What We Bring into the Room:
A Psychodynamic Perspective on the Value of Personal Therapy for Therapists

David R. Robinson, M.A.

A Clinical Research Project presented to the faculty of the Hawai‘i School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

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This Clinical Research Project by David R. Robinson, directed and approved by the candidate's Clinical Research Project Committee, was approved by the faculty of Hawai'i School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

Sean Scanlan, PhD, Director
Hawai'i School of Professional Psychology

Clinical Research Project Committee

Lianne T. S. Philhower, PsyD, MPH
Lianne T. S. Philhower, PsyD, MPH (Jul 29, 2020 16:44 HST)

Lianne T. S. Philhower, PsyD, MPH
Chair

Ricky Trammel, PhD
Ricky Trammel, PhD (Jul 29, 2020 15:02 HST)

Ricky Trammel, PhD
Committee Member

07/29/2020

Date

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Dedication

For my children, Michael and Katie, the two most important reasons why I try to be better than I was.

Acknowledgments

My deepest appreciation and respect go to Dr. Lianne Philhower whose support and guidance have been a source of stability and clarity in my professional development. She has consistently exemplified the qualities of a mentor and psychologist I hope to achieve. A special thank you to Dr. Ricky Trammel whose patience, compassion, and pleasant demeanor have influenced how I try to interact with others in my personal and professional life. I would like to express my profound gratitude to Dr. Spencer Walton, the first person to make me feel heard. He was the reason I first considered becoming a psychologist.

Abstract

Psychotherapy can be seen as a relationship, one in which the client engages in self-disclosure with the intent to facilitate their clinician's application of interventions to improve the client's quality of life. The application of therapeutic interventions is underpinned by a clinician's theoretical orientation, the philosophical understanding of what causes maladaptive functioning and how it can be changed. Psychodynamic psychotherapy emphasizes the therapist-client relationship, viewing the therapist and the therapeutic alliance as components of treatment. Personal therapy is one possible avenue through which a therapist is able to develop their personal attributes and address biases. Through a comprehensive review of the literature on the potential impact a therapist can have on treatment outcomes, and on the common insights clinicians gain from personal therapy, a model is presented to illustrate how personal therapy can help the psychodynamically oriented therapist's ability to strengthen the therapeutic alliance and increase overall treatment efficacy.

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CHAPTER I. INTRODUCTION

When people are asked to share the intimate details of their lives, their pains, shame, and guilt, much thought is placed on their vulnerability; but little is considered with respect to the one who must hold that space open without being consumed by it. The therapist is, by definition, an individual whom others can turn to, in moments of emotional distress and turmoil, for guidance, solace, and comfort. As relational creatures, the capacity for a therapist to heal can be matched by the capacity for what that healing costs the therapist. When a therapist "holds" a space for the other, they are required to secure their own biases, thoughts, and opinions so as to not interfere in or detract from the client's experience or processing.

What little a therapist might disclose to their clients of their own internal world is weighed on how much of the reveal is because of their own needs versus the potential benefit to the client. For example, if a client is sharing their experience of the loss of a loved one, is it necessary or even appropriate for the therapist to share their own countertransference of loss and grief that is activated by the clients sharing? Although it is quite possible that the client might find connection in that disclosure, it is ultimately subjective to each relationship. There exists the likelihood though that, like in the previous example given, a therapist might be struggling with his own loss and grief; and the expectation is that he must intently listen to and support the client amidst those burdens. That begs the question then, should the therapists receive personal therapy so that they might be more fully present and engaged with their clients?

Situating the Study

Situating a study provides a contextual frame for the reader. It provides a brief introduction to the topic of the study, the researcher's personal stake or interest in studying the phenomenon, as well as its relevance in providing utility to the existing body of research

(Glesne, 2016). Researchers provide this contextual frame in an attempt to answer two important questions: “so what?” and “who cares?” When a researcher situates their study, they are presenting the utility and importance of studying a particular phenomenon; the “why” of the study. This frame provides the reader a justification or a sense of the broader purpose the research is a part of that will aid a particular population or group (Glesne, 2016).

While there is no question that therapists and other mental health professionals seek out their own personal therapy (Mahoney, 1997) to practice self-care and process their own challenges, the extent to which therapists of differing ideologies seek their own therapy varies drastically. Theoretical orientations can be, to many therapists of differing orientations, simply a frame in which they understand the mechanism for therapeutic change but for others it can be a philosophical extension of their fundamental being. Orientation, whether it is dynamic, behavioral, cognitive, or systemic, can so well espouse an individual’s paradigms that it gives language to what has always felt “true” for them. With these thoughts in mind, this study will review the current literature in order to develop a psychodynamically oriented model that incorporates common insights and lessons gained from therapists who have engaged in personal therapy. Psychodynamically oriented therapists often go through their own personal work with a therapist during their training. The literature on how this personal work impacts the therapist's approach to providing therapeutic services will be explored. As therapists, we provide a unique and challenging service, a service that many therapists have personally engaged in with positive outcomes (Bike, Norcross, & Schatz, 2009).

Within the psychodynamic frame, there is an emphasis for the therapist to be mindful of how much of themselves they "bring into the room” with the client. If a therapist has never engaged in personal therapy, would they be aware of how their personal beliefs, biases, and

assumptions impact the client? While a therapist might never completely eliminate their biases or assumptions, which might impact treatment, personal therapy offers an opportunity for the therapist to "sit in the other chair" and be on the receiving end of the services they are expected to provide. What lessons have therapists learned about themselves, therapy, and adaptive functioning that could also benefit their clients? This study hopes to illustrate how personal therapy impacts the therapy provider's services and proposes a model to incorporate personal therapy into professional practice.

Personal and Professional Relevance

Throughout my life, I have always struggled with understanding myself, my place in the world, and why I am who I am. I intuitively “knew” that to understand this was to not only know myself but to understand the world and my place within it. I did not fully comprehend the reverberations that early developmentally significant experiences had on my life until I gradually became aware of how these experiences established and reinforced particular maladaptive cognitions and behaviors. “Pathological identification” is defined as, “a learned psychological phenomenon in which patients unconsciously repeat pathological behaviors, attitudes, and affects their parents displayed in the past causing current problems in relationships with spouses, children, coworkers, and friends” (Foreman, 2018, p. 15). I struggled to understand my own behaviors and, through the first encounter I had with a clinical psychologist, gradually began my journey of self-exploration.

My first therapeutic experience was when my high school counselor, a clinical psychologist, took me aside after an incident with a teacher and simply listened to me. He did not attempt to question, criticize, or condemn, but listened and modeled non-judgmental acceptance. Weekly sessions became a regular occurrence for me and, quite frequently, they were the only

times I felt secure enough to be vulnerable. I am forever influenced by this experience. Through the simple yet incredibly deep act of listening to a 17-year-old high school student, my school counselor had given me something that I did not even know I wanted until I received it; a voice, to be heard, to be seen. I have been on a journey of self-acceptance, self-understanding, and most of all self-love ever since this experience that led to my own pursuit of a doctorate degree in clinical psychology. Regardless of whether I knew it at the time or not, engaging in my own personal therapy at 17 altered the trajectory of my life.

As my life has moved on, I have always kept that experience close to my heart. Now that I am coming to the end of my training in a doctorate program, pursuing something incredibly meaningful to me on my own terms, I find that I value the opportunity to process with a therapist or even consult with a peer. My own engagement in therapy has deepened over time. Initially I struggled to identify and process the deeper pain that I instinctively knew to be there, to now having gained the language to describe my world and what I feel with clarity. Therapy has led to personal awareness and insight of misguided beliefs and maladaptive coping strategies that have, in turn, led me to grow and facilitate greater harmony internally and interpersonally. While the work is by no means done, and I believe it never will be, the journey of my own self-growth truly began with that first personal therapy experience so many years ago. My hope for this study is that through examining and synthesizing the available research, I can present an empirically grounded model of how personal therapy can enhance professional therapeutic practice.

Rationale for the Study

The statement of the problem provides a rationale or justification for conducting the study (Creswell, 2009). The statement of the problem is generated after a thorough review of the literature in which omissions or missing items from the current body of research are identified.

Because the identification and potential addressing of these omissions is central to the statement of the problem, the primary function of the statement of the problem is to address a study's utility and moral praxis. It is important to generate a statement of the problem because the researcher is then identifying, presenting, and addressing omissions found during their review of literature and how the research will address these missing areas. It is central to understanding the fundamental purpose or "point" of the research and how it will contribute to the current body of research.

While the evidence on whether or not personal therapy does in fact provide objective benefit to the therapist or to their clients is still debatable, there is strong support that the therapist who is struggling with their own emotional turmoil is less effective therapeutically than the therapist who is able to process and grow from their tumultuous experiences (Orlinsky, 2013; Probst, 2015; Rizq & Target, 2008). While personal therapy is not a necessary component of psychodynamic therapy, psychodynamic supervision incorporates a thorough examination of the supervisee's countertransference and self-awareness in order to bring as little of themselves into the room. I am interested in exploring how personal therapy can facilitate greater self-awareness, which in turn influences the clinician's ability to successfully provide meaningful therapeutic services to their clients.

Much research has been conducted in regards to a therapist's theoretical orientation; how an individual determines their orientation, what the theoretical orientation means to them, as well as the relationship between an individual's paradigms/personality and his or her orientation (Heinonen & Orlinsky, 2013; Larsson, Kaldo, & Broberg, 2010; Ogunfowora, & Drapeau, 2008; Potvin, 2013; Pruitt, 2014). Much is also known about therapists' attitudes regarding the engagement of mental health providers in personal therapy (Chaturvedi, 2013; Hackman, 2017;

Kumari, 2011; Mahoney, 1997; Norcross, 2010; Orlinsky, 2013; Pope, & Tabachnick, 1994; Probst, 2015; Rizq & Target, 2008). However, there is little literature regarding how different theoretical orientations conceptualize the importance of the practitioner's ongoing personal therapy and whether or not personal therapy can expedite the acquisition of skills necessary to effectively practice psychodynamic psychotherapy.

Theoretical orientations often resonate with therapists at a core level of their personality and while most mental health providers will attest to or at least promote personal therapy for therapists, not all engage in their own personal therapy nor do all states require participation in personal therapy as a requirement for licensure. There is also little evidence demonstrating that therapists who continue their personal therapy have better client outcomes (Kumari, 2011; Chaturvedi, 2013). Identification of a theoretical orientation is a crucial component of an individual's journey through their training program that resonates with their internal beliefs (Heinonen, & Orlinsky, 2013). Therapist's perceptions of their own personal therapy were shown to have a positive impact on their own client's therapeutic experiences, but only when the therapist perceived their personal therapy as meaningful, effective, and necessary (Kumari, 2011). This study will attempt to categorize commonly identified characteristics of effective therapists and whether or not these characteristics are affected by personal therapy.

Purpose of the Study

If the Rationale for the Study is the identification of omissions or missing knowledge in the existing literature, then the Purpose of the Study would be how those omissions will be addressed and for what purpose or reason is it important that they are explored. The statement of purpose would speak on the utility of a study and the practical application of the knowledge gained by gaining a greater understanding of the phenomenon.

The purpose of this research project is to develop a psychodynamically informed model that brings to light the important insights and lessons gained from therapists who have engaged in personal therapy. The result will be a model that illustrates how personal therapy impacts the therapy provider's services. At this stage in the research, *theoretical orientation* will be provisionally defined as – "a roadmap for psychologists," guiding them through "the process of understanding clients and their problems and developing solutions" (American Psychological Association [APA], 2017).

Research Questions

Research questions are general questions designed to identify the overall focus of a study; what one wants to explore in a study. The purpose of the research question is to provide a guide or direction of the study and its overall intent. This is determined by significant omissions in the review of literature which then aid in the identifications of boundaries of the study (i.e., who and where can I get to the closest aspect of the phenomenon the research is attempting to explore) (Rossman & Rallis, 2017). Aside from increasing the researcher's theoretical sensitivity, research questions direct the focus of the research, specifying exactly how the proposed model will attempt to address the omissions in the current research. Research questions identify the overall intent of the study and are based on a need identified during the review of literature (Glesne, 2016)

The research questions guiding this theoretical paper are as follows:

1. Do therapist's subjective characteristics impact treatment outcomes? If so, which?
2. How might a therapist's subjective characteristics influence their perception and experience of personal therapy?
3. How can a therapist's personal therapy impact treatment outcomes?

4. How can personal therapy be used as a pedagogical method to facilitate better treatment outcomes?

Significance of the Study

While the identification of the omissions and elaboration on the methodologies are presented in the problem and purpose statements, the significance of the study is a general aspirational statement presenting the hopes of the study and it's identified major stakeholders. Specific benefits to each major stakeholder group are identified as well as why they might be interested in the study. The statement of significance helps to clearly identify the intended audience of a study, why they should be interested, and how a researcher would hope to benefit those stakeholders. By doing so, the researcher is facilitated in considering what besides his or her own agenda might be important to investigate as part of the study, thus enhancing the study's utility. This study facilitates the continued exploring, building, and refining of theory so the practical utility of the model will be presented more towards the local and immediate users of model; providers who incorporate the model into their own clinical practice.

While most clinicians will attest to the value of therapy for everyone, including other therapists, there is incongruence between what they believe therapists should do and what they actually do themselves. Hopefully, through this model, psychodynamic psychologists will gain a greater understanding of the value of personal therapy and how to incorporate insights gained from their personal therapy into their professional practice. With increased insight into theoretical orientation and attitudes towards personal therapy, the overall intent is to help facilitate the psychologist's personal growth and thus positively influence professional practice.

Clinical psychologists may benefit by having the opportunity to consider the role of theoretical orientation in clinical practice, personal and professional development; how it may

contribute strengths and recommendations to practice with diverse clients; and how it shapes their views about therapy's role in professional development. Training faculty may benefit by possibly gaining a deeper understanding of the subjective experiences personal therapy can have on their students as well as guide their academic/training curriculum towards developing more effective therapists through evidence-based research. Field supervisors may benefit through identification of potential areas of development that they may focus on (i.e. assisting the trainee/supervisee in identifying and working from a more dynamically oriented approach while examining countertransference within their supervisee's sessions) or particular areas to avoid. Another possibility could be in approaching their own supervision based on what was beneficial and what was identified as detrimental by therapists who have undergone their own personal therapy.

In the following vignette, I introduce a therapist, Max, who is beginning to experience personal and professional stressors that negatively impacts his therapeutic efficacy. After an introduction and explanation of the model, we will examine the application of the model on this vignette.

Case Vignette

Max is a 32-year-old Asian-American therapist who feels frustrated and incompetent by his continuing struggle to feel comfortable and confident while in session with his clients. He recognizes that he experiences anxiety about truly being able to help his clients achieve their treatment goals. Although he believes that having concern for your client's treatment outcome is a concern to be valued by a therapist, he finds that he is so concerned about "taking care" of his client's that he can lose his objectivity at times. Max feels pulled at times to explain psychological concepts, diagnoses, or therapeutic processes in an attempt, he believes, to

reassure what he identifies as his client's anxieties about therapy. While Max is aware of this need to reassure his client's emotional distress, he finds himself engaging in supportive behaviors more frequently than his supervisor feels is necessary. Specifically, his supervisor suggested that Max encourage his clients to elaborate on their feelings of anxiety, depression, and emotional turmoil while he attempts to remain "neutral." Max thinks that though his supervisor's feedback is well-intentioned, he cannot help but feel as though he should be doing more in the sessions, that by being silent he is making his clients uncomfortable or feel unsupported. This desire to reassure his client's and "take care" of them when they express emotional turmoil is further reinforced by many of Max's client's expressing gratitude for his nurturing and caring attitude. Max infers that their appreciation for his approach might possibly be due to the fact that Max's reassurance and nurturance is something they have not historically experienced when they have attempted to share their vulnerability with others. He feels stuck because he feels that being supportive is "right" and his clients appear to appreciate his actions, while his supervisor continues to identify what Max should not be doing in his sessions.

