University of Alberta

The Experiences of Therapists as Clients

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

in

Counselling Psychology

Department of Educational Psychology

Edmonton, Alberta

Fall 2006

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Your file Votre référence
ISBN: 978-0-494-23020-6
Our file Notre référence
ISBN: 978-0-494-23020-6

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Abstract

An assumption in the training of therapists was that therapists will experience therapy as clients. Although these expectations have changed over time, the majority of therapists still have therapy at some point in their careers. There have been several recent qualitative studies exploring the connection between therapists' therapy and their practice, however few studies have explored the overall experience of therapists as clients.

Using a basic interpretive analysis, the question, "What is the experience of therapist as client" was posed to 7 therapists from Alberta and Northern California. I identified four main themes: "Boundaries", "Connection", "Dual Processing" and "Learning Through Experience". The theme of "Boundaries" encompassed the participants' positive and negative experiences of boundaries between self and others both in and out of therapy. Positive experiences resulted from early clarification of roles, recognizing responsibility in personal and professional relationships, containment in sessions through safety and pacing, and role modelling by their therapists. Negative examples of boundaries resulted from lack of role clarity and lack of structure which led to a decreased feeling of safety in sessions.

The theme of "Connection" included experiencing trust and safety in their therapy and the resulting feeling of being empowered and understood by their therapists. "Dual Processing" captured what was unique to therapists' therapy when compared to the therapy of laypersons. Dual processing was the result of the participants learning both personally and professionally from their therapy through their roles as apprentices and clients. The final theme, "Learning Through

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Experience" represented what participants transferred from their experiences of therapy to how they conducted therapy with their clients. Therapy: impacted their supervision of students, demonstrated the vulnerability of clients, and sensitized therapists to the importance of validating the clients' strengths and avoiding harm. It was clear that posing the question, "What is the experience of therapist as client?" participants in this study were able to elaborate on what they felt was pertinent to their story. This led to important discussions regarding both the potential harm and the powerful healing that can result from therapists' therapy.

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Acknowledgements

I would initially like to thank each of the seven participants for allowing me the time for interviews and corroborative communications. I appreciate that they were willing to share their experiences with me and allow me into their 'sacred spaces'.

I would like to thank my supervisor, Dr. Robin Everall, for your constant support during the research process. I know that you have gone above and beyond your official role and for that I am appreciative. To Dr. Mary Ann Bibby, thank you for taking time on your sabbatical to provide helpful suggestions. Thank you also to Dr. William Whelton for your feedback regarding clarity and organization of this document. To my other committee members, Dr. Carol Leroy, Dr. Linda McDonald and Dr. Anne Marshall, I appreciate your interest in my topic as well as the feedback and supportive comments during my defense.

I would also like to thank several individuals for their personal support during this process. Thank you to my mom and dad for their unconditional support of me throughout my life. To my brothers and their families for always reminding me of what is truly important. Thank you also to my grandma, Mabel Roose, who always doubted her intelligence but is the smartest woman I know. To Dr. Louise Mackay and Dr. Sophie Parkins for their understanding and encouragement to persevere.

Finally to my partner, Chandra Kirn Ashton, for her constant encouragement and understanding throughout my research. I appreciate your willingness to help with whatever I needed during this process. I could not have completed this without your love and unconditional support. I am blessed that you entered my life and decided to stay.

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For my dad

Dr. L. M. Dushinski

for inspiring my love of learning

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CHAPTER ONE

INTRODUCTION

Since the early stages of the practice of psychotherapy it was presumed that therapists would experience their own therapy as part of their professional development. The presumption stemmed from the discipline's historical roots within the psychodynamic tradition, which encouraged students to undergo individual analysis as the foundation of their training. Freud (1937, 1964) stated, "Where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession? The answer is in an analysis of himself" (p. 246).

In agreement with Freud, Fromm-Reichmann (1950) would have us believe that it is dangerous to conduct therapy without experiencing it first-hand.

> Because of the interrelatedness between the psychiatrist's and the patient's interpersonal processes, and because of the interpersonal character of the psychotherapeutic process itself, any attempt at intensive psychotherapy is fraught with danger, hence unacceptable, where not preceded by the future psychiatrist's personal analysis (Fromm-Reichmann, 1950, p. 42).

At the time these statements were made however, little research had been done to confirm what is stated unequivocally. Molitor (1984) claimed that both Jung and Freud gave credit to one another regarding the stated importance of analysis for the analyst. Jung (1966) apparently felt however, that Freud gave individual analysis more credence, unlike his own belief that the personality of the therapist was the most important aspect of therapeutic effectiveness.

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In contrast to the belief about the importance of therapists receiving therapy, Derner (1960) stated that to:

> Judge a priori who will be a good therapist by the use of personal therapy experience as a major prediction continues to be questionable. If humanness can be put at the disposal of the patient, he will be a successful patient (p. 134).

Dubovsky and Scully (1990) go further by suggesting that individual therapy for the therapist could instead pose a distraction thereby potentially harming clients of the therapist.

Clearly there are diverse views about the importance of therapy for the therapist. According to the literature, one's theoretical orientation is a key factor in determining the importance given to one's own therapy. Historically, Freud's assumption that human beings are inherently flawed led to the belief that therapy was necessary in the ongoing development of therapists. As psychology evolved over time to include more diverse perspectives about human nature, the presumption of individual pathology changed. What once was a required activity in the personal and professional development of a therapist became an optional activity to be pursued by individuals when deemed necessary.

The theoretical orientation of a therapist also influences his or her definition of what therapy encompasses. Many of the original articles exploring this topic focused on the psychiatric profession with its roots in Freudian theory. Most recent research however, expanded the discussion to include a variety of perspectives. For the purpose of this study of therapists' therapy, therapy will be defined as "the psychological treatment of mental health professionals by means of various theoretical orientations

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and therapy formats" (Geller, Norcross & Orlinsky, 2005, p.5). This definition acknowledges that the format of therapy has changed since the time of Freud to encompass diverse methods of providing services to clients and therefore will allow for an inclusive discussion of past and present research.

Despite diverse viewpoints, overall research suggests that the majority of therapists feel therapy is a valuable experience (Garfield & Kurtz, 1974; Prochaska & Norcross, 1983; and Williams, Coyle & Lyons, 1999). There were many noted benefits of therapy for individuals ranging from improved self-esteem to learning about therapeutic techniques (Buckley, Karasu & Charles, 1981; and Pope & Tabachnick, 1994). The strong belief in the importance of therapy for therapists led some programs to require therapy as part of training and professional development. Therapy during training created greater vulnerability for students than therapy later in professional development (Williams et al., 1999). Therefore the timing of one's participation in therapy appears to be a significant contributor to the overall therapy experience.

The majority of research in the area has been quantitative, limiting the ability to capture subtle aspects of therapists' experiences. Recently qualitative research efforts have allowed greater depth by providing personal accounts of the therapists' therapy. These qualitative studies focused on how the therapists' therapy impacted their work with clients. Although there is a logical connection between their experiences of therapy and their own practice, it is not the focus of the current study. Instead I explored the overall experiences of therapists in therapy avoiding the implicit

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assumptions made in previous qualitative research as I felt that participants should be free to highlight whatever was pertinent.

