

If you answered yes to question D, please answer questions E-K. If you answered no, please skip to questions L and M.

E. What was/is the theoretical orientation of your therapist? (check no more than **two**)

1. _____Behavioral
2. _____Cognitive-Behavioral
3. _____Eclectic
4. _____Existential
5. _____Feminist
6. _____Gestalt
7. _____Humanistic
8. _____Psychoanalytic/Psychodynamic
9. _____Solutions-Focused
10. _____Systems
11. _____Other (specify): _____
12. _____Don't know

F. For what reasons did you pursue personal therapy? (check all that apply)

1. _____Depression
2. _____Anxiety
3. _____Bipolar Disorder (I/II)
4. _____Adjustment Disorder
5. _____Marital Problems
6. _____Grief
7. _____Stress
8. _____Other (specify): _____

G. To what extent did you find your therapy emotionally/personally beneficial? (**circle one number**)

Very Beneficial Beneficial Neutral Not Beneficial Harmful
1----------2----------3----------4----------5

H. In general, did you find/have you found your personal therapy professionally useful?

_____ Yes
_____ No

I. If you answered **YES** to question H, in what areas did you find yourself professionally benefited by your personal therapy? (check all that apply)[5]

1. _____Knowing how it feels to have therapy
2. _____Taking care of self
3. _____Recognizing that therapists can be clients
4. _____Therapist provided a role model
5. _____Learning to be one's real self
6. _____Knowing one's boundaries and limitations
7. _____Knowing what not to do
8. _____Giving clients space
9. _____Holding back from jumping in to help
10. _____Separating own feelings and client's feelings
11. _____Working at a deeper level
12. _____Judging the pace of therapy
13. _____Increased confidence in the usefulness of therapy

[5] (Macran, Stiles & Smith, 1999)

J. If you answered **NO** to question H, briefly describe in what ways you found your personal therapy non-beneficial or harmful to your professional development:

_____
_____
_____

K. How long did you attend/have you been attending personal therapy?

1. _____ 1-6 weeks
2. _____ 2 months – 6 months
3. _____ 6 months – 1 year
4. _____ 1-2 years
5. _____ more than 2 years

If you answered NO to question D please answer questions L and M; if YES to question D, please skip to question N.

L. Have you ever considered attending personal therapy for yourself?

_____ Yes
_____ No

M. For what reasons have you not attended personal therapy? (check all that apply)

1. _____Don't feel I need personal therapy
2. _____Confidentiality
3. _____Cost
4. _____Concern about what others would think
5. _____Uncertainty about what services are available or how to find services
6. _____Concern about what I would find out about myself
7. _____Concern that being in therapy would affect how colleagues view me
8. _____Concern about dual relationships or conflicts of interest
9. _____Lack of transportation to reach services
10. _____Other (specify): _____

Please answer the following questions to help us better understand the demographics of the participating respondents:

N. Gender:

_____Female
_____Male

O. Age: _____years

P. What is your race/ethnicity? (check all that apply)

1. _____African American
2. _____Asian American
3. _____Hispanic/Latino/a
4. _____Native American, First Nation, American Indian
5. _____European American (non-Hispanic/White)
6. _____Other (specify): _____

Q. What is your relationship status? (check one)

1. _____Married
2. _____Single
3. _____Divorced
4. _____Widowed
5. _____Partnered
6. _____Other (specify): _____

R. What is the **HIGHEST** level of education you have completed? (check one)

1. _____BA
2. _____BSW
3. _____MA
4. _____MSW
5. _____PhD/DSW
6. _____Other (specify): _____

S. In what year did you obtain your **HIGHEST** degree? _____

T. In what ways do you believe that NASW could/should provide resources or education regarding self-care for social workers? (use space provided)

Please feel free to use this space to provide any additional comments, concerns, or issues you would like to raise regarding personal therapy for social workers.