As Max continues to engage in these supportive behaviors, he gradually begins to feel frustrated and annoyed with his supervisors' continued insistence that his approach to therapy is not congruent with his expressed theoretical orientation. Max becomes defensive with his supervisor, believing that he is justified in his anger at his supervisor's comments because he thinks that therapeutic styles are unique to the therapist. Max feels as though his supervisor is telling him that he is a "bad" therapist and he believes that his supervisor is questioning his competency without actually offering helpful suggestions or clear expectations. As these feelings of defensiveness, frustration, and incompetence mount up, Max's ability to regulate his emotions in and out of therapy starts to diminish. He finds that he is less motivated and engaged in his

work with his clients, attempting to remain “neutral,” what he has come to believe as “emotionally distant.” He becomes aware of the impact his mood is having on his professional and personal life as he finds that the thought of going to work increases his anxiety. He has decreased his supportive behaviors and now feels as though he is not engaging with his client’s in an honest and genuine manner; he cannot help but feel as though he is being dishonest with his client’s which makes him feel guilty and ashamed. Max eventually realizes that he does not feel comfortable discussing these feelings with his supervisor for fear that it will only further diminish how his supervisor sees him. While he understands that his supervisor does not “hate” him, he feels distrustful of expressing any personal vulnerability believing that it will negatively impact his evaluation and cause his supervisor to “micro-manage” him.

CHAPTER II. REVIEW OF LITERATURE

A review of literature is a brief but concise examination of the existing knowledge about a phenomenon for the purposes of providing a working definition as well as an overview of what is and is not understood. The review of literature is utilized as a way to frame the model.

In this chapter, I will be reviewing the available literature on how the therapist's characteristics (personality, emotional regulation, self-awareness, and temperament) can have an effect on their client's treatment. The first section will present current research on the impact and importance that the therapist's self-awareness and self-regulation can have on their client's treatment, as well as their own psychological well-being. The second section will examine how the therapist's subjective variables have an impact on their therapeutic efficacy, client's treatment outcomes, and professional practice.

Murphy, Irfan, Barnett, Castledine, and Enescu (2018) found, through a systematic review and meta-synthesis of qualitative research into mandatory personal psychotherapy during training, that six common themes emerged for therapists from their personal therapy. These themes are examined against commonly identified subjective variables of the therapist that were shown to affect psychodynamic psychotherapy outcomes (Lingiardi, Muzi, Tanzilli, & Carone, 2017).

Education, training, and theoretical orientations have extensive research but systematic and rigorous examinations of lessons learned in personal therapy and how they can benefit the clinicians therapeutic efficacy is limited (Bike et al., 2009; Chaturvedi, 2013; Kumari, 2011; Norcross, 2010; Orlinsky, 2013; Probst, 2015; Rizq & Target, 2008). The emphasis of the model is on the therapist's discovery of their clinical paradigm and refinement of their clinical practice through processing in personal therapy.

Importance and Impact of Self-Awareness

The graduate student's identification of a theoretical orientation marks a point in their professional careers where they have identified the frame that resonates with them, best parallels their personality, and will become the foundation of their practice. Although this insight into the integration of their personal and professional identities is a significant milestone, Larsson, Kaldo, and Broberg (2010) and Pruitt (2014) note that as a therapist's experience grows, there can be a change in the level of investment to their particular theoretical orientation as an extension of their identity.

So, what does it mean to follow a particular theoretical orientation and what does a specific theoretical orientation say about the individual who adopts it? Heinonen and Orlinsky (2013) found that psychotherapists had a tendency to view themselves in certain ways, particularly in their personal relationships, that was consistent among other psychotherapists of similar theoretical orientations. For example, Heinonen and Orlinsky found that individuals who identified with a Cognitive Behavioral Therapy (CBT) theoretical orientation generally valued concrete practical applications in their personal lives over intuitive or subjective anecdotal experiences. Assumptions can be gathered from current research suggesting that therapists' identification with a particular theoretical orientation are, at least partially, attributable to personal preferences and particular personality profiles or proclivities (Ogunfowora, & Drapeau, 2008).

Taking Care of the Caretaker

A personally relevant component to a therapist's approach to treatment is whether or not they engage in their own personal therapy. Though the topic has been studied extensively, the literature is still mixed on whether or not personal therapy is beneficial for every therapist or

impacts the outcomes of their clinical work with clients. Although several studies have quantitatively demonstrated that the majority of polled clinicians view personal therapy as a meaningful and valuable endeavor (Hackman, 2017; Norcross, 2010; Orlinsky, 2013; Pope, & Tabachnick, 1994; Probst, 2015; Rizq & Target, 2008), the evidence is mixed on whether or not personal therapy is professionally or personally beneficial for all therapists (Chaturvedi, 2013). Engagement in personal therapy is seen as a task undertaken to address certain issues the individual believes to be relevant to their life. Therapy also has the potential to increase the clinician's awareness of the client's experience of therapy and adds to their clinical repertoire by increasing awareness of themselves and the overall counseling process (Rizq & Target, 2008).

The public assumption of the mental health profession is one where individuals believe that when they seek mental care they are working with a competent and trained professional who can help with their issues, not exacerbate them further. This assumption that mental health professionals are trained in effective mental and emotional resolution techniques might lead to an incorrect assumption that these professionals do not have personal issues or at least be able to resolve their own problems; this is a fallacy. The developed lens that a competent therapist or counselor possesses would also have to be aimed at themselves in order to identify when they are beginning to experience symptoms of a mental health disorder and the potential impact those symptoms can have on the client. When a mental health professional becomes too consumed with the bombardment of emotional stressors from their clients, they have already begun their first steps toward burnout (Gil-Monte, 2012). It is understandable and quite common a counselor could experience guilt from believing that they have "failed" their client's in some way (D'Souza, Egan, & Rees, 2011; Kottler, 2010). Several authors also note that there is a high probability that this "guilt" might be influenced by perfectionistic tendencies within the clinician,

the patient's unrealistic expectations of counseling or the counselor, or if the professional begins to personally identify with the patient or their shared experience (countertransference) (D'Souza et al., 2011; Kottler, 2010).

The mental health profession is significantly more impacted than the general population in terms of incidence of burnout and severity of delayed or ineffective care. Considerable negative ramifications are evident when a therapist is not treated for burnout as the quality of care the patient receives is diminished and the likelihood of the professional committing unethical behavior rises with delayed treatment. Therapists are also frequently exposed to the stress and emotional turmoil that is the nature of psychotherapy where individuals come to seek guidance, growth, and alleviation from the pain of their experiences. As individuals exposed to this on a magnitude rarely seen outside of the caregiver profession, it is common for mental health providers to experience burnout, compassion fatigue, and emotional drainage that can negatively impact psychological and physiological well-being, as well as professional efficacy (Hackman, 2017; Mahoney, 1997; Pope & Tabachnick, 1994). If not capable of "curing" clinicians suffering from stress-related disorders or "burnout" personal therapy will at least provide an opportunity for the therapist to become aware of their own struggles. This self-awareness can be significantly valuable in the room, especially when working with transference and countertransference, as many psychodynamically oriented therapists do (McWilliams, 2004; Summers & Barber, 2010). Personal therapy would provide the therapist an opportunity to process their own emotions and possibly even gain insight, through their own processing, of how to better connect, engage, and guide their clients.

Unlike a medical doctor or surgeon who might be able to maintain some semblance of emotional distance from their patients, the effective mental health professional is encouraged to

share in the intimate and vulnerable details of another's personal life, oftentimes a part that the client has rarely shared. Given the intimate interpersonal nature of the therapeutic alliance, it is understandable that a possibility exists that the client will overly identify or enact relational dynamics with the counselor and vice versa. This transference-countertransference dynamic can be difficult for any one individual to manage alone, especially considering the fact that the professional must engage multiple clients daily, must be on call ready to assist an individual experiencing a crisis, as well as be expected to deal with their personal obligations towards their family, friends, etc. The American Psychiatric Association (2000) notes that stress on the mental health professional is exacerbated due to the subjective nature of treatment options that are not only viable but effective and how one treatment that was effective for a specific individual might have no effect on another, or might even trigger a negative experience. This subjectivity forces the professional who wishes to effectively and ethically treat their patient to personalize each treatment plan, and this personal factor requires the therapist to engage their patients on a deeper level. Kottler (2010) notes that this personal approach to effective care can have detrimental impacts on the mental health professionals well-being simply due to the fact that they are required to deal with the daily stressors everyone must deal with in their lives as well as share the burdens of a number of different patients.

Due to the limited number of qualified professionals employed in the mental health field, the workload per counselor can be daunting (Soderfeldt, Soderfeldt, & Warg, 1995). Previously, in psychotherapy, the target audience was mainly middle age, middle to upper class, white, and female but the demographic has shifted considerably with gradually decreasing stigmatization in the mainstream culture of psychology and counseling (Kottler, 2010). An intervention that might produce effective results for one client might not be appropriate, or even harmful, to an

individual with different cultural values or norms. The therapist's awareness of their client's culture, their own culture, and the cultural norms of external variables impacting their client must all be given some consideration. One culture's "delusions" could be seen as appropriate in another culture (e.g. believing that the spirits of deceased loved ones can directly communicate with the client). It is the clinician's empathetic bonds and professional obligations to try and assist those who seek their services which can lead them to personally experience turmoil, frustration, and guilt if they believe they have failed to provide effective treatment (Gil-Monte, 2012).

Individuals are able to mitigate the stressors that they face through a variety of positive external lifestyle choices as well as internal perceptions. External strategies that aid in managing stress can include enjoyable hobbies such as: hiking, reading, exercise, spending time with family and friends, and traveling (Kottler, 2010). Aside from the previously mentioned activities that promote psychological well-being, processing stressors by discussing them with another person can provide opportunities for clarity and perspective. Therapists are encouraged to seek professional consultation with colleagues on clinically relevant ethical issues and treatment approaches, such as discussing possible interventions for a particular client. These consultations can serve an additional purpose in that they facilitate the therapist in feeling supported by a peer (Kottler, 2010). Internal variables, such as the therapist's ability to self-regulate, can reduce ego depletion, allowing the therapist to be adaptive and flexible to stressful situations (Baumeister & Vohs, 2016). The ability to self-regulate has been associated with the prosocial behaviors of self-sufficiency, resiliency, and generosity (Bleidorn et al., 2020). When an individual shifts their focus away from the negative aspects of an event and is able to view stressful situations as either

the natural course of events or as opportunities to learn and grow, the individual is applying a basic therapeutic skill of positive reframing.

Burnout

In this study, burnout is defined as the therapist's personal feelings of psychological depletion and emotional exhaustion due to prolonged exposure to stressors (Kumar, 2007; Suran & Sheridan, 1985). There is a connection between feelings of guilt within the psychologist and incidences of burnout; the mental health professional feels guilt which leads to burnout, typically resulting in depression or beliefs in failure (Gil-Monte, 2012). When an individual has a perfectionist attitude towards the effective emotional and mental treatment of patients suffering with disorders or issues, the individual is taking their patients troubles upon themselves and see any failure on the part of the client to successfully manage their disorder as their own personal failure in not being able to "fix" the patient. All individuals are different and because of this, all treatment plans are not universal in their application and efficacy; there might be an individual who does not respond well to most treatment options and their clinician will see this as a sign that they are failing the patient. When feelings of guilt begin to enter the mind of the therapist that individual must be vigilant and accepting of their emotional turmoil but not to let it overwhelm them; all patients will respond in their own time to treatment and those who cannot find treatment can at least learn techniques to mitigate their disorders. When a therapist is able to grasp the concept of letting a patient go because they are not able to provide the most effective care that the individual needs, the mental health professional will gain a measure of humility and avoid the subsequent burnout by appreciating what they were able to do as opposed to how they failed. To ensure that burnout is prevented, or at least mitigated, the therapist must come to the understanding that they cannot help every individual that walks through their doors; it is not a

failing on their part but rather an inherent aspect of being human; fallibility. When an individual is able to address the issues within themselves, they are able to direct that sense of guilt into motivation to accomplish a meaningful action (Southwick, Gilmartin, Mcdonough, & Morrissey, 2006). While an individual can take their sense of guilt and utilize it to identify an issue that must be addressed then motivate them to resolve it, with regards to tragic optimism in the face of suffering, the individual can only determine their own meaning to the events (Southwick et al., 2006).

D'Souza et al. (2011) note that one of the most important factors in understanding burnout is the common mentality of mental health professionals who experience it. A potential risk factor of burnout can be perfectionistic traits, possibly due to a desire to control themselves or a situation to decrease distress or anxiety (D'Souza et al., 2011). Through an analysis of 87 Australian clinical psychologists, D'Souza et al. found that a perfectionist mentality, one where everything the individual does has to be "perfect," has high positive correlations with stress and a negative subjective sense of well-being. The study finds that all individuals with obsessive tendencies have more sensitivity towards stress as well as personal belief that they experience more stress than others (D'Souza et al., 2000). This high correlation with stress is an indicator of whether or not a mental health professional will experience burnout. An awareness of these attitudes can assist in identifying those individuals who will be more prone to experience burnout. Self-regulation can be established to ensure that these individuals recognize their perfectionist attitudes and mitigate the behavior through controls; i.e. taking the time to appreciate the work they have done as opposed to constantly criticizing it and focusing on appreciation rather than cynicism.

Insights gained from personal therapy may increase an individual's ability to consciously view experiences through a mindset of growth and learning as opposed to pessimism and resentment, enhancing resiliency and protecting against burnout. One method of developing resilience and coping with significant life stressors is to find personal meaning within the suffering (i.e., What did I learn from this experience or how can I use what I learned from this experience to help me in the future?). Though the event itself might not be viewed as a positive experience, if the individual is able to view it in the light of a learning experience, a general event that could have happened to anybody and is not the norm, or as an opportunity to change something about them into something better, this is resilience (Moffic, 2011).

The psychological and emotional burden of continuing to be expected to listen to and deal with other individuals' problems can start to mount up until eventually the clinician is overwhelmed (Leahy, 2009). If the counselor is able to attribute a positive connotation towards what they do, such as acknowledging and accepting the understanding that not all patients might be cured but the ones that do seek treatment have an increased chance to develop adaptive functioning, then they are able to view their hardships as necessary and even beneficial to those seeking aid as well as for their own development. When a mental health professional is able to view the daily stressors that they may face in their careers with a more positive mental framework, they experience a less subjective sense of negativity regarding their jobs (Moffic, 2011). Though the amount of stress might still be the same regardless of the intervention or not, how the professional chooses to perceive the stressors can make all the difference in their reactions. If the perception of stress and professional obligations is associated in a negative context the individual will sense that any subsequent stress is detrimental to their well-being, their situation or overall life will be seen as something negative. If an individual sees their career

and the associated stress as meaningful, in spite of how much stress they might face, they can see themselves serving a necessary purpose thus giving validation to their career and stress (Kumar, 2007; Moffic, 2011).