There are three key differences between this study and past qualitative studies. First, by avoiding the assumption implicit in prior research questions, it was felt that participants would be free to highlight what was pertinent in their experiences of therapy. Therefore this study will add to the breadth and depth of prior work by focusing broadly on the overall experience of therapists in therapy. A second important distinction of my study is that therapy cannot have been required as part of training or licensing. This will hopefully ensure that therapists have had therapy of their own volition rather than as a requirement of their program or licensing board. A third distinction from past research is that therapists must have been providers of therapy during their experience of therapy, either as students or as professionals. I felt this was an important clarification because of the obvious impact being a provider of therapy would have on one's experience of therapy.

A basic interpretive method, which focuses on individual experience of a phenomenon, was used to deepen the understanding of what it was like for therapists to be clients. It also allowed the participants to share what was important in their experiences. Increasing awareness of the more tangible aspects of therapists' experiences will help to clarify how therapy is valuable to therapists. As well, therapists' descriptions of both positive and negative experiences will help to increase understanding thereby informing practice and positively impacting both therapists and future clients.

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Outline of the Dissertation

This first chapter has provided an introduction to the importance of this research. Chapter Two includes a discussion of the relevant literature on the topic. Chapter Three explores the rationale for a qualitative study and presents a discussion of the methodology and methods including participant selection, data analysis and ethical concerns. Chapter Four presents the participants' experiences as grounded in the data. Chapter Five summarizes the main themes that were identified in participants' experiences. Finally, Chapter Six presents a discussion of the results of this study and how it contributes to our understanding of therapists in therapy in relation to past findings. Considerations of the study and suggestions for future research are also presented.

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CHAPTER TWO

LITERATURE REVIEW

Several reviews of the literature have been completed regarding therapists' use of therapy. Macran and Shapiro (1998) offered a framework for the quantitative literature which will be used in the following discussion. The literature review will include an exploration of survey research to gain a better understanding of overall numbers and characteristics of therapists in therapy. The framework used by Macran and Shapiro (1998) included studies regarding how therapist efficacy and process with clients was impacted by their own therapy. Some studies focused on therapeutic outcomes comparing clients of therapists who had therapy to clients of therapists who had gone without. Other research explored the common impetuses behind therapy, namely therapy for the purpose of training and therapy to address impairment. Extending the discussion of impairment is an exploration of burnout and vicarious trauma as it relates to therapist functioning. The research discussing the types of characteristics therapists seek in their therapists and the ethical issues arising within this unique dynamic are explored. Finally, recent qualitative contributions to the research will also be discussed in order to point out the areas of research that are lacking.

Previous Reviews of the Literature

There have been several reviews completed exploring the literature on therapists' experiences as clients. Although the authors reached different conclusions, one agreed-upon finding thus far is the need for further research in the area (Greenberg & Staller, 1981; Clark, 1986; Herron, 1988). Clark (1986) reviewed

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empirical research on personal therapy with therapists and found that only one study by Holt and Luborsky (1958) supported the hypothesis that individual therapy would improve therapists' performances. These authors compared two groups of psychiatric residents who had and had not had individual therapy. Supervisors then rated their overall performances with clients. Unfortunately the study was limited by the different motivations behind seeking therapy. Some participants sought therapy as part of training while others required support to address personal problems. The difference in motivation between the two groups was problematic because it created a different potential for improvement. Although few studies clarified this factor, the motivation behind therapy clearly had an impact on the overall experience of therapy.

In several other studies (Katz, Lorr & Rubinstein, 1958; McNair, Lorr & Callahan, 1963; McNair, Lorr, Young, Roth & Boyd, 1964) reviewed by Clark (1986) there was no significant relationship between the therapists' personal therapy and client outcome. Clark (1986) was critical of the research because it had not been "empirically demonstrated that personal therapy is beneficial to client outcome" (p. 542). Researchers however, had often supported personal therapy without validation from the literature. Instead the author claimed that future research should focus on the mechanisms or conditions under which personal therapy impacts client outcome.

In a review in the same year using similar core articles, Glass (1986) contradicted Clark (1986) and found there was support for the view that therapists' therapy positively effected client outcome. Glass claimed the opposite was sometimes true for student therapists because of the students' preoccupation with their own issues. Despite reviewing similar articles to Clark (1986), Glass asked not whether

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therapy was necessary but when it would be most appropriate for the therapist to benefit from its positive effects.

In their analysis of the literature, Norcross, Strausser-Kirtland and Missar (1988b) found six common themes regarding how therapy impacted the therapist. The themes were: improved emotional functioning, increased understanding of personal dynamics and countertransference issues, furthered conviction of the therapeutic process and internalization of the role of healer, increased sensitivity to the vulnerability in the client role, and providing concrete examples of clinical methods. It is interesting that this analysis of the quantitative literature led to similar overall themes found in the qualitative research to be discussed later. Macran and Shapiro (1998) divided past quantitative studies into four areas: survey research, outcome studies, experimental studies and process studies. In order to aid the organization of this review of the literature, a similar structure will be used.

Quantitative Studies

One of the main benefits of quantitative literature on therapists' therapy is that it included surveys of large numbers of therapists regarding specific aspects of their therapy experiences. As well, quantitative methods have been used to test theories regarding the impact of therapists' therapy on therapeutic efficacy. This section will include a discussion of the quantitative literature regarding the therapists' experiences of therapy as clients. Initially survey research will be discussed in order to provide a picture of the overall popularity of therapy, the perceived benefits of therapy, and other issues arising from the experience. Experimental studies focused on the responses of therapists to "situations that are supposedly analogous to real-life

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therapy" (Macran & Shapiro, 1998, p. 17). Another group of studies focused on the in-therapy processes rather than the results with clients. Finally outcome studies involved comparison between client outcomes of therapists who had been in therapy with those who had not had therapy.

Survey Studies

Barker, Pistrang and Elliott (1994) described survey research as a systematic study of a large sample either through mail-out questionnaire or interview. As is common in psychological studies, surveys of therapists have been used to gather data in order to reach a large number of clinicians in a cost effective manner. Surveys of therapists from a variety of backgrounds have been conducted over the last thirty years. The types of information gathered included the percentage of individuals that have participated in therapy, information regarding who accessed therapy (gender, age, theoretical orientation and professional background) and the overall impressions of the therapy experience. Survey studies are limited to the items included in the questionnaires. Therefore the overall contribution of these studies to increasing our understanding is specific to the questions posed. Nevertheless, a discussion of this research is necessary to further our understanding about what is known about this important topic.

In one of the earliest survey studies, Garfield and Kurtz (1974) found that 63% of their sample of 855 clinical psychologists had received therapy. Thirty six percent of this sample rated therapy as 'very important' and a prerequisite for performing therapy. Forty-five percent felt that all clinical psychologists should undergo therapy. In a further analysis of their data, Garfield and Kurtz (1976) added that theoretical

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orientation was significantly related to how one viewed therapy, with psychoanalytic therapists holding the most positive view. Private practitioners were found to be more likely to attend therapy when compared to university professors in psychology. Another finding was that female clinicians were more likely to participate in therapy compared to their male counterparts. These findings will also be discussed later as they relate to help-seeking behaviors.