Unrealistic expectations can lead to feelings of responsibility and guilt for things that the therapist never had control over from the start, such as the client's feelings, thoughts, or behaviors. This is not to say that the clinician does not have an ethical and moral responsibility to their clients, but rather to acknowledge and reinforce that a lack of self-awareness can potentially result in the blurring of boundaries. For example, a clinician might believe that they genuinely care about the well-being of their client's and, in order to address what they perceive as maladaptive behaviors or beliefs of the self, they challenge a client. Though the intent of this challenge might be well-meaning, if the perception of the client's behavior as maladaptive or adaptive is influenced by the clinician's own personal perspective or bias then they are inadvertently imposing their beliefs onto the client. The possible negative ramifications of this behavior could be the client feeling as though the clinician is condemning their beliefs or actions, an increase in defensiveness, transference, and rupture in the therapeutic alliance. Not all clinicians will have a desire to work with every population but the clinician must be aware of themselves enough to know whether or not their own biases are impacting their approach to treatment, interpersonal style with their client's, and even their overall definition of what it means to be "healthy."

Soderfeldt et al. (1995) bring forth an important point by noting that though the individual and personality factors a professional holds have significant impact on their own mental and emotional well-being, another key fact that can lead to stress, and possibly burnout, is workplace and organizational factors that are detrimental to the well-being of the clinician. If a

mental health professional is working in an organization that is stifling to its employees' needs, bureaucratic in their hierarchy, and places more of an emphasis on the bottom-line than on the welfare of their customers, the patients and clients as well as employees then workplace stress increases exponentially. As workplace stress grows, an employee within that organization grows to negatively associate work with stress and difficulty rather than as a helping profession with a daily opportunity to help multiple people. A mental health professional is given the rare opportunity to make a true difference to a few people's lives every day they go to work but if the organization the clinician works under is stressful then the work becomes negatively associated with emotional and mental strain; work begins to be seen as a chore to do rather than as an opportunity to help. The burden lies on the psychotherapist to address these issues and seek outside assistance if necessary.

Therapeutic Alliance

Dynamic psychotherapy is uniquely suited to facilitating an increase in self-awareness and understanding on the part of the clinician. Though no one standard definition exists within dynamic psychotherapy, as different authors have different conceptualizations of the theoretical orientation, there exists underlying commonalities of these various definitions. McWilliams (2004) characterizes psychoanalytic psychotherapy as an extension of the therapist; the curiosity, respect for subjectivity and identity, and reflective reflection. McWilliams notes that one of the possible reasons why psychodynamic psychotherapy is challenging to quantify and standardize is that the emphasis of dynamic therapy is less on delineating the human condition to measurable metrics. For example, one client's reported symptoms of depression might mirror those of another client, yet their prognosis and treatment outcome might vary considerably. McWilliams states that current mental health treatment in western states have gradually moved from a healing

relationship to one of techniques applied to a discrete category of diagnoses. With this gradual change then, the emphasis of treatment focuses more on the application of interventions rather than on the fluid interaction between therapist and client in order to achieve subjective qualitative goals as opposed to objective quantifiable metrics (e.g. finding meaning in life versus reporting a sadness level of four compared to a sadness level of eight). Gunderson and Gabbard (1999) views the therapeutic relationship as a "two-person field" that the therapist will contribute to regardless of whether or not it is their intent. Regardless of the clinician or textbook defining what psychodynamic psychotherapy is, they all emphasize one thing above all else that is unique to psychodynamic work, the relationship between therapist and client (Summers & Barber, 2013).

No other theoretical orientation emphasizes the importance of the therapeutic relationship more so than psychodynamic psychotherapy. The interactions between the therapist and client are not only seen as potential avenues of facilitating change but the relationship is also seen as the primary medium through which the client is able to acknowledge, explore, and address the maladaptive thoughts, beliefs, and behaviors that cause disruption in their life and psychological distress. Less self-directed hostility within the therapist, combined with an increased sense of strong social support and comfort with closeness in relationships has been shown to increase the strength of the bond between the therapist and the client (Summers & Barber, 2013). An increase in the strength of the therapeutic alliance increases the overall efficacy of treatment (Summers & Barber, 2013). Barry (2004) notes that even within the context of a brief or short-term model of therapy, psychodynamically oriented therapists' emphasis on the therapeutic relationship, as well as building and maintaining rapport still can affect treatment efficacy. Given the significance that

rapport and the therapeutic relationship has on treatment outcomes, it is no surprise that students are trained to develop their ability to quickly establish and maintain a positive working alliance.

Mentalization can be described as the process with which individuals consciously and unconsciously become aware of and process the mental states (needs, wants, beliefs, feelings, etc.) of themselves and others (Wallin, 2015). A therapist's therapeutic efficacy is influenced by their ability to attend to the client's mental states, as well as their own. Summers and Barber (2003) suggest ways in which students might develop their ability to establish and maintain a therapeutic alliance, by recognizing and addressing countertransference issues and enactments as they arise. The authors also note the beneficial impact that the therapist's positive regard for the client can have on their ability to empathically attune to the sessions, conveying a sense of genuine compassion and respect (Summers & Barber, 2013). One way in which this positive regard, and the resulting increase in empathy felt for the client, can be developed is through an attitude of curiosity. For example, preoccupation or disinterest with a client and their presenting problem could result in feelings of boredom and disengagement which might be noticed by the client. If the therapist is able to closely examine the factors that might be contributing to his own lack of engagement in the session, as well as contributing factors to the client's presenting problem then they can provide reflection, insight, and value to the client's self-disclosure. A critical component to providing effective therapy, thus facilitating meaningful change, is the client's ability to share their vulnerability with the therapist. Being vulnerable is a risk, a risk that client's might not feel entirely comfortable with taking and are hurt by when the risk does not produce the desired reward. In psychodynamic psychotherapy, the clinician takes an active role in helping the client to express their vulnerability and to demonstrate to them that their vulnerability will not be in vain.

Self-reflexivity, as understood within this model, is the ability for an individual to consider the effect that they have, as well as how they are in turn affected by, on relationships and events around them (Hedges, 2010). Within regards to therapy, a clinician's self-reflexivity is evident when they are able to consider how they impact the client, as well as how they are impacted by the client, while they are interacting with the client and adjust their behaviors as needed. Psychodynamic therapists attempt to recognize and manage countertransference as to not disrupt or detract from the client's treatment, yet this can be incredibly challenging if the therapist is not even aware of some possible triggers to their countertransference. In their interpretative phenomenological analysis, Rizq and Target (2008) found that one of the most significant benefits of personal therapy was that it increased a therapist's ability to be self-reflexive. Self-reflexivity requires a combination of self-awareness, emotional regulation, and mindfulness that can be developed through experiential exploration of their vulnerabilities (Scaife, 2014).

Clients, therapists, supervisors, and supervisees interact within a unique interpersonal relationship; one of intimacy, distance, power differentials, and explicit acknowledgment of privilege and marginalization. Social justice within psychology is defined as the professional practice of identifying and changing societal practices and policies that undermine the efforts of marginalized and disenfranchised groups to the same opportunities of self-determination as other members of society (Hailes, Ceccolini, Gutowski, & Liang, 2020). This practice can be accomplished within the micro, meso, and macro levels whether it is through advocacy and policy reform or even how the therapist navigates addressing issues of justice with their own clients. For example, given the implicit power dynamics within the therapeutic relationship, a client might enter into the therapeutic relationship with a view of the psychologist as an authority

figure to be trusted and not challenged. If the therapist is not mindful of this possibility, they might not be fully aware of the weight that their words and actions can carry to the client, as well as the discomfort the client might experience in expressing disagreement or dissatisfaction with the therapist's performance.

Hailes et al. (2020) suggest a possible guideline on how psychologists can ethically incorporate social justice into their practice through seven principles. These principles encourage critically examining and addressing power dynamics in psychological practice by empowering clients, advocating for marginalized communities, and honoring our professional obligations to promoting well-being. Without dedicated and honest examination of ourselves, our privileges, and our influence on the clients and communities we interact with, therapist's might inadvertently promote systemic marginalization.

Therapeutic Rupture and Repair

Not only is creating and developing a therapeutic relationship with the client important, but so too is the ability to repair inevitable ruptures in the relationship. While we most often think of relationship conflicts within the context of romantic relationships, 69% of which were determined to be "unsolvable," they can occur in any relationship given sufficient interaction (Gottman & Silver, 2015). In therapy, this conflict might present as resistance, or the obstruction or avoidance of therapeutic change. Another form of conflict might be the client's transference onto the therapist and/or the therapist's countertransference. As with any other relationship, conflict might not be able to be completely avoided and successful resolution of conflict within the therapeutic relationship might provide the client with a new experience and understanding of themselves, others, and interpersonal experiences. A client might attempt to bring the therapist into an enactment, likely without consciously aware that they are doing so, and if it is recognized

and addressed by the therapist the client might feel rejected or defensive. For example, a client might idealize their therapist as doing so could make the client feel as though they are close to someone who is wonderful and nurturing. Depending on the therapist, client. and therapeutic alliance, it could be easy to expose this transference and challenge the client in order to reinforce a more developed and secure sense of self. In client's with low self-esteem, insight, or ego strength challenging this admiration too directly or too often might result in the client feeling shame, embarrassment, defensiveness, and resentment towards the therapist.

While training programs and clinicians might all have different expectations and understanding of psychodynamic therapy, Strupp, Butler, and Rosser (1988) identified certain characteristics that are still relevant and applicable over 30 years later. These components are just some of the areas in which a trainee might be evaluated and developed in their practice of psychoanalytic and psychodynamic psychotherapy: genuineness, adequate emotional control, self-objectivity, and positive mental adjustment. Strupp et al. (1988) go on to note that while the research demonstrating personal therapy as a factor in directly contributing to the clinician's professional abilities is limited, personal therapy can foster positive mental and emotional adjustment which can influence therapy process and outcome. Genuineness can be seen as a potential positive component in therapy due to the aforementioned risk that the client assumes when engaging in therapy. The client takes a chance by trusting and confiding in the clinician, with the belief that doing so will aid in their mental or emotional well-being, but if the therapist engages in a cold or insincere manner this only compounds the challenges of establishing and maintaining rapport. Personal therapy alone might not be a panacea for a lack of maturity, adjustment, or emotional well-being in the clinician, it does however provide an opportunity to address these issues rather than avoiding them.

Psychodynamic treatment efficacy relies not only on the clinician's ability to identify transference-countertransference but also in how they address it with the client. In the previous example, a therapist might feel discomfort at the intensity of admiration that a client expresses towards them, but they must be able to contain this discomfort in order to gradually and gently temper the client's perception to a more realistic one. The therapist's understanding that his discomfort at the client's behavior might be justified is coupled with the recognition that the client likely engages in this idealization to address unmet needs, possibly their need for acceptance, love, and nurturance. Regardless of the function that the transference serves it is still only a potential opportunity, it lies on the therapist to recognize the transference, have the self-awareness to not engage in the enactment, and finally help the client develop a more adaptive interpersonal style.

Subjective Variables that Impact Psychodynamic Psychotherapy

Foundational knowledge of a theory and its application is only one facet of the therapist's ability to enact change within the client. Another component of the therapeutic dyad is the therapist themselves and the subjective characteristics and idiosyncrasies that they bring into the room. Some therapists find it easy to establish and maintain rapport with their clients while others might find themselves struggling to fluidly interact with their clients, not due to a lack of training or competency, but due to the clinicians own social skills. It is noted that while there exist countless studies on the efficacy of treatment modalities and therapeutic interventions, very little has been studied on the effects that the personal qualities of the therapist can have on treatment outcome (Lingiardi et al., 2017). Specifically concerning psychodynamic psychotherapy, which emphasizes the intersubjectivity of the therapeutic relationship more so than most other theoretical orientations, who the therapist is has been shown to affect symptom

reduction in both short and long-term therapy (Lingiardi et al., 2017). While it might be unsurprising that therapists who demonstrate personally healthy coping and conflict resolution strategies as well as positive emotional adjustment might have increased therapeutic efficacy, the data is still limited on how these personal characteristics contribute to the therapeutic dyad and to what extent. The following personal variables have been identified as personal characteristics of the clinician that could potentially impact their therapeutic efficacy: attachment style, interpersonal style, mentalizing ability, self-concept, values, and personality

Attachment Style

Attachment can be seen as an enduring emotional bond that connects two individuals regardless of space or time. Attachment styles or attachment patterns stemmed from attachment theory, the early works of Dr. Mary Ainsworth and Dr. John Bowlby who were influenced by evolutionary biology, ethology, and developmental psychology (Wallin, 2015). Through their research, most notably the “Strange Situation” study where reactions of children who were left in an unfamiliar room by their caregivers were studied, it was found that a child’s connection with their primary caregiver could have ramifications for social and emotional development (Wallin, 2015). Attachment is developed and reinforced through early developmental experiences with primary caregivers in the individual's life, typically their parents. Attachment is theorized to have stemmed as an evolutionary adaptation to increase the likelihood of survival through establishing an emotional connection with a caregiver and then seeking proximity to that caregiver whenever the infant or child senses dangerous or unfamiliar stimuli (Wallin, 2015). For example, because humans are entirely dependent on their caregivers for much of their early development and understanding of the world, there is an intrinsic human need to foster emotional connectivity with their primary caregivers. This bonding will increase the child’s overall longevity and chance

for survival by now ensuring a “safe base” with which to navigate their world from (Wallin, 2015).

Unfortunately, if this emotional bond is not possible or likely, either due to the primary caregiver’s absence from the child’s life, neglect, and/or abuse, then maladaptive coping strategies will develop which can impact overall interpersonal functioning. Attachment styles have far-reaching consequences on the individual’s ability to successfully or unsuccessfully navigate romantic, professional, familial, and social relationships (Wallin, 2015). Within the psychodynamic frame, the central mechanism with which an individual's mental or emotional distress is largely due to their early developmental experiences. These early developmental experiences create a foundational framework with which an individual learns to understand and interact with the world around them; they are the ways in which we understand ourselves, understand others, and understand the interaction between the two. The type of early experiences a person has can contribute to the development of one of four possible attachment styles: secure, anxious-ambivalent, anxious-avoidant, and disorganized (Wallin, 2015).

A secure attachment style in children is demonstrated by their willingness to explore new surroundings when their caregivers are present, become visibly upset when their caregivers leave, and are able to once again quickly regulate their emotions when their caregivers return (Ainsworth, Blehar, Waters, & Wall, 1978). This attachment style is seen as the most adaptive attachment style because the child demonstrates an awareness that their caregiver will be present when they need them, suggesting a sense of security. Securely attached children typically have received caring attention from their parents through consistent responsive and appropriate interactions. Secure attachment in adults has been linked to adaptive emotionally regulated responses to threats and stressors (Ahmad, Mohammad, & Shafique, 2018). Within the context

of romantic relationships, securely attached adults demonstrate effective conflict resolution strategy, cognitive flexibility, attunement to their partners emotional needs, and overall positive emotional adjustment (Wallin, 2015). The ability for the securely attached individual to regulate their emotions has a positive influence on their partner as research suggests that one partner's secure attachment is enough to promote healthy emotional functioning within the relationship (Ahmad et. al, 2018; Wallin, 2015).

Anxious-ambivalent attachment styles manifest as an individual's inability to successfully regulate their own need for intimacy, dependency, and responsiveness with their attachment figures and romantic partners later in life (Ainsworth et al., 1978). Children who exhibit this attachment style are likely to receive inconsistent nurturing and responsiveness from their caregivers. Frequently vacillating between emotional availability and intrusiveness, caregivers with anxious-ambivalently attached children presented an interpersonal dynamic to their children that was inconsistent and confusing (Ainsworth et al., 1978). This confusion is developed and reinforced through repeated experiences of finding their parents reassuring and nurturing one moment then insensitive or emotionally unavailable the next. These incongruent experiences of their primary attachment figures can result in the child feeling uncertain about their caregiver yet also desperately wanting the closeness and affection that they have received at times. In adulthood, this pattern can emerge in romantic relationships by the individuals exacerbated distress and anxiety if there is a threat of rejection or abandonment by their partner. These individuals will seek comparatively high levels of intimacy than their partners, preoccupied with eliciting approval and responsiveness from their partners (Wallin, 2015). As in with children, this responsiveness does not always have to take the form of affection but merely overt displays from their partner that they are paying attention or responding to the individual. Individuals with this

style might have both a distrust of others and a distrust of themselves, repeatedly reinforced through their caregiver's inability to consistently be responsive as well as their own emotional dysregulation.

An individual might develop an anxious-avoidant pattern of attachment when their primary caregiver is not attentive to their needs. As the name suggests infants with this attachment style will avoid or ignore their caregivers, outwardly displaying very little when their caregiver departs the "Strange Situation" or when they return (Ainsworth et al., 1978). While the child possesses an instinctual drive for closeness and emotional attunement with their caregiver, if that caregiver has historically been unavailable or unresponsive to the child's needs then the child might come to believe that communicating their emotional needs will not produce a desired result. Avoidance becomes the defensive strategy for the child to cope with distressing situations such as rejection of their emotional needs by their parent; a decreased emphasis on the individual's own perception of their desire for closeness. With adults, this attachment pattern presents itself as the individual who desires a high degree of independence and autonomy, often distancing themselves from others who might present conflict. These individuals might suppress their emotional distress and desire for meaningful relationships, choosing instead to direct their efforts to external metrics of success, worthiness, and/or achievement (Wallin, 2015).

The final category or classification of attachment styles is often debated as whether or not it should encompass its own style or fall as outliers under the anxious-ambivalent or anxious-avoidant patterns, disorganized (Wallin, 2015). With disorganized attachment patterns, researchers observed stereotypies when the child's caregivers left the room, such as rocking back and forth, head-cocking, and pacing (Main & Solomon, 1993). While children who exhibited these behaviors might have displayed a separate attachment pattern or style, it is also possible

that what the researchers were observing were heightened fear and self-soothing responses in children who would otherwise fall under one of the three aforementioned categories of attachment. Of note however is that in subsequent studies, researchers have identified that over 50% of the mothers of the children who exhibited disorganized attachment disclosed struggling with some form of unresolved trauma before the child's birth facilitating severe depressive symptoms (Main & Solomon, 1993). It can be speculated then that the mother's own depression negatively impacted the attachment to their child which then impacted the child's ability to effectively self-regulate and tolerate distress.

Attachments styles have been covered extensively due to the wide range of potential impacts that a therapist's attachment style can have on their interpersonal relationships. What the therapist might consider to be innate aspects of their personality may in fact be behaviors and patterns established long ago with the clinician's primary caregivers that can affect the therapeutic relationship. A therapist who is securely attached could potentially have a preexisting ability to navigate conflict and emotional dysregulation in others before they even begin their clinical training. As these individuals have had their emotional needs responded to in an appropriate and consistent manner by their primary caregivers so too might they instinctually engage in that responsiveness and nurturing with their clients. Ahmad et. al (2018) note that securely attached individuals are more likely, than other attachment styles, to experience lower levels of personal distress and dysregulation while also demonstrating high cognitive flexibility and openness to intimacy. When a client is sharing their vulnerability with their therapist, it can be beneficial for the therapist to be able to empathically connect with the client while also not becoming flooded themselves.

While a clinician who exhibits anxious-avoidant, anxious-ambivalent, or disorganized attachment does not mean that they cannot attend to the therapeutic relationship and facilitate positive treatment outcomes, research does demonstrate that individuals with these attachment styles likely struggle with intimacy and emotional regulation in their personal lives (Wallin, 2015). A key point to be made about the separation of professional and personal roles is that, regardless of the situation, circumstances, or people, the core principles that guide an individual remain the same. That is to say, while we might adjust our roles based on the social context we are in, fundamentally we still believe certain things about others, relationships, and ourselves that permeates throughout our life. Would it not be reasonable to assume that if someone struggles with intimacy and closeness in the personal relationships then they might struggle with the intimacy of the therapeutic relationship? Why is closeness in the therapeutic relationship an important factor to consider?

Research has demonstrated that there exists certain "common factors" within therapy that can have significant impacts on treatment outcomes, sometimes even greater than the specific treatment modalities and interventions used (Wampold, 2015). One of the most important common factors identified to impact successful treatment outcomes is the "Alliance," specifically the ability for the client and therapist to form a strong and positive working relationship in order to achieve the treatment goals (Wampold, 2015). In a meta-analysis of the impacts of common factors in therapy, Wampold (2015) found that regardless of the client's own attachment style, if the therapist is able to form a positive working relationship, there was a better prognosis. To put it another way, research shows that a clinician who is able to form a strong therapeutic alliance with a wide range of patients has better treatment outcomes than a clinician who does not. Clinician's ability to form "real relationships," ones developed and

maintained through genuineness and empathy, is partially determined by their attachment style and has a greater impact in the therapeutic alliance than the client's own ability to form meaningful relationships (Wallin, 2015; Wampold, 2015).

Through a review of existing literature, Watkins and Riggs (2012) have found that the supervisory relationship can be "meaningfully conceptualized as an attachment situation" (p. 265). The attachment styles of the supervisor and supervisee were both found to have an impact on the overall supervision experience, with a securely attached supervisor having the most favorable outcomes (Watkins & Riggs, 2012). If a supervisor enters into the supervisory relationship with a secure attachment style, they are able to provide the supervisees with a stable sense of security and sensitive responsiveness that facilitated the supervisee's development (Watkins & Riggs, 2012). Attachment styles can negatively or positively influence every interpersonal relationship in the therapist's personal (family, friends, and loved ones) and professional (client's, supervisors, coworkers, and supervisees) lives.

Personality Traits

In their research on personality traits, Bleidorn et al. (2020) collected data from 137 experts in trait psychology, 77 scholars with expertise in positive psychology, and 516 undergraduate students on what they considered characteristics that comprised a "psychologically healthy individual." These characteristics and traits were determined by the Revised NEO Personality Inventory (NEO PI-R) and the Five-Factor Model Rating Form (FFMRF). These two measures are based on research into the "Big Five" or the five-factor model which hierarchically organizes 30 personality traits within the five domains of: neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness (Bleidorn et al., 2020). The researchers found that there was high agreement among experts, scholars, and

undergraduate students that individuals who have healthy personality functioning demonstrate the following tendencies: high scores in the traits of openness to feelings, positive emotions, and straightforwardness, as well as an overall low score in the neuroticism domain (Bleidorn et al., 2020). The researchers then examined data from six independent studies, totaling 2,463 participants, that examined various dimensions of relatedness between scores on personality traits and measures of: subjective well-being, positive adjustment, self-control, aggression, narcissism, and psychopathy (Bleidorn et al., 2020). Through their research, Bleidorn et al. were able to determine that psychologically healthy individuals are more likely to be satisfied with their life, are able to effectively regulate their emotions, have an optimistic outlook on life, self-sufficient, self-aware, resilient, and generally experience more positive affect than negative affect. Additionally, Trull and Widiger (2013) even suggest that an individual's scores on the 30 personality traits of the FFM could have wide reaching implications for mental health diagnosis and treatment, especially with regards to personality disorders.

With regards to psychodynamically oriented clinicians, Lingiardi et al. (2017) found that while extroversion might be beneficial in short-term psychodynamic treatment, findings suggest that long-term psychotherapy clients might achieve more favorable outcomes with a therapist who is more reserved. This is not to suggest that all clients in long-term psychodynamic psychotherapy will benefit from a less gregarious or lively clinician, rather it further demonstrates how something like the therapist's own idiosyncrasies, influenced by personality traits, could impact treatment outcomes. Another point to keep in mind is that the FFM was presented as a way to structurally and categorically present the abstract concept of personality and personality traits. Therapists who do not score particularly high in the domain of extraversion might still display a high level of assertiveness and warmth. As Trull and Widiger

(2013) note though there exists maladaptive variants to personality traits that most societies consider prosocial such as agreeableness, typically seen as the ability to cooperate with others while being considerate and kind, which can manifest as self-sacrificing selflessness, subservience, and self-effacement when taken to the extreme.

A therapist might possess an assertive personality which, in measured doses, can be helpful in enforcing structure and boundaries within the therapeutic relationship yet can also result in authoritative and domineering attitude in excess. A therapist's level of agreeableness can impact the therapeutic alliance by influencing the importance the therapist might unconsciously place on cooperation, humility when challenged by their client, and trust they place in the client. A high level of agreeableness might cause the therapist to be overly accommodating and sympathetic towards the client which could impact their objectivity and clinical judgment. It should then be no surprise that since the overall domain of neuroticism was negatively correlated with healthy psychological functioning, high levels of therapist neuroticism were significantly related to more problems in therapy (Bleidorn et al., 2020; Lingiardi et al., 2017). Challenges in therapy due to the therapist's level of neuroticism could be due to evidence demonstrating that neurotic individuals are more likely to experience strong negative emotions, have difficulty managing their response to stressors in adaptive ways, and are more prone to mental health disorders (Guo, Sun, & Li, 2018). This is of particular significance to psychodynamically oriented therapists because there is evidence to suggest that those individuals who are more psychodynamically oriented are more prone to have neurotic traits than therapists of different orientations (Lingiardi et al., 2017). Neuroticism contributes to an overall decrease in prosocial behaviors by affecting a neurotic individual's self-efficacy, emotional intelligence, self-esteem, and ability to mentalize and empathize with others (Guo et al., 2018). This negative impact to

successfully engage in prosocial behaviors could make it challenging for the psychodynamic therapist to establish and maintain rapport, as well as calmly and effectively navigate ruptures in the therapeutic alliance.

Culture

Foster (1998) proposed that for a counselor to consider themselves "culturally competent" they must not only be aware of cultural factors that could influence their client's lives but also their own culture. This "cross-cultural therapeutic dyad" includes the influence that the therapist's own intersecting cultural identities can have on the therapeutic alliance, course of treatment, and the client. Foster goes on to state that the therapist's "cultural countertransference" can be particularly challenging with clients whose culture, socioeconomic status, and race are different than the therapists. What is most disconcerting though is not that the therapist could have countertransference towards their client's but, as Foster puts it, clinicians will "disavow" their countertransference reactions. The disavowal of these reactions are then exerting an influence on the therapeutic dyad, often are noticeable to the client, and yet remain unaddressed by the clinician. Therapists reactions could be due to the cultural norms that were exposed to early on in life and have become unconscious influences on their thoughts, feelings, and behaviors. For example, across many Asian cultures it is common for a doctor to be considered a position of authority and so individuals might easily feel uncomfortable questioning or challenging what their clinician might say to them. If a clinician is from an Asian culture that accepted the authoritative role of the doctor then it could be possible that they might experience emotional reactivity towards a client from a more individualistic culture that is also more direct in their interpersonal style (Lee, 1997).

DiAngelo (2018) writes that scolding or silencing a child when they make a racist or culturally insensitive comment does not help the child develop understanding of why their comment was inappropriate, it simply teaches them to censor themselves. I believe that this is also apparent in therapists and their own countertransference reactions. Clinicians receive training on the limits of personal disclosure and the need to contain who they are within the therapeutic relationship so that their own biases negatively impact the client's successful treatment. It is important to always be mindful that the client is the person receiving the treatment and not the therapist, but it is also possible to move too far into the opposite end of the spectrum. When a clinician disavows or fails to recognize how they, not only as the therapist but also as an individual, are impacting the therapeutic relationship at all times, I would argue that this is a form of avoidance. A clinician censoring himself might have positive intentions to not unduly influence their client's treatment, but they are failing to recognize that regardless of whether or not they want to, no counselor can be a blank and objective slate for the client. Becoming more aware of our own intersecting identities, triggers, and biases will allow us to be more aware of when those personal factors are intruding into our work with our clients. Tummala-Narra (2015) suggests that a possible consideration moving forward for psychoanalytic psychotherapists to practice in a more culturally competent manner is to extend examination of early developmental experiences to also take into consideration how cultural values and norms could have played a role in the client's early developmental experiences, as well as their interpretation of these experiences.

Interpersonal Style

The therapist's personality traits, attachment style, have a potential impact on the client and the therapeutic relationship by influencing the therapist's ability to demonstrate prosocial

behaviors, manage their own life stressors, and regulate their mood. In short, the early developmental experiences we have had, our innate temperament and other genetic predispositions, as well as our personality traits impact how we interact with others and ourselves. Interpersonal styles are unique to each individual and can influence the comfort we feel in speaking to others, how we react to another's expressed emotions, and how effectively we communicate our own emotions. As opposed to the traditionally stereotypical cold and detached clinician who attempts to provide objective interpretations to the client, research demonstrates that the most effective psychodynamic psychotherapists showed encouraging, friendly, helping, warm, and engaging interpersonal behaviors (Lingiardi et al., 2017).

Cultivating a more optimistic approach to addressing stressors, practicing perspective-taking, and replacing self-recrimination with self-compassion can be some of the potential avenues of exploration in personal therapy. While there is a myriad of factors that could contribute to the overall treatment efficacy, personal qualities of the therapist have an undeniable effect on many aspects of therapy including rapport, management of conflict, and use of interventions (Lingiardi et al., 2017; Orlinsky, 2013). Psychodynamic supervision can help the clinician in gaining a greater understanding, awareness, and competence of the interventions to utilize with their clients. Personal therapy can help the clinician gain a greater understanding and awareness of how they personally influence the client's treatment, as well as can facilitate more adaptive personal and professional interpersonal functioning.

Therapists are caretakers of their client's psychological well-being. They provide the factors needed to elicit a positive treatment outcome for whatever their client's presenting problem. The therapist's ability to provide this treatment can be influenced by personal and professional life stressors, the therapist's personality, training, education, culture, attachment

style, and interpersonal congruence with their clients. Therapist's subjective variables that positively impact the therapeutic alliance, repair ruptures in that alliance, and facilitate adaptive functioning were congruent with a healthy personality functioning, secure attachment style, and self-regulation. Successfully identifying and developing these positive subjective variables, through personal therapy, can enhance the therapist's personal and professional functioning.