In a study with a different focus, Buckley, et al. (1981) interviewed psychiatrists about their experiences of psychoanalysis or psychotherapy. The researchers assumed that this special population of clients would help to identify discrete elements of change as a result of therapy due to their expertise and knowledge of the process. Among the indicators of therapeutic efficacy were: 94% improved self-esteem, 84% improved work function, 86% improved sex life, 89% character change and 73% alleviation of symptoms. Results also demonstrated that mutual liking and the feeling of being understood corresponded highly with a reported positive outcome in therapy. Buckley, et al. expressed dismay that 21% of the respondents viewed some aspect of their personal analysis as harmful. These harmful aspects were often related to what were described as "unresolved transference issues". While this study provided support for the claim that therapy was beneficial for therapists, the sample was limited to psychodynamically trained psychiatrists.

Using a different population, Prochaska and Norcross (1983) surveyed members of the American Psychological Association's Division 29 (Psychotherapy). Eighty-three percent of their sample compared to 63% of the Garfield and Kurtz (1974) sample reported undergoing some type of personal therapy. The most common

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orientations listed by the participants included psychoanalytic (33%), psychodynamic (21%) and eclectic (17%). Almost half of the sample or 47.4%, felt that their personal therapy was 'very important' in their work as a therapist, which is comparable to Garfield and Kurtz. At the same time, 9.4% of the Division 29 sample felt that their personal therapy was 'not at all important' or 'unimportant'.

In another sample of psychologists, Guy, Stark and Poelstra (1988) surveyed 749 individuals in the American Psychological Association (APA) Divisions 12 (Clinical), 29 (Psychotherapy) and 42 (Independent Practitioners) and found that of the 335 responses received, 82.1% had participated in some form of personal therapy during their lifetime. The authors expressed concern however that 22.9% of the sample had never received individual therapy and 18% had no therapy at all. Individuals providing the most therapy also received the most therapy as clients. Finally, those receiving therapy in training were more likely to re-enter therapy later in their careers.

In order to compare different professions, Norcross, et al. (1988b) surveyed equal numbers (500) of psychologists, social workers and psychiatrists. The authors found similar trends to Garfield and Kurtz (1976) in that women and "insight oriented" therapists were more likely to have had therapy. According to the results 75% of psychologists, 67% of psychiatrists and 72% of social workers reported participating in personal therapy. Over 90% of the respondents indicated symptom improvement as a result of receiving therapy, while 2 to 3% reported symptom deterioration.

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A more recent study by Pope and Tabachnick (1994) found 84% of their sample of 476 psychologists had been in therapy. Of the group that had been in therapy, 86% had found it helpful and 26% of this group viewed increased self-knowledge and self-awareness as the benefit of personal therapy. Also a majority (70%) of the sample believed graduate schools should 'probably' or 'absolutely' require therapy for students of psychotherapy.

There have also been surveys given to British psychologists regarding their views of personal therapy, which has been an important development in providing a multi-country perspective. The initial survey by Norcross, Dryden and DeMichele (1992), involved 993 Clinical Psychologists, 38% of whom reported undergoing personal therapy, a figure much lower than their American counterparts. Although there were many consistencies with studies done in the U.S., two interesting findings arose. Firstly, the average length of men's therapy was significantly longer than women's therapy. Secondly, therapy provided by psychologists and psychiatrists was more frequently perceived by clients as ineffective when compared to counsellors and lay analysts.

Other studies completed in the United Kingdom demonstrated interesting findings. Darongkamas, Burton and Cushway (1994) surveyed 496 Clinical Psychologists in the United Kingdom regarding their personal therapy experiences, professional activities and job related stress. Consistent with prior studies, psychodynamic therapists were much more likely to have experienced personal therapy. Another finding was that cognitive behaviorists chose therapists from an

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orientation other than their own. Finally, those therapists who had therapy were more likely to recommend it to other therapists.

Unlike previous American studies, only 41% of the therapists polled had had their own therapy. Darongkamas, et al. (1994) felt this low number was a reflection of the trend that therapy was less popular in Britain. Another possible explanation was that the majority of the sample was cognitive behavioral therapists who were noted to be less likely to attend therapy. Other interesting findings from this research were those psychologists who had had therapy perceived their jobs to be more stressful than those psychologists who had not had therapy. Also British therapists were not only less likely to seek therapy, but they were also less likely to seek therapy as part of training. A final result of the survey was that 17% of the sample reported unsatisfactory results with their therapy compared to 21% (Buckley et al., 1981) who found their analysis harmful and 2 to 3% (Norcross, et al., 1988b) who reported deterioration in symptoms.

In a smaller British study using a different population, Williams, et al. (1999) surveyed 192 counselling psychologists to see how they viewed their personal therapy. Overall, 88% of respondents felt therapy should be a requirement of training, while 27% viewed some aspect of the experience as negative. Analysis of the motivation and reasons for entering counselling led to the conclusion that "whatever the reasons for entering therapy, there is a clear distinction between dealing with personal issues within therapy and using it as a medium for learning about therapy" (p. 552). Williams, et al. felt that trainees should focus initial sessions on resolving personal issues, and then move toward increased understanding of the therapeutic process in

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later sessions. This is a key finding in the research because it raises two very important issues. First, a person's experience of therapy may be altered by their reason for attending therapy. Secondly, when therapy occurs during a therapists' training it has a tremendous impact on the dynamics within the session and the overall experience of therapy.

In summary, therapy was viewed as helpful by a majority of therapists surveyed despite varying samples by profession, theoretical orientation and country of origin. In most studies North Amercian, the majority of therapists surveyed had had therapy; 83% (Prochaska & Norcross, 1983), 82.1% (Guy, et al., 1988) and 84% (Pope & Tabachnick, 1994). According to Norcross et al. (1998b), the therapists' profession impacted their level of participation in therapy with 75% of psychologists, 72% of social workers, and 62% of psychiatrists having therapy. The theoretical orientation of the therapist also played a key role in whether they chose to have therapy, as did their country of origin. Psychodynamic and psychoanalytic therapists had the highest rates of participation, while cognitive behavior therapists demonstrated the lowest rates of therapy. Therapists in the United Kingdom had therapy at lower rates of participation than their American counterparts (Darongkamas, et al., 1994 and Norcross et al., 1992). Generally women were more likely to participate in therapy (Garfield & Kurtz, 1976) however one study found that men participated in therapy longer than women (Norcross et al., 1992).

Many but not all of those surveyed agreed that therapy should be required for students as part of their professional development. Positive rewards for participating in personal therapy were: improved work functioning, improved self-esteem, improved

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sex life, character change, alleviation of symptoms (Buckley et al., 1981; Norcross et al., 1988b) and increased self-knowledge (Pope & Tabachnick, 1994). Some therapists felt that their therapy either was not important (Prochaska & Norcross, 1983), unsatisfactory (Darongkamas, et al., 1994), or had a harmful impact (Buckley et al., 1981). Negative consequences included deterioration in symptomology (Norcross, et al., 1988b) and 'unresolved transference issues' by the therapist (Buckley et al., 1981). Although survey research helped to illuminate certain aspects of the phenomenon of therapists in therapy, it is clear that other forms of research are needed in order to deepen our understanding of therapists' experiences as clients.

Experimental Studies

Experimental methods have also been used to explore the impact of therapy on therapists. Macran and Shapiro (1998) described this research as consisting of "laboratory-based studies of therapists' responses when asked to respond to situations supposedly analogous to real-life therapy" (p. 17). Herron (1988) concluded from the literature that it was extremely difficult to design studies that successfully isolate variables and therefore researchers should avoid experimental designs when researching the issue of therapists in therapy. Despite the difficulty in constructing effective studies, some researchers have attempted to isolate elements of the therapeutic process.

In one of the earliest studies completed in this area, Strupp (1955) elicited samples of therapists' verbal responses after presenting case studies of client situations. Quantification of the therapists' responses was accomplished by means of Bales' (1950) system of interaction process analysis. The researcher then compared

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the responses of 'analyzed' therapists, those individuals who had undergone psychoanalysis, and 'non-analyzed' therapists, those individuals who had not undergone psychoanalysis. Strupp found that 'analyzed' therapists were more active than 'non-analyzed' therapists as evidenced by fewer non-verbal responses to suicide threats, transference phenomenon, and schizoid presentations. He concluded that the 'analyzed' therapists responded more appropriately to the clients than the 'non-analyzed' therapists.

In the second experimental study, MacDevitt (1987) sent out a demographic questionnaire and the Therapy Vignette Questionnaire (TVQ), a scale developed for the study. The TVQ consisted of 25 multiple-choice items that included a vignette of a therapy situation followed by five alternative choices. The alternatives included one of interest which measured the "subjects' preference for engaging in self-examination in order to resolve impasses and understand clients" (p. 695) or what researchers described as Countertransference Awareness. The other four choices included alternatives of: a preference for taking action, sharing feelings or thoughts, rationalizing and reassuring oneself that one's reaction is understandable, and judging or blaming the client. Based on the results, MacDevitt suggested that awareness of countertransference issues was positively related to the number of hours of personal therapy and to claiming a psychoanalytic orientation.

Despite the difficulty of constructing experimental studies on this topic, Strupp and MacDevitt felt their studies demonstrated that therapists who had therapy were more appropriate in their responses with clients and more aware of 'countertransference issues'. These results would suggest that the main benefit of

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personal therapy was increased understanding of the impact of self on the session which led to more appropriate responses to clients.

Process Studies

Macran and Shapiro (1998) described process studies as looking at the "relationship between personal therapy and ratings of clients' and therapists' within-session experience" (p.19). The authors felt that methodological issues have limited these studies including small sample sizes and inadequate controls. Despite these obstacles, Strupp (1973) concluded from his sample of psychiatrists that empathy ratings were higher in therapists whose training had included personal analysis. This difference was not apparent in therapists who had had less than three years of experience. Another related finding was that the empathy ratings in experienced analyzed therapists were not affected by their attitude towards the client. These results would suggest that through analysis, experienced therapists were able to put their biases aside in order to be empathic toward their clients. The lack of difference found with less experienced therapists again suggests that the therapy process is somehow altered for this population.

In another process study, Peebles (1980) attempted to provide support for the hypothesis that the number of personal therapy hours would be positively associated with the therapists' ability to display empathy, warmth and genuineness. Rogers (1957) viewed these qualities as contributing to "the necessary and sufficient conditions of therapeutic personality change" (p. 95). The study involved 17 male and female doctoral students in clinical psychology who submitted their tapes of client sessions for review. Professionals trained in the Truax and Carkuff Scales (1967) for

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Accurate Empathy, Nonpossessive Warmth and Genuineness rated the tapes. The results yielded support of the view that personal therapy hours positively influenced the therapist's ability to display empathy and genuineness. There was a positive but not significant relationship between the warmth demonstrated by the therapist and the number of hours of personal therapy.

Clearly the studies focused on in-therapy processes were limited in number and demonstrate the challenges involved with this research approach. Tentative findings suggested however the therapists who had therapy were more able to set aside biases and display empathy and genuineness towards clients. Due to the complexity of the therapeutic process and the difficulty isolating and measuring variables the results of the above studies should be viewed as indeterminate evidence that personal therapy for therapists positively impacts clients.

Outcome Studies

Another approach to understanding the impact of therapists' therapy on their clients was to examine therapeutic outcomes. Greenberg and Staller (1981) summarized eight studies they viewed as important to clarifying whether therapists' therapy influenced client outcomes. These studies focused on whether client outcomes of therapists who had had therapy were more positive than with therapists who had no therapy. The researchers concluded that the only study to suggest a positive effect of personal therapy on client outcome was one by Kernberg (1973). This study explored the connection between personal analysis and patient improvement with experienced psychoanalysts and students undergoing analysis. The findings showed that experienced therapists who completed individual analysis achieved greater patient

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improvement when compared to more inexperienced therapists who had not yet completed their analyses. The main weakness of the study however was that the researcher did not control for the amount of experience of the therapist which may have interfered with any conclusions that personal therapy led to increased performance.

Katz et al. (1958) explored patient improvement related to whether their therapists had therapy or not. The researchers compared 232 cases on three different scales measuring antisocial behaviors, anxiety and authoritarianism. Three therapist variables were also included: therapists' years of experience, therapist diagnostic categorization of patients, and the presence or absence of personal analysis in the experience of the therapist. Results showed that patients who were diagnosed as "less severely ill were more likely to be rated improved, regardless of the therapists' experience" (p. 41). Secondly, patient improvement appeared to have minimal to no relationship to whether the therapists had or had not undergone analysis but rather related to the amount of experience they had as practitioners.

Garfield and Bergin (1971) found a negative relationship between therapists' therapy and client outcome. The authors used three measures to assess client change: the Depression and K scales in the Minnesota Multiphasic Personality Inventory (MMPI) and a disturbance scale as rated by the therapist before and after therapy. The therapists studied were graduate students in a psychotherapy practicum. They were categorized into three groups according to the amount of personal therapy they had received. The groups included therapists with no personal therapy, those who had received 80 to 175 hours of therapy and those who had between 200 and 450 hours of

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therapy. Results illustrated that "clients of those therapists who had no therapy consistently demonstrated the greatest amount of change" (p. 251). Another trend noted was that clients of therapists who had received less therapy (80 to 175 hours) achieved greater change on two of three measures than clients of therapists with the highest amount of therapy (200 to 450 hours). It is unclear from the research however, whether prior therapist impairment or pathology was considered as a possible explanation for why their clients achieved less change than the clients of therapist that had not had therapy. Another possible explanation for these results was that the therapists who had not had therapy may have instilled more confidence in clients regarding their ability to change.

The authors explored whether the number of hours of personal therapy were related to overall therapist disturbance. Therapists' MMPI scores were compared and it was concluded, "there were no differences in the amount of therapy received by the more and less disturbed therapists" (p. 252). The researchers claimed therapists' personal adjustment positively related to change on the MMPI in clients and that with respect to student therapists, some therapy may be worse than none due to the therapists' preoccupation with their own therapy. This study again highlights the issue of therapy during training as being potentially distracting to the trainees thereby negatively impacting their clients.

In a study of the same year, Strupp (1973) also found therapy had a negative effect on inexperienced therapists' ability to show empathy. It was found that the empathic ability of these therapists was lessened when they were in therapy thus supporting the claim made by Dubovsky and Scully (1990) that individual

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psychotherapy for the psychotherapist may pose a distraction from focusing on client issues. Despite the findings of the previous studies that therapy during training has proved problematic it is sometimes required or recommended by programs from a variety of therapeutic disciplines. This important issue will be explored later in this review following a discussion of the qualitative research on therapists' experiences of therapy.

Qualitative Studies

The aforementioned discussion regarding the importance of individual therapy for therapists has existed since the time of Freud. Implicit in this debate are questions regarding whether having individual therapy makes a person a more effective therapist. Initially the methods used to explore this question were quantitative and involved isolating variables in order to test theories. As this review has shown, it was difficult to find evidence to support the claim that therapy was advantageous for therapists and their clients. Recently, in order to enhance our understanding of therapists experiences of therapy, qualitative methods have been used to further explore this phenomenon.