CHAPTER III. “WHAT WE BRING INTO THE ROOM”

While personal therapy is not the only way that an individual can become aware of the impact that they have on the client or the overall outcome of treatment, the therapeutic journey has the potential to allow the therapist to be placed into that vulnerable other position. Regardless of the therapist's theoretical orientation or desire to approach the relationship in a collaborative manner, there still exists a hierarchy within the counseling room that must be acknowledged. This hierarchy is established very early on in the therapists interactions with the client in the following ways (this is by no means an exhaustive list): client’s must meet certain conditions before they are able to utilize the clinician’s services, there is some form of contractual exchange that is inherent in each therapeutic relationship, once the therapist has taken on the individual as their client there are now ethical and legal obligations that the therapist must uphold to the client, these obligations become less stringent as certain conditions are met. One of the most obvious factors that can contribute to the hierarchy of the therapeutic relationship is the fact that clinicians are trained professionals who provide a regulated service; the therapist receives payment and the client receives therapeutic services that the therapist is licensed to provide. If the client fails to meet the conditions under which they are eligible to be seen by the clinician then they are no longer entitled to receive the clinician’s services, at least until they are once again eligible (eligibility might refer to university or government enrollment, direct payment for services, or legal stipulations). Even if the therapist is receiving payment to provide counseling services to an individual, other factors are taken into consideration as to who is actually considered the “client.”

With so much consideration given to the multitude of potential factors that can influence a therapeutic relationship, there is still a simple underlying truth: the therapist provides a service

to the client under a contract. Within the counseling room, it is not the clinician that is seeking the services of the client but the client who is paying (directly or indirectly) for the clinician's services. If the client is voluntarily seeking the services of a clinician, it is likely due to their belief that the clinician can assist them in some way. Whether it is by providing direct counseling, assessment, or other services, the client is under the assumption that the clinician is the "expert" in the room. Due to this unspoken agreement that the clinician is the expert who can help the client, the client might believe that whatever the counselor is saying or doing fits the narrative that it will help the client in some way. We ask our clients for a tremendous amount of trust, to share with us the stories that they have shared with few in the hopes that we can help them. For many individuals seeking counseling services, their counselor might be the first person that they have ever verbalized their most intimate thoughts, feelings, and experiences. There is a degree of vulnerability behind the closed door of a therapist's office that is uncommon to say the least.

Rationale for the Model

While many training programs emphasize the importance of the therapist's responsibility to practice ethically, competency is not only reliant on the therapist's ability to provide evidence-based interventions but to manage the multitude of subjective variables that they personally bring into the therapeutic relationship. The clinician is fallible, flawed, and human so their treatments will also inherently be imperfect. Individuality is what differentiates each person from the next and the subjective experiences that can influence mental health disorders can be just as individualized. As mentioned in an earlier example, two individuals reporting similar symptoms of depression might receive the same diagnosis but the subjective impact that their depression can have on their life as well as their response to different interventions can vary dramatically.

Would it not be reasonable to believe that just as experiences of interventions might differ based on the individual, so too does the individual's experience of a particular therapist? For another example, while those same two individuals are referred to a clinician in order to receive treatment for depression, one might experience great difficulty in expressing vulnerability in front of the therapist while another may not. What are some of the potential factors that could be contributing to the differences in the therapeutic experience? While there might be a host of unknown variables (i.e., readiness for change, transference, openness to therapy, social support systems) one variable should be considered: the relationship, specifically the client's experience of the therapist and vice versa. While the therapist affects the client, the therapist is also in turn affected by the client and their relationship. Some clinicians might refer to certain clients as "difficult" or "challenging," yet how often do clinicians look inward and ask themselves whether or not they might be the ones who are experiencing the challenge, that they are the ones who are experiencing difficulty? A therapist might attempt to conceptualize the challenges they are facing with developing and maintaining rapport as an extension of the client's underlying mental health disorder or personality, so too should they consider the possibility that they too contributed to the relationship or lack thereof.

While personal therapy and its utility in facilitating professional ability is a familiar concept and one that has been studied to some extent, there is minimal research on common lessons learned by therapists from their own personal therapy that can be incorporated into their therapeutic competency. The information presented is intended to shed light on the possible benefits that personal therapy can have for individuals working from a psychodynamic theoretical framework. Most mental health professionals approve of clinicians engaging in their own personal therapy, yet we find that many do not (Pope & Tabachnick, 1994). Hopefully the

model presented here will facilitate the development of insight and awareness of some of the common experiences that client's engaging in therapy might experience. If the clinician is able to pull from their own experience of therapy, it might then lead to a greater understanding of self and compassion for what the client is experiencing.

Theoretical Foundations

This model is influenced by attachment, psychodynamic, and the five-factor model of personality. Specific emphasis is placed on the psychodynamic concept of utilizing the therapeutic alliance as a medium to treat the client. Research is still limited on the impact that the therapist's personality, attachment style, and interpersonal style can have on treatment outcomes. This model is created through an examination of the available research on how the therapist's ability to mentalize, emotionally regulate themselves, and manage conflict can have meaningful results on their client's quality of care. Though all clinicians should strive to have competency in the clinical and interpersonal skills necessary to facilitate meaningful change in their clients, it is particularly meaningful for psychodynamic therapists who use the very relationship with their client's as an intervention. A psychodynamic therapist's increased self-awareness and ability to engage in introspective reflection only goes to further enhance their ability to establish and maintain a positive therapeutic alliance (Summers & Barber, 2010).

In traditional psychoanalytic psychotherapy, the therapist attempts to present themselves as a void for the client to fill with their own transference in defining normative ways to relate. In the absence of a defined relationship between the psychoanalytic therapist and their client, the client will interject their own definition of the situation including the expectations of each individual. It is then the psychoanalytic therapist's job to identify and reflect back the idiosyncrasies in the client's attempts to define the situation (therapeutic relationship) in order to

facilitate the client's awareness of these behaviors, as well as how and why they contribute to the client's distress. Psychodynamic psychotherapy is closely aligned in the overall goal of traditional psychoanalytic psychotherapy to help the client develop greater self-awareness of how their attempts to understand situations based on past experiences influence current dynamics in their life. Modern psychodynamic psychotherapy has incorporated a clear understanding that the therapist has a subjective impact on the treatment regardless of whether or not he attempts to be neutral or is vigilant of transference and countertransference. With this understanding, therapists are now not only encouraged to examine the reflections of the client but to also practice self-reflexivity to become more aware of the impact that they might have on the treatment.

Core Assumptions

As in the interpretivist paradigm there exists an assumption that the clinician and client's realities also interact (Glesne, 2016). The challenge, however, is that the clinician's role is to accurately capture the reality of their client's experiences while being mindful of the inherent influence on the client. In order to accomplish this, clinicians must be aware and vigilant of the therapeutic dynamic and strive to reflexively examine, understand, and minimize the effects of his personal paradigms on the client (Moustakas, 1994). In counseling, heavy emphasis is placed on the client's rights and the clinician's responsibilities that are guided by a universal standard to all human beings (Rossman & Raillis, 2017). The assumption is that humans have certain unalienable rights like privacy, free speech, and due process (Kant, 2015). An example of an ethical theory of rights and responsibilities is the categorical imperative of Immanuel Kant which posits that a human being is unconditionally valuable (Kant, 2015).

The doctrine of social justice emphasizes the assurance that while personal therapy can benefit the clinician, the ultimate recipient of any potential benefit is the client. Ethical theories of social justice, like critical ethics, view the context of the situation and understand that value judgments can change if the circumstances change and that power differentials do exist between the counselor and the client (Hailes et al., 2020). These differentials must be effectively managed, or the therapist can inadvertently cause harm to the client.

As a model grounded in psychodynamic theory, this model also assumes that early developmental experiences create and reinforce defense mechanisms that help the child cope with painful realities. These unconscious psychological mechanisms help us early on in life navigate the confusing and scary experiences we might have, they can also be seen as heuristics to guide our understanding of ourselves, others, and relationships. It is assumed that all humans develop these unconscious responses to their environment that continue to influence their personality, interpersonal style, and ability to regulate their emotions. For example, an individual whose parents were abusive and inconsistent in the attention they gave could potentially be wary of intimacy in interpersonal relationships and rightfully so given their past painful experiences with their primary caregivers. Later in life, this individual might find themselves desiring intimacy and connectedness with others but finds that they struggle to maintain meaningful relationships. The model assumes that the clinician has his own unconscious defense mechanisms, established through early developmental experiences, that can influence the way in which they interact with their clients.

Based on research into the five-factor model, healthy personality functioning in an individual is characterized by an openness to feelings, more positive than negative affect, straightforwardness, and low neuroticism (Bleidorn et al., 2020). Overall, these individuals

reported greater life satisfaction, emotional regulation, optimism, self-sufficiency, self-awareness, and resiliency. Psychodynamic therapists who were less cold, hostile, and neurotic, as well as more assertive, nurturing, and interpersonally engaging are more likely to produce better treatment outcomes (Lingiardi et al., 2017). The model assumes that the therapist's subjective characteristics influence the therapeutic relationship which, in turn, influence treatment outcomes. Although personal therapy is not the sole avenue for the therapist to develop the aforementioned awareness of their subjective characteristics, research demonstrates that many therapists who have engaged in personal therapy have gained insights which have positively impacted their professional identity and practice (Moe & Thimm, 2020; Norcross, 2005; Norcross, 2010; Orlinsky, 2013; Probst, 2015; Rizq & Target, 2008). This model assumes that personal therapy will provide the therapist with an opportunity to gain insight and awareness of their own attachment style, interpersonal style, and personality traits. With this gained understanding and through reflexive practice, the therapist will become more aware of potential countertransference issues and how their subjective characteristics can impact their client's therapy.

The Model

This model posits that the client has the right to their own story and as such they are not only the experts of their own self but also collaborate with the clinician in interpreting the experiences they choose to share. Emphasis is placed on fidelity or loyalty to the client and their treatment, making sure that the tools to enact their effective treatment are the most effective and appropriate. Tools in counseling include both the interventions that the clinician will utilize, as well as the clinician themselves.

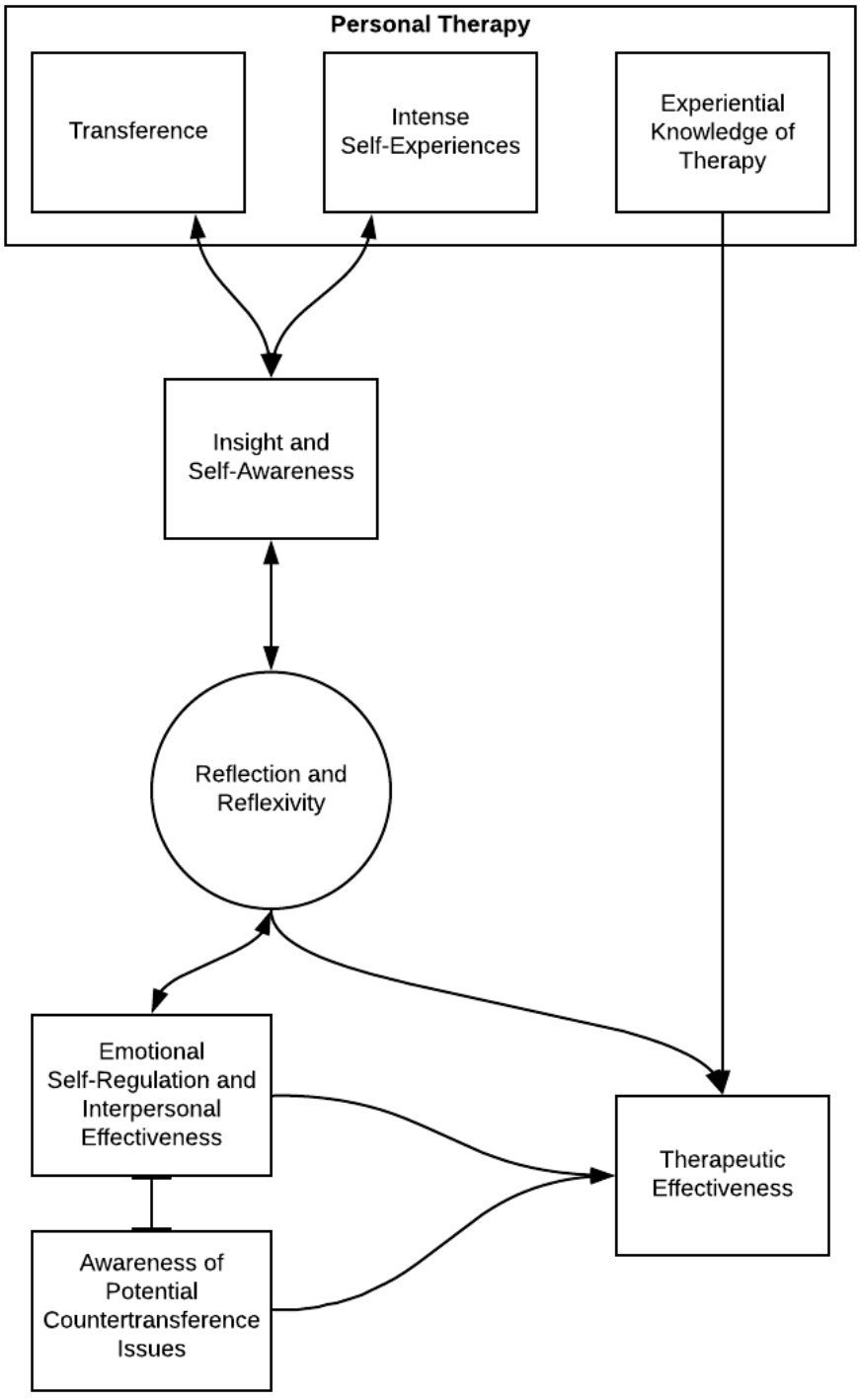
Personal biases address those subjective experiences unique to us that might influence our judgments and predisposition towards certain paradigms. The challenge arises when the client's worldviews, values, and beliefs differ or are diametrically opposed to the therapists own. As Summers and Barber (2010) note, a therapist's clinical effectiveness is not measured by whether or not you have your own personal reactions to the client or what is being discussed in session but by how well you manage those reactions. The author's go on to note that many early clinicians report feelings of guilt and shame over the feelings that come up for them during their therapy sessions. These feelings of guilt and shame suggest the early clinician's perceptions of their personal reactions as unacceptable and even a personal failing on their part as the professional. Dismissing or minimizing the personal reactions and feelings elicited by clients or the therapeutic relationship does not facilitate the development of understanding and change but encourages censorship, distrust of self, and avoidance.

Preconceived notions of why a client is experiencing a particular issue, based on limited information, and the determining the best response to that issue can have potential consequences on the therapeutic alliance. The therapist believes that they already know what the client's presenting problem is and then formulates a plan to address this belief. When the plan does not address what the therapist believes to be the client's issue, the therapist can then experience defensiveness and invalidate, dismiss, or minimize other treatment considerations. It does not fall on the client to convince their therapist of the impact that experiences have had on them, it is the therapist's responsibility to help the client based on what the client chooses to share.

The therapist must strive to remain open to learning about the client, conveying a sense of security and acceptance, while concurrently managing their own thoughts, feelings, and reactions. Without successful management of the therapist's own countertransference the

therapeutic alliance can rupture, leading to the client believing that they need to defend themselves or justify their beliefs either because of the therapist's reactions or responses. Reflexivity promotes an attitude of curiosity towards the self and the client, the reactions triggered by each, and the intention behind responses. Although supervision can help facilitate the clinician's awareness of their own emotional state while in session, given the hierarchical nature of clinical supervision, there are professional barriers to self-disclosure and vulnerability that can be displayed. The proposed model attempts to capture the impact that personal therapy can have on the therapist's subjective variables; thus, addressing these variables can impact a clinician's therapeutic effectiveness (Figure 1.)