One of the earliest qualitative studies was completed by Molitor (1984) and explored the interrelationship between therapists' therapy and their professional work. The author interviewed two masters and two doctoral students from four different orientations including Freudian, Jungian, Gestalt and Family Systems. Using Colaizzi's (1978) phenomenological method, the researcher identified five themes about how the interrelationship between personal therapy and professional work. 'Role modelling', included descriptions of how student therapists learned from their

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therapist, absorbing styles, attitudes and techniques. 'Empathy', highlighted the perceived increase in empathy for the client role and for avoiding issues that the therapist had not yet dealt with. 'Use of past experience in the therapeutic process' captured the increased sensitivity of participants to the process of therapy. The fourth theme, 'Learning of theory', described the student therapists' increased understanding of the subtleties of theory. The final theme, 'Therapeutic relationship', included the enhanced understanding of transference/counter transference issues and other aspects of the therapeutic relationship through the experience of therapy. To summarize these findings it appeared that therapists' therapy provided tangible examples of the therapeutic process which enhanced empathy and understanding for clients. The main themes of this research, although slightly altered, continue throughout the remaining qualitative studies.

With a different professional group, Mackey and Mackey (1993) explored the impact of personal therapy on the clinical practice of social workers. The researchers posed the question "Do social work students and practitioners see a connection between their personal psychotherapy and their practice and if so, how do they understand the nature of that connection?" A qualitative method of data gathering was also used in this study which Mackey and Mackey felt was essentially "a phenomenological question explored most effectively through focal question interviews" (p. 99). The interviews were conducted with 15 students and 15 Masters of Social Work clinicians. Three themes emerged in both groups: 'Therapist as model', which focused on qualities like genuineness, acceptance and empathy; 'Increased understanding of the therapeutic process', which described learning techniques,

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understanding therapeutic dynamics and increased confidence in confronting issues; and 'Integration of personal and professional aspects in life'.

Although most participants had positive experiences of therapy, half stated that mandated therapy as part of professional development would somehow "undermine the essential pre-conditions for successful treatment, motivation and readiness" (p. 109). A main difference between the two groups was that students referred to how their therapy was complemented by their supervision while practitioners focused on increased self-awareness as a result of therapy. Clearly the two groups demonstrated differences in what they were able to gain from therapy. The students appeared to use therapy to advance their therapeutic skills while practitioners were able to use therapy for personal growth.

The following year, Mackey and Mackey (1994) completed a second qualitative study with 15 practicing social workers exploring the question of personal psychotherapy and the development of a professional self. Despite posing a different research question than in their previous study, similar themes arose. Commonalities included: seeing the therapist as model, enhancement of empathy, and understanding the therapeutic process. New themes described increased self-awareness and the importance of therapy for personal and professional development. The researchers concluded from their findings that personal therapy for social workers was an essential part of the development of a professional identity that included empathy, genuineness, acceptance and respect for the client.

Macran, Stiles and Smith (1999) completed a similar study to Molitor (1984) and Mackey and Mackey (1993, 1994). They explored the question, "How does

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personal therapy affect therapists' practice?" The authors interviewed seven therapists with at least 3 years experience practicing therapy. Other parameters for participants were that they spent at least 40% of their time in the delivery of psychotherapy, and had had therapy no more than 5 years ago. The researchers found 12 themes, which they then grouped into three different domains, 'Orienting to the therapist', 'Orienting to the client', and 'Listening with the third ear'. The first domain concerned therapy's contribution to the participants' understanding of their presence in therapy as well as their roles as therapists. The second domain described the ways therapists learn from their own experience of therapy how to give clients space to process difficult emotions. The final domain referred to an increased understanding of boundaries regarding the differentiation of client and therapist issues. Macran et al. (1999) explained that the "the most subtle result of personal therapy for therapists was that it seemed to help them understand their clients more deeply and accurately" (426). Despite the acknowledged limitation of a self-selected sample of therapists who may have only had positive experiences in therapy, the researchers pointed out how many of the findings were similar to previous quantitative and qualitative studies.

More recently, Wiseman and Shefler (2001) explored therapists' experience of personal therapy. The study used narrative accounts of psychoanalytic therapists' own individual therapy. The participants were five experienced psychoanalytically oriented therapists chosen for their professional reputation and interest in the topic. Six domains arose: importance of personal therapy for therapists, impact of personal therapy on the professional self, impact of personal therapy on one's being in the session, the therapist as patient (past and current experiences), the therapist as patient

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(self in relation to the personal therapist) and mutual and unique influences on didactic learning. An underlying assumption of the study was that "personal therapy has a unique place not only in the personal development of psychotherapists, but also in their professional development, the two being inseparable" (p. 137).

Each of the qualitative studies discussed in this section included participants from different professional groups and to some degree posed variations of the same question regarding the impact of personal therapy on the practice of therapy. Commonalities in themes involved the therapist as a role model, the professional and personal impact of therapy, and learning about the subtle aspects of the therapeutic process. Increased understanding of the therapeutic process allowed for enhanced empathy and deeper appreciation of the client. There were key differences between the experience of students and practicing therapists, mainly that students utilized therapy more for professional development while more experienced therapists were able to use therapy for personal growth.

Reasons for Accessing Therapy

Therapy as Part of Training

Although there are many reasons behind therapists' therapy, one consistent reason given in the literature was that therapy was an essential aspect of therapists' training. Due to the historic importance and relative support of therapy for therapists, many programs considered or implemented mandated therapy. Initially researchers surveyed therapists in order to comment on the prevalence of mandated therapy and students' reasons for seeking therapy. Later, researchers focused on how various theoretical orientations viewed the issue of therapy as part of training. One study

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explored the help seeking behaviors of students in order to discover what might be interfering with students accessing therapy. Finally other studies offered suggestions for programs on how to address student impairment and ethically implement therapy during training.

In their sample of clinical psychology program directors, Wampler and Strupp (1976) found almost unanimous opposition to mandated therapy for students. Nevertheless, to facilitate access for students who wanted therapy the authors suggested clinical programs remove tangible barriers, such as cost, confidentiality and the lack of guaranteed quality practitioners. The authors felt that as an alternative to mandating therapy, removal of the barriers would allow students experiencing distress to access services.

In an effort to uncover the prevalence of programs mandating therapy Rachelson and Clance (1980) surveyed 518 American Psychological Association (APA) members. They found that 62% of their sample of graduate programs mandated personal therapy. Of the 62%, 80% claimed that inexpensive or free psychotherapy was offered to students.

Farber (1983) explored the stress of training programs in psychology and found that there were several areas of concern for beginning therapists. One of the main sources of stress was the increased awareness of their own frailties, unconscious processes and difficulties. As well, the potential over-identification with client difficulties also impacted the functioning of new therapists. Farber also felt that due to limited resources in some programs, new therapists were frequently given the most disturbed clients. This led to an exacerbation of other problems resulting from client

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contact. Another source of tension for therapists in training was the supervisory relationship which the author claimed led to an overall feeling of inferiority by trainees due to their tendency to underestimate their own abilities. There were numerous issues contributing to stress however one of the key concerns that arose is that students may be a greater risk to over-identify with clients during training years. This could be due to a lack of professional development or the result of the many stressors during this period of transition.

In addition to the reasons mentioned previously, a significant contributor to whether or not students sought personal therapy was the theoretical orientation of their training program. McNamara (1986) acknowledged the reluctance of behavior therapists to involve their students in individual therapy because of its association with the psychodynamic tradition. McNamara explored the use of personal interventions for behavior therapists and found that instruction of students through supervisor-directed, self-management techniques led to increased sensitivity and awareness of client variables related to outcome. The author found students gained a greater understanding of the demands on clients and what was required to experience change. As well, it offered an alternative method of enhancing empathy for the client role which was seen as a key benefit in the literature of therapists' therapy. The study also highlights the parallels in process between supervision and therapy.

Family therapy has a long history of involving students in their own therapy. Two articles discussed the importance of family therapy for graduate students. Guldner (1978) encouraged students' own family therapy in order to assist in the comprehension of theoretical concepts, acquiring techniques and skills, and to increase

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self-awareness. Based on feedback from the students, the experience of family therapy was viewed as extremely important in integrating theory with practice. They suggested it also positively involved families in their professional and personal development. The author cautioned the need for strong delineation between supervision and therapy so individuals may benefit from therapy without feeling evaluated by the person providing therapy. Guldner suggested guidelines to ensure that supervisors would not provide therapy. In addition it was recommended that anyone providing therapy to students would have limited teaching contact with those students. A final stipulation was that therapy should be contractual between parties based on individual need.

In the second article, Patterson and Utesch (1991) found that of their sample of 51 students in family therapy, 88% felt that all therapists should have some form of therapy during their career. The most common reasons for seeking therapy were individual problems and relationship difficulties. Of those students who participated in therapy most viewed it as an essential part of training while those who had not had therapy felt it should not be required. Though the majority of students had participated in therapy, researchers acknowledged the practical constraints of seeking therapy during training including cost, time constraints and dual relationships with supervisors or instructors. The training program in which the research was conducted provided a referral list of therapists who were willing to see students at a significantly reduced fee as well as a letter discussing some of the benefits of personal therapy as part of graduate training. It was believed that by addressing the perceived barriers to therapy, students would be more likely to seek help if needed.

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Holzman, Searight and Hughes (1996) explored the use of personal therapy by clinical psychology graduate students. The estimated prevalence of therapy in their sample population was 75%. Generally speaking students reported positive views of their therapy however, responses were again influenced by the student's theoretical orientation. As in previous studies with practicing therapists, students with a psychodynamic orientation voiced the most favorable opinions, while cognitive behavioral oriented students expressed the least favorable opinions.

Reasons for seeking therapy in Holzman, et al. included personal growth (70%), desire to improve as a therapist (65%), adjustment or developmental issues (56%), and depression (38%). The authors were surprised by the high number of students suffering from depression and cautioned therapists treating students not to rule out the possibility of coexisting clinical distress. Those students who chose not to enter therapy endorsed the belief that they had no need for it (56%) or that finances limited them (53%). The authors added that providers of therapy to students should consider a sliding scale or reduced fees for the "economically stressed graduate student" (p.100), thereby eliminating a barrier to these students seeking treatment.

In a more recent study of psychiatric residents in the United States, Daly (1998) found that 100% of analytic programs and 69% of psychodynamic programs recommended therapy for their students. A related finding was that the programs that recommended therapy also provided financial and referral assistance to residents, resulting in higher numbers of residents in therapy.

In contrast with potential benefits, there were studies that explored the possible negative effects of therapy for students. Dubovsky and Scully (1990) cautioned

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readers about the negative ramifications of long-term therapy for psychiatric residents. Included in the hazards were: stunted professional development due to intensive self-scrutiny, treatment tailored to faculty desires rather than client need and the obvious financial commitment involved in long-term psychotherapy.

Wheeler (1991) made similar conclusions regarding the danger of therapy for counsellors-in-training. While studying the therapeutic alliance with anorexic and bulimic clients, she found that there was a significant negative correlation between the number of therapy sessions the student therapists had and the measure of therapeutic alliance with their own clients. The suggestion was that participating in therapy was somehow distracting to the therapists while in training so that it negatively impacted the relationship with clients. It should be noted that this is a similar finding to Farber (1983) and Dubovsky and Scully (1990) that therapy during training could pose a significant distraction for students thereby negatively impacting their clients.

In one of the few Canadian studies, McEwan and Duncan (1993) explored potential obstacles created by personal therapy during training. Of the 400 clinical or counselling psychologists surveyed in the province of British Columbia, 41% had undergone therapy as part of their clinical training. The researchers found several problems in the manner in which therapy was conducted. Of those clinicians who participated in therapy, 46% were mandated. Sixty-two percent of those mandated were unable to choose their therapist and 69% had an academic colleague (faculty or students) provide therapy.

In addition, the authors felt supervisors had not properly prepared students for possible negative consequences of therapy. Other concerns expressed by the

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researchers were potential safety issues with respect to the students' confidentiality and the "unscrupulous use of information presented in therapy" (p. 191). And finally students discussed the lack of follow-up care provided by the program. Despite these limitations, the participants highlighted several benefits of therapy namely learning empathy, gaining role models and aiding in personal and professional growth. Clearly the limitations were not enough to colour the students' overall impressions of therapy allowing them to find positives in their experiences.

Another factor contributing to whether or not students pursued individual therapy was their attitudes towards help-seeking. Farber (2000) discussed the development and validation of a scale measuring counsellor and psychology trainees' attitudes towards seeking therapy. In this study, four dimensions of help-seeking attitudes were found: the importance of therapy for professional development, concern regarding professional credibility, concern over confidentiality, and the need for self-sufficiency which involved a desire to solve problems independently. Despite encouragement from their programs and efforts to reduce barriers to treatment, students still had several concerns which prevented them from having therapy. The author offered suggestions to overcome perceived barriers to treatment.

As an alternative to mandated therapy, Suran and Sheridan (1985) suggested that training programs help support students through the graduate school process. The authors felt it was important to balance performance demands with the student's personal growth and to educate students about the costs and ethical implications of impairment. Another suggestion was to create a non-evaluative course on life span development. This course would educate students about topics including: the stages in

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professional life, burnout, stress management, and other important features. A third proposal was to eliminate the unnecessary and unrealistic demands on graduate students that contribute to anxiety and self-doubt their development. Lastly, the authors commented on the need for 'balance' in professional and personal development.

Therapy to Address Impairment

Another trend in the literature was therapists' therapy being used as a remedy to professional impairment. The first formal concern regarding professional impairment in psychologists was raised at the 1980 American Psychological Association meeting (Kilburg, 1986). Impairment was defined by Guy (1987) as the "diminution or deterioration of therapeutic skill and ability due to factors which have sufficiently impacted the personality of the therapist to result in potential clinical incompetence" (p. 199). Addressing therapist impairment is important at two levels. At the individual level, colleagues who are struggling deserve our attention and assistance, as do their clients. At a larger level, addressing impairment increases both professional credibility and public perception of the therapeutic process.

In a study by Guy, Poelstra and Stark (1989) the authors found that 36.7% of their sample of therapists surveyed indicated their own personal distress had decreased the quality of care provided to their clients. Of those therapists self-identified as in distress, only 70% sought some form of intervention leaving many clinicians without assistance. Thoreson, Miller and Krauskopf (1989) found that when faced with an emotional or personal problem, respondents sought assistance from psychologists (27%), psychiatrists (14%), and physicians (14%). Nine percent of the sample

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identified themselves as having an alcohol problem and many felt they were ineffectively dealing with their problem. The researchers expressed dismay that individuals in a helping profession lacked the insight to deal with their problem behaviors.