Figure 1. Developmental Model of Personal Therapy



Core Components

Experiential Knowledge of Therapy

While personal therapy does not automatically provide the clinician with greater insight and awareness of their own attachment and interpersonal style, as well as potential countertransference issues, it does provide an opportunity for this understanding to occur. Beyond the personal impact that therapy can have on the therapist, it also provides an experiential understanding of the therapeutic relationship versus the academic or theoretical knowledge gained through formal education. The therapist is no longer considering theoretical scenarios in which they must apply techniques and interventions to produce an outcome, they are now participants in an intimate relationship self-disclosing their own intimate vulnerabilities. It is one thing to be in a classroom learning clinical concepts, another to actually put that knowledge to practice, and something else entirely to be on the receiving end of those skills.

Each dimension of a therapist's training affords them with a depth of understanding that is synergistic with the other dimensions. I am the medium through which my clients benefit from my clinical abilities. As I become educated on and practice the application of therapeutic skills, I develop my intellectual understanding of therapy. As I engage in my own personal therapy, reflexively examining my own thoughts, behaviors, and emotions, I develop my experiential understanding of therapy.

Clinicians take into consideration the factors that contributed to their impression/experience of personal therapy to gain awareness of what did or did not resonate about their therapist, the therapeutic relationship, and the interventions used. Close examination of the content of what is discussed in personal therapy and the process of therapy itself affords the clinician with valuable information on the more nuanced and subtle variables that can impact

their client's treatment. For example, maybe the therapist experiences feelings of guilt or remorse at not doing "enough" for their clients during the session. This therapist then goes to their own personal therapy and communicates his fears and insecurities to his own therapist, while they listen and reflect on what is shared. The therapist feels reassured, validated, and supported but realizes that their own therapist was only engaging in simply reflecting, in fact the therapist realizes that he talked for most of the session. This experience, and possibly repeated interactions, combined with reflection might help the therapist develop an appreciation of doing "less" with their own client's. The therapist might also gain awareness that their feelings of guilt and remorse at not being able to do "more" for their clients has very little to do with their client's and more to do with their own expectations, personality traits, and developmental experiences (D'Souza et al., 2011).

Transference

Mindfulness to their own transference and enactments could provide some understanding of the potential countertransference they might experience with their own clients. As a clinician becomes aware of the etiology of their own emotional turmoil it can be enticing to simply suppress these emotional experiences with the intention to not allow them to interfere with the counseling of their client. Though it is important not to allow our own reactions and personal biases to negatively impact the client's treatment during the session, failure to address or even acknowledge our feelings is an unsophisticated defense mechanism, avoidance.

Compartmentalizing personal reaction during the therapy session cannot be achieved without awareness that a reaction even exists. Traditionally, therapists are encouraged to be mindful of their professional role in counseling in order to maintain a level of emotional distance from their client and the client's disclosures (Summers & Barber, 2010). The challenge then

becomes whether or not the therapist is even aware of when they are experiencing an emotional reaction or if they even care that they are having a reaction. Strong emotional reactions can signify poignancy within the individual and closer examination of what elicited these strong reactions can provide information as to the function they serve.

Exploration of early developmental experiences is central to psychodynamic psychotherapy because they provide an idea of how recurring patterns in an individual's life were established, reinforced, and are currently present. By connecting the established patterns of the past, and the reasons why these patterns developed in the first place, to the individual's current functioning we get a sense of why clients might be engaging in dysfunctional or maladaptive strategies. While at one point functional in helping them fulfill their needs, these patterns can become counterintuitive to the client's desires. A clinician might be aware of the importance of rapport and of fostering a positive therapeutic relationship yet still struggle to genuinely connect with their client because this would require a level of intimacy that is unfamiliar or uncomfortable to the therapist.

Intense Self-Experiences

Intense self-experiences and possible transference can occur in personal therapy and, depending on the abilities of the therapist, provide an opportunity to notice the reaction and discuss the reaction with another person that could provide perspective. Therapists will have their own emotional reactions to interactions they have with the clients and processing these emotions during the client's session not only detracts from the focus of the client's treatment but can cause the therapist and client to engage in an enactment. Personal therapy can offer a place for the therapist to examine and process their triggers without potentially compromising their client's treatment. Aside from an opportunity to examine the therapist's own emotional turmoil,

if the therapist experiences transference or a significant emotional experience within their personal therapy then their own therapist could provide another clinical perspective on the transference or reaction. Awareness of the reaction allows the therapist to engage in reflexivity, in the moment assessments and responses to what is happening externally and internally. By being able to practice this skill in the confidential and secure space of their personal therapy, the therapist develops their ability to be reflexive with their own clients.

Insight and Self-Awareness

Self-awareness and insight alone do not correct behavior, they simply represent the therapist's own level of understanding of how they are impacting and being impacted by the therapeutic relationship. By engaging in their own personal therapy, a therapist is making a dedicated investment into more closely examining themselves, thoughts, feelings, behaviors, and experiences. Whether or not the topic being explored is related to their work-related duties is ultimately irrelevant due to the fact that the insight and self-awareness gained is solely concerning the therapist. Regardless of whether or not the therapist discusses specific topics, personal therapy is more an opportunity to understand how the individual reacts or responds to internal or external stressors.

An adage that I have touted so often to my own clients is that “negative” emotions, such as anger, sadness, fear, are not “good” or “bad” in their own right, rather it is what you do when you feel those emotions that truly matters. For example, if a therapist felt upset about something a client said or did to them then it would be the therapist’s response to their client’s behavior that would determine whether or not they were engaging in “healthy” adaptive functioning. A therapist can only independently know if they are engaging in “healthy” or “unhealthy” behaviors if they consciously make an effort to examine their thoughts, feelings, and behaviors in

the context of the situation. Without self-awareness will a therapist even realize how their words and behaviors might be inadvertently affecting their clients?

Awareness of Potential Countertransference Issues

As transference issues arise in the therapist's personal therapy, they will again gain experiential knowledge of how transference-countertransference issues might arise and be navigated in the therapeutic relationship. The model is synergistic in the sense that, as a therapist experiences one component of the model, it will facilitate development of other components. For example, if a therapist were to experience transference within their personal therapy, this could signify an unresolved aspect of their psychological functioning that was first established in early childhood. Without methodical and consistent exploration of these early developmental experiences, the defense mechanisms they created, and the patterns that continue to impact their current functioning a therapist is vulnerable to enacting or engaging in dysfunctional dynamics within the therapy room. Through continued exploration of potentially emotionally reactive topics, the therapist gradually becomes more mindfully aware of the impact that their actions have in and out of therapy and are able to adjust their behaviors accordingly (reflexivity). This reflexivity is particularly of significance in psychodynamic psychotherapy where a key area of therapeutic intervention is dedicated to being aware of the client's transference, the therapist's own countertransference, and vigilance to ensure that that enactments are avoided, minimized, or addressed appropriately.

Reflection and Reflexivity

Reflexive practice is the habitual application of the self-awareness and insight gained from personal therapy towards developing more adaptive and functional ways of perceiving and interacting with the self, other, and within relationships. Psychodynamic therapy is a recursive

process because as an individual reflexively practices more functional and adaptive ways of living their life, based on reflecting on the insights and awareness they gain in therapy, they are provided with feedback that adjusts their reflexive practice. Through reflection of insights gained of why the therapist thinks, feels, or behaves the way they do, they become more aware of triggers to those reactions and better manage the reactions when they do occur.

Personal biases address those subjective experiences unique to us that might influence our judgments and predisposition towards certain paradigms. The challenge arises when the client's worldviews, values, and beliefs differ or are diametrically opposed to the therapists own. The therapist must strive to remain open to learning about the client, conveying a sense of security and acceptance, while concurrently managing their own thoughts, feelings, and reactions. Without successful management of the therapist's own countertransference the therapeutic alliance can rupture, leading to the client believing that they need to defend themselves or justify their beliefs either because of the therapist's reactions or responses. Reflexivity promotes an attitude of curiosity towards the self and the client, the reactions triggered by each, and the intention behind responses. Sitting with the silence, asking open-ended questions, allowing the client to answer as they see fit, as well as emphasizing poignancy through reflection and summarization can decrease the therapist's own subjectivity from unduly influencing the client.

Emotional Self-Regulation and Interpersonal Effectiveness

As noted in the literature review, characteristics of healthy personality functioning was evident in a decreased likelihood to experience negative emotions, better self-regulate when experiencing negative emotions, and engage in more prosocial behaviors (Bleidorn et al., 2020). Specifically, therapists who exhibited a greater degree of prosocial behaviors and healthy

personality functioning were less likely to experience burnout and more likely to produce more positive treatment outcomes in their clients (D'Souza et al., 2011; Lingiardi et al., 2017). Reflexivity can be considered an umbrella component of healthy personality functioning and it is understood within this model as one's ability to be aware of their personal feelings, thoughts, and reactions then make in-the-moment adjustments to behaviors based on consideration of those thoughts, feelings, and reactions.

When an individual practices reflexivity many processes occur through directed conscious effort in examining internal signals, this increased awareness then develops an individual's ability to be more mindful of the emotions they are experiencing and to express those emotions in adaptive ways. Self-regulation of emotional reactions results in decreased emotional reactivity and increased emotional mindfulness. As emotional reactivity decreases and emotional mindfulness increases, overall interpersonal functioning increases (Baumeister, & Vohs, 2016; Bleidorn et al., 2020). Therapists who exhibited greater degrees of interpersonal functioning, less aggression, less hostility, and better emotional regulation had clients who reported greater degrees of comfort within the therapeutic relationship and more positive treatment outcomes (Lingiardi et al., 2017).

Application to Case Vignette

Max's social support systems are limited, and he feels as though even if he could talk to someone, most of the people he could talk to would not understand the exact nature of the conflict he is experiencing because they are not therapists. Max seeks out a community therapist in the hopes that someone with clinical training, experience, and objectivity will be able to provide him with some insight into how to address his professional problems and personal feelings. As Max's first appointment is about to begin, he feels incredibly anxious and worried,

fearing that this mental health provider will negatively judge him for what he is about to share. He begins to question whether or not speaking to someone about the struggles he is currently experiencing is even a good idea as it might affect his ability to provide therapy to his client's. As his name is called and he is led to a private room by his therapist, he internally laughs at the irony of his current anxiety and trepidation of therapy, thinking "I wonder how many of my own clients have felt what I'm feeling now as I lead them to my office?"

As Max sat in his therapist's office, he continued to debate how much he should share, where he should begin, and how to accurately capture everything he wanted. He knew that the better he could accurately and concisely communicate why he was seeking counseling and the distress he was feeling it would help this stranger in front of him do his job. His therapist began to cover the standard first session points (limits of confidentiality, asking about the informed consent, etc), all familiar to Max as he had done the same with so many of his own clients. His therapist then smiled at him and asked him to share what he was hoping to achieve with therapy. Max verbalizes hesitation at where he should even begin, disclosing that he also provides therapeutic services and vaguely states that he's been struggling with his supervisor's feedback, his feelings about this feedback, and his feelings in the room with his clients. Gradually, as he becomes more engrossed in self-disclosing, he feels a pressure to release everything he has been holding onto for the past few months. The frustration, fear, anxiety, guilt, and sadness come pouring out of him as though these feelings were growing until finally given an opening to escape. The whole time he is speaking, his therapist does not say a word, he simply listens and asks questions to ensure that he is accurately understanding what Max is going through. When Max is finally done speaking, he feels exhausted, relieved, and somewhat panicked as he now realizes that he has said far more than he ever anticipated saying within the first session. He

apologizes for sharing so much and “overwhelming” the therapist shortly after meeting him. This prompts a quizzical look from the therapist who asks, “if you think it’s overwhelming for me to hear for 30 minutes about what you have been through, I wonder how you feel having actually gone through it for months?” Max realizes that he has been attempting to avoid thinking about his experiences over the past few months for exactly this reason, it was just too much for him to go through.

Over the course of the following sessions Max is struck by his therapist's calm and curious approach to therapy. He believes that he is coming to therapy to “vent” to his therapist, something that he felt detracted from his own client’s progress, and wonders if his therapist is bored or annoyed with his excessive talking. Max is also struck by his therapist's questions about what is currently happening at work with his supervisor, as well as questions about the reactions that these experiences illicit and the feelings associated with those reactions. Initially Max’s defensiveness starts to present itself again, he fears that his therapist is negatively judging him about his reactions to his supervisor’s feedback and how he has let his mood affect his clinical abilities. As he has been having these feelings, over the past few sessions, his therapist continues to ask him about his fears that his supervisor would negatively evaluate his performance and the belief that he is being “dishonest” towards his clients. While Max is explaining the reasons his supervisor could potentially negatively evaluate him for his insecurities, Max’s therapist asks “how do you feel in sharing these things with me, in your own therapy?” Max quickly minimizes his feelings by stating that sharing his vulnerabilities with the therapist makes him somewhat anxious but understands that this self-disclosure is a necessary part of the process. Max’s therapist reflects back to him the fear, shame, and guilt he verbalized feelings about his professional performance, as well as disclosing these feelings to his supervisor. His therapist

asks if these feelings might currently be present in Max's own personal therapy due to his fears of being perceived by the therapist in a negative manner. It strikes Max that this is accurate, that he has been guarded about how his therapist will perceive him and that a fear of being perceived negatively contributed to his reluctance to share his feelings with his supervisor.

Over the course of his personal therapy Max is able to identify, through his therapist's open-ended questions, that some of the reluctance to his supervisor's feedback was due to Max's own fear that he was not doing "enough" for his clients. His desire to reassure his clients also stemmed from this self-narrative that if he was not able to alleviate his client's distress then he was not a "good therapist." Notably over the course of his own personal therapy, Max has come to value his own therapist's use of reflection and open-ended questions to guide Max to his own conclusions. His initial shame and guilt over his feelings gradually diminish as he comes to recognize the value in being allowed to "sit" with his emotions so that he can accurately identify what external and internal factors contributed to his feelings and the accuracy of those factors. Even his own therapist's acknowledgment of Max's hesitation to be vulnerable in his own personal therapy helped bring awareness to the ingrained beliefs he had about his feelings. Discussion of early developmental experiences identified that Max's family were often discouraging expressions of vulnerability (making mistakes, crying, expressing sadness). While Max's attempts to nurture and reassure his client's whenever they express vulnerability is with the intention to help them, he gains awareness that they are also to alleviate his own discomfort with these expressions of vulnerability and can inadvertently convey a message similar to ones he received as a child; being vulnerable is not okay, it is something to be "fixed." Having gained this insight, and through reflexive practice, Max is able to better recognize the moments his defensiveness with his supervisor and the urge to console his clients emerges. With this

awareness he can attend to the feedback his supervisor presents and accept the distress his client's express without feeling as though they are a personal attack on his identity.

Aside from the personal revelations he has gained through personal therapy, Max is also able to incorporate the unintended lessons he learned from his experience with his own clients. He appreciated his own therapist's open-ended approach to helping Max gain insight and awareness. He discusses the anxiety that engaging in therapy could cause for his clients many of whom, like Max, will be speaking about their intimate thoughts and feelings for the first time in their lives. He has a greater awareness of how a client's own fears and insecurities might manifest in the therapeutic relationship and the importance of discussing this dynamic within therapy, something that is not too often done in our personal lives.