As the role of most psychologists is to help individuals in distress, it is discouraging that "psychologists have been somewhat slower than other professional groups to recognize the problems of impaired colleagues" (Laliotis & Grayson, 1985, p. 87). The hesitancy on the part of colleagues to report impairment was discussed by Wood, Klein, Cross, Lammers and Elliott (1985) who estimated 7 to 14% of the profession would admit to some impairment however would not seek assistance for their difficulties. Although many psychologists stated they were willing to help colleagues, only a small minority was willing to risk reporting a colleague. Good, Thoreson and Shaughnessy (1995) explored the lack of reporting of colleagues abusing alcohol and found that despite knowledge of a colleague's impairment, those surveyed were hesitant to confront a colleague or report to their local boards.

Laliotis and Grayson (1985) speculated that the lack of reporting might have to do with a lack of services for rehabilitation. Between 1998 and 1999, Barnett and Hillard (2001) surveyed State and Provincial Psychological Associations about the services available for assisting distressed psychologists. Sixty nine percent the areas polled did not have colleague assistance programs. The authors stated, "although psychologists may be considered experts in the identification and rehabilitation of clinical distress and impairment, it seems that many fail to assess and acknowledge personal feelings of distress" (p. 206).

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Acknowledging personal distress was not the only barrier to treatment. Norman and Rosvall (1994) agreed that often external factors could impact the help-seeking behavior among therapists. In their survey of mental health practitioners in Utah, a total of 57% of the therapists (including social workers, psychologists and family therapists) reported participation in personal therapy. Factors listed that affected help seeking behaviors were the therapist's gender, the area of professional work and the number of children in the therapist's family. The researchers found that as the number of children the therapist was responsible for increased, the likelihood of seeking help decreased. Consistent with the results in Deutsch (1985), Norcross, et al. (1988b) and Pope and Tabachnick (1994), women were viewed as more likely to seek help for psychological distress. Finally, practitioners in agency settings were less likely to seek therapy despite the increased likelihood of impairment in this environment (Raquepaw & Miller, 1989).

There are numerous external barriers facing psychologists when they seek help for personal difficulties however, internal barriers also impacted their help-seeking behaviors. Liaboe (1988) explored whether locus of control impacted psychotherapists' use of personal therapy. Results indicated that therapists who sought personal therapy did so due to self-knowledge and their own desire to have therapy rather than as a result of any external factors, for example, the involvement of supports or professional boards. This has enormous implications when looking at the issue of impairment and whether psychologists recognize their own difficulties.

Another explanation for therapists' lack of participation in therapy was that therapists have better self-care patterns and more diverse ways of coping when

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compared to layperson samples. Norcross, Prochaska and DiClemente (1986) explored the coping strategies of laypersons in comparison to professional psychologists. The researchers administered the Processes of Change Questionnaire, designed to measure intentional processes of change, to 270 laypersons and 158 psychologists. Eighty-nine percent of the layperson sample identified at least one episode of distress compared to 82% of the psychologist sample. In addition, results indicated that psychologists' coping strategies were both more extensive and more varied. Unfortunately the researchers did not control for the level of education of the two groups since education level was positively associated with the use of a variety of change strategies (Norcross, et al., 1986).

In other coping studies, Norcross and Prochaska (1986) compared three groups of women: psychologists, counsellors and laypersons. The authors found that although the women judged themselves as moderately successful in their coping, the layperson group viewed themselves as coping less successfully than the psychologists and counsellors. The study suggested that a range of accessible strategies rather than a single coping mechanism led to successful coping in each of the groups surveyed. Unfortunately, the study did not control for the homogeneity of the groups and as in Norcross et al. (1986), the educational level of the clinicians differed from the laypersons'. It is interesting for the purposes of this study however that Norcross and Prochaska (1986) suggested therapists may "possess a larger coping repertoire and be more selective and knowledgeable in their coping strategies" (p. 352).

McCarley (1975) and Chernin (1976) also speculated regarding why therapists hesitate to have therapy. The researchers speculated that individuals in healing

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professions hold a double standard for self and others and should learn to accept nurturance in order to act as effective healers. Deutsch (1985) discussed the silent sufferers or therapists who were too ashamed to admit that they needed assistance. The author claimed, "whether individuals have been in therapy or not may tell us less about their mental health than whether they needed therapy but did not seek it" (p. 312). As Millon, Millon and Antoni (1986) wrote, there may be "an unspoken expectation that healers need no healing" (p.131). Guy and Liaboe (1986a) also cautioned the view of therapists as superior in their coping ability because it could hinder the ability to identify a need for help. The authors stated that it was "ironic that so little attention is given to promoting the emotional health and stability of psychotherapists who are devoted to enhancing the emotional well-being of others" (p.22). This is especially true due to the impact of therapy on the therapist in the form of vicarious trauma and burnout.

Vicarious Trauma and Burnout

Another consideration regarding the impact of conducting therapy is that individuals in the helping professions were more prone to 'burnout' (Maslach, 1982) due to the intense interpersonal nature of their work. There have been a number of studies that discuss the effects of conducting therapy on the therapist. Guy and Liaboe (1986b) discussed the impact of conducting therapy on therapists' interpersonal functioning. Although both positive and negative effects were noted, the problematic aspects included emotional distancing from friends and family, depression and anxiety. Ackerley, Burnell, Holder and Kurdek (1988) reported that more than a third of their sample of doctoral psychologists reported high levels of emotional exhaustion

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and depersonalization. Mahoney (1997) found that the most common personal problems reported by his sample of 155 psychotherapy practitioners were emotional exhaustion and fatigue.

Although a different phenomenon, vicarious trauma should also be considered a hazard for therapists dealing with clients who have experienced trauma. Pearlman and MacIan (1995) explored vicarious traumatization with therapists dealing with trauma. They found that those therapists who had traumatic histories showed more negative effects as a result of their work than those therapists without a traumatic background. It was also interesting that even those therapists without a personal history of trauma were negatively affected in the area of other-esteem which was described as the belief that others are valuable. It is clear from this study that therapists dealing with trauma should be especially cognizant of the symptoms of vicarious traumatization and how these symptoms may increase their risk for professional impairment. It also highlights the need for therapist providers to be informed about the therapist client's history of trauma.

Well-Functioning

Other researchers have tried to increase understanding about therapist impairment from another perspective. In an attempt to understand how to avoid impairment, Coster and Schwebel (1997) interviewed psychologists identified by their peers as well functioning. Open-ended interviews were conducted based on the questions about what contributed to their well functioning. When asked to choose the one item deemed most important, 22% of participants chose therapy. Although there seems to be general support of the importance of therapy to address impairment (Guy

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& Liaboe, 1986a; Mahoney, 1997; Norcross, 2000), well functioning is a multifaceted issue requiring a diverse perspective.

Special Considerations of Therapists' Therapy

The Therapist's Therapist

A unique dynamic is created when therapists seek therapy. Therapists are put in a position to determine which qualities they value in a therapist. In an early study on this topic, Grunebaum (1983) sampled 23 therapists regarding the criteria they used to select their therapists. The main criteria described by the researcher were the therapists' level of professionalism, reputation for competence, personal warmth and a caring attitude. Another important factor identified by the sample was the issue of confidentiality. Participants chose therapists whom they would be unlikely to encounter outside of their sessions. A final factor identified was a preference for an active clinician who talked rather than remained silent.