While personal therapy did not "fix" Max's problems in a linear sense, it did help him gain a greater awareness of his feelings, increased his acceptance of those feelings, and helped him recognize potential feelings that his client's might have about the therapeutic process. The experiences he had within his own personal therapy helped him understand that to be an effective therapist Max does not constantly need to be "doing" something in counseling. That the frequent desire to be active in session with his client's was more so due to his own need to feel "useful" and "worthy." While Max's supervisor might have been encouraging this concept of "less is more," what translated this from theory to reality was for Max to experience it in his own therapeutic relationship. Through personal therapy, insights were gained then utilized to consciously behave in a more adaptive manner. Personal therapy also contributed to a refinement of his professional practice as he found personal value in reflections, open-ended questions, and being more collaborative with his clients.

Strengths and Limitations

The most significant limitation of this model is that it is presented specifically through a psychodynamic conceptualization of personal therapy. Research demonstrates that the perceived or self-reported benefit that a therapist believes they experience from personal therapy, as well as the positive impact that personal therapy has on their professional practice, is significantly influenced by the therapist's theoretical orientation (Larsson et al., 2010; Orlinsky, 2013). Typically, therapists who strongly identify with the psychoanalytic/psychodynamic frame have already engaged in their own personal therapy at least once and believe that it was a valuable component of their professional and personal growth. Whether or not this model will be effective, or even appropriate, for clinicians with different theoretical orientations cannot be determined at this time. Information on attitudes towards personal therapy based on theoretical orientation is limited but research does demonstrate that seeking out personal therapy is not limited to only psychodynamic therapists (Norcross, Bike, & Evans, 2009). Closer examination of whether or not a therapist's theoretical orientations, as well as their perception and experience of personal therapy, can influence the potential impact personal therapy has had on their professional practice should be explored.

Personal therapy affords the clinician something that many supervisors are reluctant to do or are adamantly opposed to engaging in due to ethical boundaries, addressing the supervisee’s personal characteristics. Psychodynamic supervision can be somewhat unique in that the supervisor is attempting to foster the development of the supervisees clinical competency by actively engaging in discussions of psychodynamic theory, application, and examination of countertransference issues. Though psychodynamic supervision is not therapy, there is close attention paid to the trainees own emotional reactions to their client’s, as well as how to potentially address those reactions in future clinical practice.

One significant limitation of psychodynamic supervision, which further gives weight to the importance of personal therapy, is that the supervisor-supervisee relationship is inherently influenced by expectations and limitations that might make disclosure, openness, and vulnerability challenging for both the supervisor and supervisee. For example, a supervisee might be experiencing ongoing conflict with a romantic partner that could potentially influence their ability to attend to their client's or a client might trigger a countertransference reaction within the trainee. The supervisor might then attempt to address these issues within the trainee by examining the countertransference's cause and the impact it had on the trainee's client. While this supervisor could be invaluable to the trainee and could also benefit the client, the trainee might still need to address the source of the countertransference reaction within themselves. It is not enough to manage the impact of a clinicians countertransference reaction; why the reaction took place, what factors in the clinician's personal narrative could have contributed to this reaction, and how to address these factors so that they do not negatively impact future clients are also of the utmost importance. Given the evaluative nature of the supervisor-supervisee relationship, the supervisee might be justifiably reluctant to disclose certain insecurities to their supervisor for fear of being negatively evaluated. This hesitancy or reluctance to be vulnerable in supervision could be seen as an appropriate boundary to have between a supervisor and supervisee, it can also contribute to the supervisee's avoidance of addressing their own personal maladjustments. A psychodynamic supervisor's fidelity is to ensure that those who they supervise are competent enough to provide ethical services to their clients. This duty has its own limitations because the supervisor must also be mindful of not engaging in a dual relationship with the ones they supervise as both their supervisor and their therapist.

A strength of this model is that it addresses the components of an individual's clinical competency that can only be limitedly addressed in supervision, their own personal characteristics. Given the considerations for ethical issues from potential dual relationships, supervisors are limited to the extent that they can explore, question, and address the supervisee's personal variables. Therapists are afforded a unique privilege in that the service they offer is intimately tied to components of who they are; therapy can be an intimate relationship and mental health service for many individuals. Clients can benefit and be harmed by their therapists ability or inability to provide therapeutic interventions, as well as the interpersonal nature of the therapeutic relationship. Engagement in personal therapy can then be seen as a method of developing the efficacy of the instrument through which client's receive therapeutic services, the therapist. While supervision might address and, even, overlap with areas of a therapist's personal and professional development, its focus is on the impact the supervisee will have on their clients rather than the supervisee's processing of personal experiences. A strength of personal therapy is that it specifically addresses the areas of a therapist's therapeutic efficacy that is given less direct intervention towards during their training (personality functioning, processing of past traumatic experiences, emotional regulation, self-esteem, neuroticism, and self-image).

Ethical Considerations

Due to the highly subjective nature of personal therapy and the perceived benefit or detriment, if any, it might have on a therapist's client's significant consideration should be given to whether or not personal therapy is appropriate for all therapists, regardless of theoretical orientation. It is quite possible that a therapist might engage in personal therapy with the intent to develop personally and professionally yet find the experience to have a negative impact on their clinical judgement. The very nature of the model is built on reflexive practice due to insights

gained in personal therapy. The potential insights and self-awareness that can be achieved with dynamic therapy can be upsetting, disturbing, and uncomfortable for many individuals. A therapist might experience emotional dysregulation and distress due to the insights they have gained in personal therapy, which could then result in a decrease in their clinical efficacy. The challenge with personal therapy is that psychoanalytically oriented clinicians who reported the most benefit from personal therapy were engaged in personal therapy for several different reasons (Orlinsky, 2013).

For a psychologist, the ethical responsibilities of their profession is exemplified by "Principle A: Beneficence and Nonmaleficence" of the American Psychological Association (APA, 2017) Code of Ethics; "psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work." A significant motivating drive behind this model was the potential considerations, examination, and expansion of Section 2.06 of the Code of Ethics, "Personal Problems and Conflicts" (APA, 2017). The APA (2017) encourages psychologists, who become aware of personal problems that could potentially interfere with their ability to perform their work-related duties, to "take appropriate measures, such as obtaining professional consultation or assistance…" As mentioned in a previous chapter, supervision and consultation provide two possible avenues for addressing personal problems that might interfere with a therapist's ability to provide effective treatment; personal therapy affords an additional option that can address matters of a more personal nature, such as grieving the death of a loved one, that might negatively impact their ability to adequately perform work-related duties.

Many researchers have criticized that a mandatory requirement of therapists or trainees to undergo personal therapy may lack any empirical evidence for its support and is based on

traditional or anecdotal experiences (Chaturvedi, 2013). Specifically citing common negative factors that have been associated with personal therapy, Murphy et al. (2018) identify three potential themes that can negatively impact mandated personal therapy: do no harm, justice, and integrity. Within these major themes are sub themes that encompass considerations such as the financial burden that mandatory personal therapy will place on the therapist, as well as the potential distress a therapist might experience (Murphy et al., 2018).

This model should not be considered an argument for or against therapists to engage in their own personal practice. It is a proposed method of processing and incorporating the reported perceived benefits that personal therapy has offered other clinicians presented through the author's own biased favorable outcomes of personal therapy. Other avenues of personal development and pedagogical methods of therapeutic effectiveness are necessary to develop a truly competent clinician. Ultimately, it is up to the therapist to determine whether or not they wish to engage in personal therapy but prior to doing so there is a responsibility to consider the potential ramifications it can have on their mood, clinical abilities, and transference. The very same intense self-experiences that provide some therapists with opportunities for reflection and growth can be so uncomfortable for others to bear that they disengage or become resentful of the therapeutic process. As a psychodynamically oriented therapist, I would question that if a therapist were to have negative reactions to personal therapy due to the painful or disturbing experiences it created then would that not suggest that these are areas for the therapist to address or at least gain some self-awareness?

A final consideration to emphasize is the detrimental impact that a psychologist's lack of appropriate self-care can have on their work-related duties, ultimately resulting in a negative treatment experience for their clients. When stress is not effectively managed the potential

effects could encompass either *impairment* or *improper behavior* (Wise, Hersh, & Gibson, 2012). *Impairment* can be considered the "objective change in the psychologists professional functioning that may result in ineffective services or cause harm" (Wise et al., 2012, p. 488). This impairment, while not intentional or desired by the psychologist, could result in behaviors that could detrimentally affect the quality of services provided such as timeliness of appointments, successful completion of paperwork, and ability to focus and attend to sessions. *Improper behaviors* encompass the actions of the psychologist that are clear violations of ethical standards such as "sexual or fiscal improprieties with clients" (Wise et al., 2012, p. 488). While self-care strategies should not be seen as a panacea against impairment or improper behaviors, therapists who successfully incorporate self-care strategies into their lives provide a protective factor against overwhelming stress and emotional exhaustion (Wise et al., 2012). Protection, in the context of this model, can be understood as a therapist's ability to regulate difficult emotions, develop greater self-compassion, and decreased rumination.

Cultural Competence

While cultural sensitivity and competency is emphasized in the APA Code of Ethics under "Principle E: Respect for People's Rights and Dignity," it is only recently that there has been an increased awareness of the importance of how culture plays a role in successful therapeutic treatment (APA, 2017). Psychoanalytic psychotherapy has always attempted to examine early developmental experiences and their contributions into the establishment and reinforcement of interpersonal and intrapersonal functioning. While examining these early developmental experiences, it would not be uncommon for a psychoanalytic psychotherapist to touch on subjects concerning their client's culture(s) and how they have been, or currently are being, affected by their intersecting identities. Cultural competence is a dual process that

involves awareness of how cultural factors could have, or are, impacting the client, as well as how the therapist's own culture(s) have an impact on their therapeutic practice. As a therapist gains awareness of their own paradigm, special attention must be paid to the attitudes, values, and judgments they hold about themselves, others, and normative behavior because these are all also heavily influenced by the therapist's culture(s).

Summary

Though empirical research on the quantifiable benefits that the therapists personal therapy can have on their clients is limited, extensive self-report measures and surveys have found that an overwhelming majority of therapists who engaged in personal therapy found it to be beneficial for their clinical practice (Chaturvedi, 2013; Orlinsky, 2013). What is noted in the research though is that a therapist's subjective variables, such as their degree of neuroticism, can have an impact on treatment outcomes (Lingiardi et al., 2017). This model is based on inferences developed by examining researched outcome measures for therapists' personal characteristics and the consistent themes that therapists reported experiencing from their personal therapy. Therapists who engaged in personal therapy, the reported subjective benefits they gained from personal therapy, and how those benefits could apply to the subjective therapists' qualities identified in the research as having a potential impact on their client's treatment outcome are what the model is attempting to conceptualize. By providing a structurally organized and targeted emphasis to the potential areas of benefit of personal therapy, the intent of the model is to help facilitate the therapists reflexive practice to achieve both personal and professional growth.

CHAPTER IV. DISCUSSION

Revisiting Research Questions

Do therapist's subjective characteristics impact treatment outcomes? If so, which?

Therapist's subjective characteristics, education, experience, and theoretical orientation influence their client's treatment outcomes. Subjective characteristics of the therapist are described as the personal qualities unique to the therapist that may be influenced by their attachment style, interpersonal style, personality traits, and culture. These personal qualities can, in turn, influence the therapist's preference towards a particular theoretical orientation, ability to establish and maintain a therapeutic alliance, and successful management of therapeutic rupture.

Therapists with less neuroticism, aggression, and insecure attachments were found to not only have poorer overall treatment outcomes but also negatively impact their effectiveness in supervision. While supervision can provide a trainee with a certain degree of oversight and awareness of countertransference issues impacting treatment, it is an inherently hierarchical professional relationship with role boundaries. The supervisor-supervisee relationship is entered with the mindful consideration of not engaging in a dual relationship where the supervisor becomes a therapist to their supervisee. With these considerations in mind, the supervisory relationship itself can be negatively impacted by an individual's subjective characteristics.

Personal therapy provides a clear delineation between professional and personal dynamics which allow the therapist to examine themselves outside of their professional role. As applied within the vignette, Max's interpersonal conflict with his supervisor negatively impacted his work-related duties, specifically his ability to consistently and confidently attend to his clients during their sessions. His subjective feelings of insecurity were exacerbated by his interpretation of his supervisor's feedback causing *impairment* (Wise et al., 2012). Max did the

ethically responsible thing by addressing his *impairment* through personal therapy, as well as within his supervision.

How might a therapist's subjective characteristics influence their perception and experience of personal therapy?

A therapist's attachment style and early caregiver experiences have been shown to have some interaction effects with the severity of their client's symptoms and treatment outcomes, as well as their own openness towards personal therapy. Specifically, insecurely attached therapists were found to endorse more anxiety, less self-confidence, ambivalence, and/or resentment while engaged in their own personal therapy. Interpersonal style can impact the therapist's ability to establish and maintain rapport, influencing factors such as the client's willingness to self-disclose, trust in the therapeutic process, and response to challenges. Therapist personality traits, such as neuroticism, were negatively correlated with treatment outcomes. Specific traits, such as assertiveness and trust in others, were not only indicative of overall healthy psychological functioning but also impacted the client's perceptions of the therapist.

Neurotic therapists might find themselves struggling to engage in the necessary prosocial behaviors to effectively establish a meaningful connection with their clients in a timely manner. This difficulty could potentially be due to the therapist's emotional intelligence, self-esteem, social self-efficacy, empathy, or ability to consider the perspectives of others (Guo et al., 2018). When engaging in personal therapy, the neurotic therapist will be confronted with their vulnerabilities, insecurities, and the defense mechanisms established to manage their distress.

Max's neuroticism and perfectionistic tendencies contribute to his feelings of shame and guilt when he first seeks out personal therapy as he internalizes that he has "failed" as a therapist because he is unable to "fix" himself. The impact of Max's neuroticism on his ability to perform

his therapeutic duties, as well as his openness to engaging in personal therapy is consistent with the currently available research (Lingiardi et al., 2017).

How can a therapist's personal therapy impact treatment outcomes?

The following common components of personal therapy were identified by therapists who engaged in their own personal therapy: experiential learning, increased self-awareness, and personal therapeutic benefit which resulted in improvements to self-esteem, self-concept, emotional regulation, and reflexivity. Experiential learning deepened the therapist's regard for the therapeutic relationship, increased empathy for their client's experiences, and provided them with anecdotal evidence of specific approaches or interventions. While intense self-experiences could cause emotional distress, these many therapists saw these experiences as opportunities to develop self-efficacy by identifying and addressing transference issues. It was only through invested engagement that therapists were able to "work through" this emotional turmoil and perceive significant benefit from personal therapy.

Research demonstrates that when a therapist is intrinsically motivated to engage in personal therapy to address a problem, experience growth, and develop their clinical competency they are likely to experience a positive outcome (Orlinsky, 2013). Also important to note, trainees and students who were required to participate in mandatory personal therapy in their training programs, and initially were opposed to it, eventually not only came to value personal therapy but also reported that all counseling programs should make personal therapy a mandatory component of a therapists training (Kumari, 2011). As noted in the model, personal therapy provides an opportunity for a therapist to gain experiential knowledge of therapy, intense self-experiences of their own past and the impact that past has had on their current functioning, as well as promotes reflexivity.

Through his own personal therapy, Max was able to identify the internalized beliefs that he has about himself and how these self-expectations were influencing his reaction to his supervisors' feedback. By considering his own internal reactions to his supervisor's feedback, Max was able to acknowledge and address his emotional response, developing emotional regulation and becoming more aware of potential triggers that might occur during his own practice.

How can personal therapy be used as a pedagogical method to facilitate better treatment outcomes?

Therapists are encouraged to engage in their own personal therapy with the same authenticity and genuineness that they engage in therapy with their own clients. Deception will only harm rapport and damage the overall trust in the therapeutic relationship, which in turn will limit the depth of shared knowledge and overall efficacy of treatment. Besides the knowledge, experiences, and stories shared, it is also recommended that the clinician self-reflectively identify any potential barriers to closeness. These potential barriers might include, but are not limited to: discomfort with vulnerability, cultural norms about expressing certain emotions such as sadness or fear, as well as their own early developmental experiences that might have established and reinforced certain defense mechanisms. The teachings of logotherapy emphasize that the individual determines their own personal reason to endure the suffering, and by doing so, develop resiliency and facilitate a more meaningful existence. Adopting from this theory, a potential consideration for the therapists own personal therapy can be "tragic optimism," viewing the "suffering" of confronting their own vulnerabilities in personal therapy as an opportunity to temper themselves and grow in their professional and personal lives (Southwick et al., 2006).

By identifying the source and function of their own defense mechanisms, an individual can then attempt to replace maladaptive functioning with more adaptive strategies. For example, the therapist becomes aware that past negative social interactions with peers or family members contributed to a decrease in his social self-efficacy which in turn contributed to a decrease in his self-esteem. As the social self-efficacy and self-esteem decreased, social interactions became more challenging and uncomfortable, so the therapist feels anxiety in social situations and comes to attribute negative qualities about himself, others, and/or relationships. As a ripple on a pond, these events start off small but continue to reverberate outward throughout the individual's life, possibly influencing social interactions, mood, and perceptions of the self. Awareness of these patterns allows the individual to become a more active participant in their life by acknowledging the existence of maladaptive defense mechanisms, the function that those mechanisms served and continue to serve, and the secondary consequences of those mechanisms that were never intended. In the above-mentioned example, the therapist might find themselves limiting social interaction or being more cautious and reserved in social interactions as an adult but might not realize that he also unconsciously avoids intimacy, vulnerability, and might be somewhat distrustful of others. While this can have a significant impact on the therapist's personal life, in the context of therapy this can cause the therapist to inadvertently appear cold, emotionally distant, or even disinterested in the client.

As demonstrated with Max in the vignette, personal therapy can be utilized as a supplemental training option for those trainees who would like the opportunity to continue to understand themselves, increase emotional regulation, and develop their reflexivity. Personal therapy provided Max with a place to process his emotional reactions without feeling as though he is compromising his professional identity with his supervisor.

Clinical Implications

For clinicians, their approach to counseling may influence their role relationship with clients and also their own therapist; this can present role management issues. The clinician's more practiced role as the expert in a therapeutic relationship might go in opposition to the position, they will find themselves in as a client. Though this could be a potential barrier to the clinician's successful engagement of their own personal therapy, it also affords the unique opportunity for the clinician to address a facet of counseling that they rarely experience but their client's frequently do. Regardless of the power and influence that a person might wield outside the therapy room, in counseling they can feel just as exposed, vulnerable, and insecure as anyone else. This vulnerability and discomfort is something that I believe counselors who have not engaged in their own personal therapy have a limited experience of, at least within the context of opening themselves to a stranger.

Periodically checking with the client to ensure accuracy prevents the therapist from unknowingly applying their own assumptions to the client's personal disclosure. Accurate reflection, coupled with encouragement for the client to challenge any discrepancies in the therapist's understanding, aid in ensuring that the client's narrative is not overwhelmed by the therapist's own agenda. This could potentially pose a challenge for therapists who are subjectively more likely to exhibit avoidant attachment, emotional reactivity, or lack of awareness and/or discomfort with acknowledging their own countertransference issues.

It can be difficult to ascertain the exact impact that a therapist's subjective characteristics can have on their client's treatment, this impact can also change depending on the congruence between the therapist and client's interpersonal styles. Research does however demonstrate that the therapist's subjective characteristics, such as their personality traits, can impact treatment

outcomes by influencing the therapist's ability to establish and maintain a therapeutic alliance, repair ruptures in the therapeutic relationship, and even on their theoretical orientation. By engaging in personal therapy, a therapist seeks an opportunity to experientially learn about the process of therapy and engage in mindful discussion of their own emotional state, reactions, and past experiences. Devoting time and conscious effort to understanding who we are and why we do the things we do provides us with greater reflexivity. We can learn to better understand our client's reactions and our own reactions, distinguishing and accepting the two.

Recommendations for Future Research

Presentation of a model of using personal therapy as a pedagogical method of facilitating better treatment outcomes was done so through an examination of existing literature and the author's own subjective experiences of personal therapy. Future studies might attempt to quantify the therapist's subjective variables' impact on their client's treatment by assessing therapists on various objective and subjective measures such as personality, cognitive, and self-report questionnaires. Results of these assessments can then be examined alongside within-group and between-group differences based on clinical factors such as years of experience, clinical versus research role, current or historical engagement in personal therapy, and or client treatment outcomes.

A major challenge with any potential study into this area of research is that a clinician cannot be separated into their constituent parts; research shows that early developmental experiences and relationships can influence personality traits which, in turn, can influence congruence to a particular theoretical orientation. As opposed to a reductive examination of the individual components of a therapist, a therapist's ability to effectively provide treatment to their client's is determined by the synergistic relationship of who a therapist is and what he knows. In

combination with further examination of the subjective impact that a therapist can have on their client's, research should also identify best practices for assessing for and developing these subjective variables. It is not enough to know that a therapist's interpersonal or attachment styles can influence treatment outcomes but to also explore ways to incorporate this knowledge to the benefit of our clients and our profession as a whole. Certain professions require extensive psychological examination before a candidate can even be considered for enrollment, should the individuals administering those examinations and are entrusted to treat psychopathology also undergo similar examination?

Conclusion

Personal therapy can be utilized as a supplemental pedagogical approach to developing clinical efficacy and improving treatment outcomes. By examining current research on the potential impact that a therapist's subjective variables can have on their clients and the commonly identified benefits of personal therapy on the therapists, it becomes evident that personal therapy offers unique opportunities for professional and personal growth. Although not always necessary, intrinsic motivation and an intent to address several different areas of functioning have associated with the most perceived value of personal therapy among therapists. Clinicians who most strongly associate with the psychodynamic approach represent one of the largest groups of therapists who perceive personal therapy as an integral component of clinical practice. This finding is also congruent with my own personal experiences of therapy. The therapist, and by extension the therapy they provide, is a synergistic outcome of, not only, their education and training but also of their personality, developmental experiences, and underlying life philosophy. By gaining a greater awareness of who we are as therapists, and as individuals, we can learn to be more reflexive, less reactive, and engage in more adaptive functioning.

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Chaminade University IRB

FORM I: IRB Determination Form

Chaminade University's policy and federal regulations do not allow investigators to determine if their work or activity is human participants research and may require IRB review and approval. This form is designed to determine whether research is being conducted and if this research constitutes human participants research as defined by federal regulations (See the Federal Register, 45 cfr 46.102). This form may be submitted to funding agencies when the agency requires documentation that the IRB has made the determination that IRB approval is not necessary to conduct the work.

Investigators should complete sections 1-6 of this form. The completed form can be e-mailed to: irb@chaminade.edu. The subject line should be entitled, "Determination of Human Subject Research." The completed form can also be delivered in person to the Provost's Office: CT Ching Hall

Note: If children or minors are subjects then Full Review (Form III) is required.

1. Project Personnel

Principal Investigator Name: David Robinson
Position:
Faculty: ☐
Staff: ☐
PI Contact email: David.Robinson@student.chamin
Phone Number:
Division: Clinical Psychology
Student co-investigator name (if applicable):
Other co-investigator name: Dr. Lianne Philhower
Other co-investigator position: Faculty: ☑ **Staff:** ☐
Date of Submission: 04/27/20

2. Project Overview

Title: What We Bring Into the Room: A Psychodynamic Perspective on the Value of Personal Therapy for Therapists

Name of Funding agency (if applicable): N/A
Funding period (start and end dates, if applicable): N/A

Requested Project Start Date: 05/15/2020 **End Date:** 07/01/2020

3. Required Training

List participants and date of completion of Humans Subject Certification. Attach copies of Certifications. Note that for Determination (Form I) only PI Certification is required to be completed. For Protocol approval (Form II or III) all participants must complete training.

Name	Certification Completed	Date of Completion
David Robinson	CITI	November 26, 2019
Lianne Philhower	CITI	May 15, 2019
	CITI	
	CITI	

4. Protocol Description.

4.1. Provide a concise summary of the purpose and rationale of the activity (what is the question/hypothesis to be addressed).

This is a theoretical study. I will review the current literature in order to develop a psychodynamically oriented model that incorporates common insights and lessons gained from therapists who have engaged in personal therapy. Psychodynamically oriented therapists often go through their own personal work with a therapist during their training. The literature on how this personal work impacts the therapist's approach to providing therapeutic services will be explored. As therapists, we provide a unique and challenging service, a service that many therapists have personally engaged in with positive outcomes (Bike, Norcross, and Schatz, 2009). Within the psychodynamic frame, there is an emphasis for the therapist to be mindful of how much of themselves they "bring" into the room with the client. If a therapist has never engaged in personal therapy, could they still be aware of how their personal beliefs, biases, and assumptions might be impacting the client? While a therapist might never completely eliminate their biases or assumptions, which could impact treatment, personal therapy offers an opportunity for the therapist to "sit in the other chair" and be on the receiving end of the services they are perceived to be experts in providing. What lessons have therapists learned about themselves, therapy, and adaptive functioning that could also benefit the client's that they see? This study hopes to illustrate how personal therapy impacts the therapy provider's services.

Bike, D. H., Norcross, J. C., & Schatz, D. M. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. Psychotherapy: Theory, Research, Practice, Training, 46(1), 19–31.

4.2. Describe the proposed methods and study procedures

There will be no data collection from human subjects. This theoretical study will review the literature on outcomes of therapists who have engaged in personal therapy, their perceptions of their own therapy, as well as identification of any common factors that could potentially benefit their clients. Examination of the current literature will include outcome measures of therapists (psychologists, counselors, and other therapists) who have engaged in their own personal therapy. I will attempt to delineate between studies where individuals reported positive, negative, and neutral outcomes and categorize each study in order to identify common factors that participants reported influenced their perception within these three categories. After common factors, if any, have been identified then I will propose a model of engaging and incorporating these common factors into the professional work that the therapists might include in the treatment of their own clients.

4.3. Describe how data collection will occur and the type of information to be collected about the subjects? Indicate whether data will be identified, de-identified or coded. If coded, explain whether the code will be accessible to the investigators. If this is a Secondary Study see question 4.4.

This is a theoretical study that does not include any data collection from human subjects. This study will examine the current peer-reviewed research and literature on outcomes measures of therapists who have engaged in their own personal therapy, why they engaged in therapy and any common factors that were identified from PsychINFO, Google Scholar, and PubPsych.

4.4. Secondary Studies. If your proposed research utilizes a pre-existing data set then IRB approval cannot be given retroactively unless the data set meets ethical collection standards. Please check those which apply:

- ☐ Informed consent was obtained
- ☑ Informed consent was not required
- ☑ Investigator will not re-identify subjects
- ☑ Investigators will not contact subjects

Prior IRB Approval: Yes: ☐ No: ☑ Approval Date:
Approving Institution:

Please provide a copy of the approval letter with your application.

4.5. Do you intend to publish or present your results outside of a classroom?
Yes: ☑ No: ☐

5. Determination of whether the proposed work constitutes Human Subjects Research

5.1. Federal Definition of Research: check all that apply

A. ☑ The activity employs a systematic approach involving predetermined methods for studying a specific topic, answering a specific question, testing a specific hypothesis, or developing a theory.

B. ☐ The activity is intended to contribute to generalized knowledge by extending the results beyond a single individual or an internal unit (e.g. publications or presentations).

C. ☐ The investigator obtains specimens or data through intervention or interaction with a living individual (e.g. interviews, surveys, physical procedures, manipulations of the subject's environment, private or limited access internet sites, or any other direct contact or communication with a subject).

D. ☐ The investigator is obtaining identifiable private information about living individuals (e.g. chart reviews, lab studies on tissues or specimens, information from data or tissue repository).

E. ☐ The data or specimens are received by or provided to the investigator with identifiable private information

F. ☐ The data or specimens are coded and the investigator has access to a link that would allow the data or samples to be identified

5.1. Federal Definition of Research (continued): check all that apply

G. ☑ Your project is limited to analysis of de-identified publicly available data. The IRB recognizes that the analysis of de-identified, publicly available data does not constitute human subjects research as defined in federal regulations, and that it does not require IRB review but does require an action of the IRB to designate it as non-human subjects research. Some examples of data available from large data consolidation bureaus and consortiums are Inter-University Consortium for Political and Social Research (ICPSR), U.S. Bureau of the Census, National Center for Health Statistics, National Center for Education Statistics, National Election Studies.

H. ☐ Your project is limited to course-related activities designed specifically for educational or teaching purposes; where data is collected from and about human subjects as part of a class exercise or assignment and is not intended for use outside of the classroom.

I. ☐ Your classroom research involving collection or utilization of data on human subjects will meets all of the following conditions:

I (a) ☐ The research results are not conducted with the purpose of creating generalizable knowledge.

I (b) ☐ The course instructor has completed human subjects research ethics training.

I (c) ☐ The research does not involve vulnerable populations (children, prisoners, pregnant women, or handicapped or mentally disabled persons).

I (d) ☐ The research poses minimal risk to the participants, meaning that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests

J. Scholarly and journalistic activities that focus directly on specific individuals about whom the information is collected (information not generalizable). However, if an interview of a single person is to be perceived as 'representative' of a population then this IS research.

J (a) ☐ Non generalizable journalistic activities

J (b) ☐ Generalizable journalistic activities

K. ☐ Subjects are not living (does not apply to secondary research on biospecimens or existing datasets, ask the IRB Chair for clarification if needed)

6. Project Submission Checklist

☑ Copy of PI ethics training certificate

☑ Copy of co-investigator(s) ethics training certificate(s)

☐ Copy of conflict of interest forms for all investigators

☐ Copy of survey/data gathering instrument(s)

☐ Copy of consent form or waiver of consent

Note: if the research proposed is a Secondary Study, all of the documents pertaining to the approval of the primary study should be submitted too.

7. Outcome of Determination (to be completed by the IRB Chair only)

*If 5A and 5B are checked and at least one of 5 C-F is checked then the project **DOES** CONSTITUTE Human Subjects Research.*

*If J (b) is checked then the project **DOES** CONSTITUTE Human Subjects Research.*

*If G, H or I, K (including all subcomponents of I) or J (a) are checked then your activity is in a category that the IRB has determined **DOES NOT** represent human subject research and no further submission of Form II or III is required. However, it is recommended you document this determination by placing a copy of this completed application in your files to address any future queries about the project. This form may still be submitted for an official determination by the IRB if required by the sponsor.*

IRB Chair Certification:

Based on the information provided this proposal:

DOES ☐ *constitute Human Subjects Research and the Investigator should submit Form II or III for further review of the protocol. Research cannot start until Form II or III is approved by the IRB.*

DOES NOT ☑ *constitute Human Subjects Research and the IRB will not review it further. However, if changes to the proposed research plan occur that makes the protocol IRB-reviewable, the Investigator is required to complete a new Form I and Forms II or III as required.*

Signed,

05/15/2020

IRB Chairperson *Date*