Norcross, Strausser and Faltus (1988a) noted several trends in their sample of psychiatrists, psychologists and clinical social workers. Firstly, there was significant matching between the orientation of clients and of their therapists with the "incidence of treatment systematically related to theoretical orientation" (p.56). For example, psychoanalytic therapists chose psychoanalytic practitioners, and existentialists chose existentialists. Secondly, 82% of male respondents and 67% of female respondents chose male therapists. Also noted was a continual increase in the numbers of women seeking female therapists. Another trend was that younger therapists generally sought non-medical therapists when compared to older therapists who sought out psychiatrists. Finally, although there was an overlap between disciplines, psychiatrists

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most often sought out other psychiatrists for treatment. Despite the differences, the top four selection criteria for therapists were perceived competence, clinical experience, professional reputation, and interpersonal warmth.

Norcross, et al. (1988a) felt it was important that therapist clients had the opportunity to choose therapists that would match their gender, theoretical orientation, or discipline. They cautioned however, that matching could lead to "professional indoctrination and theoretical inbreeding" (p. 64). Norcross et al. (1988a) compared the selection criteria of therapists across orientations and found four differences between orientations: behaviorists were less interested than psychoanalytic psychologists in the therapist's professional reputation, eclectic clinicians rated openness higher than psychoanalytic clinicians, all orientations were wary of therapists who attributed everything to transference, and therapist orientation was rated most important by psychoanalytic and least important by eclectic therapists.

In recent years there have been two empirical studies that have increased our understanding of the therapist's therapist. Initially, the investigators in the Division 29 Project (Norcross, Geller & Kurzawa, 2000, 2001) surveyed the American Psychological Association's (APA) Division of Psychotherapy regarding various aspects of the therapist-as-client dynamic. Following the Division 29 Project was the SPR Collaborative Research Network (Orlinsky & Ronnestad, 2005) which is an international study of therapist development. In the SPR study, the therapist's experience level, measured by the number of years in practice, was the most important predictor of the number of therapist clients in their caseloads. Another important predictor of the therapists' choice of therapist was the number of hours per week in

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private practice. An interesting finding was the belief that therapist providers saw themselves as more skillful and more invested than other clinicians who saw few if any therapists as clients. Clearly, providing therapy for other therapists created a sense of mastery and confidence in their skills as clinicians. Finally, those clinicians that were seen as most specialized in the treatment of other therapists were influenced more by humanistic theories. In terms of differences in the therapy process, therapist providers were more likely to solve problems collaboratively with therapist clients.

Similarly, the investigators in the Division 29 study, therapists' therapists had considerably more clinical experience and were more likely to be employed in university departments or medical schools. In addition, therapists' therapists were most often from a humanistic orientation (35%). The next most popular orientation was eclectic/integrative (14%), then psychodynamic/psychoanalytic (11%), interpersonal therapies (10%) and cognitive therapy (9%). The researchers found that therapy with therapists revealed both similarities and differences to therapy with laypersons. Similarities included the level of self-disclosure, use of humour, boundaries, payment of fees, and encouragement of affective expression. The main difference noted by participants was that they were less detached and enjoyed being with their therapist clients more than their regular clients. Other differences included a heightened awareness of the process of therapy such as treatment interventions and the impact of client issues. Finally therapists paid closer attention to limiting the information in their session notes with their therapist clients.

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Ethical Considerations

There are many interesting issues that arise as a result of the dynamics when therapists seek therapy. Although there were several articles that discussed the ethical considerations of therapists in therapy, few articles explored the topic in depth. Shapiro (1976) discussed the difficulty therapist clients have differentiating from their therapists during the process of analytic training. The author stated that the client "needs to be free to utilize his own capacities, temperament, style, values, pace, and rhythms in ways that may contrast with those of his training analyst" (p. 29). The therapists' therapist has the dual burden of being a positive professional role model for the therapist client, but also for all of his or her future clients that may be impacted by the lessons learned within the therapists' own therapy.

The concern over dual relationships discussed above was viewed as a barrier to therapists' help seeking because of the potential complications around finding a therapist whom they did not know from another context. In her survey of therapists' personal problems and treatment, Deutsch (1985) found that therapists actually avoided seeking treatment because of the potential for dual relationships. This factor could potentially exacerbate therapists' personal problems thereby negatively impacting client care.

Fleischer & Wissler (1985) and Brown (2005) discussed the pressures to maintain professional boundaries when therapists treat other therapists. There may be unusual boundary difficulties if the therapist and client overlap in professional circles. Another challenge for the therapists' therapist is that they may have to overcome defenses created as a result of the client's knowledge of the therapeutic process. If the

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client is dealing with issues arising from conducting therapy, the therapist may struggle with over identification with the client's issues. It also may be challenging to avoid triangulation with the client by judging other colleagues. Finally, the authors discussed how treating therapists might lead to a sense of omnipotence regarding one's own functioning, which could result in harm to the client.

Bridges (1993) explored the implications for clinical practice of therapists who treat therapists and claimed this dynamic "taxes the treating therapist's self-and-other boundaries" (p. 34). The therapy provider may develop troublesome doubts or questions of professional worth thus increasing the potential for role confusion. As a result, these therapists must be aware of what was described as potential transference and countertransference issues that manifest in feelings of competitiveness and envy in the therapeutic relationship. Other issues presented were learning to appreciate the power differential, being sensitive to the issue of confidentiality, recognizing one's own clinical limitations and avoiding the temptation to become co-therapist with therapist clients. Bridges recommended consultation to help "examine personal vulnerabilities and clinical blind-spots to heighten their awareness of idiosyncratic issues that may be magnified or exploited by the feelings involved in treating therapist-patients" (p.43). Further suggestions included consultation with colleagues and senior mentors in order to help the therapist provider to deal with the numerous ethical implications involved in the therapeutic dynamic.

Summary and Rationale for the Present Study

In summary, it is apparent that although there have been a variety of approaches used when exploring the experiences of therapists as clients, there is a gap

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in the knowledge that has been discussed by the researchers. Quantitative methods have been used to survey therapists regarding their experiences of therapy. Despite some negative experiences, overall therapists felt that therapy was a valuable process in one's personal and professional development. Qualitative studies explored the interface between personal therapy and therapeutic practice, however only one study using a narrative method, focused exclusively on the experiences of therapists as clients. Other issues included the debate regarding therapy as part of training and the special ethical considerations involved when therapists treat therapists.

A common theme in previous reviews of the literature was a need for further research in the area of therapists as clients. To summarize what is known from the literature, a majority of therapists have participated in therapy. In the survey research reviewed, (Garfield & Kurtz, 1974; Garfield & Kurtz, 1976; Prochaska & Norcross, 1983; Guy, et al., 1988 and Pope & Tabachnick, 1994) a larger number of therapists had therapy when compared to layperson clients. Other studies focused on the high number of therapists who identified negative impacts from their therapy. Buckley et al. (1981) and Williams, et al. (1999) found 21% and 27% respectively of the therapists sampled indicated some aspect of their therapy was harmful. The more subtle aspects of what therapist clients found unhelpful however, were lost due to the limitations inherent in survey research. It is precisely these subtleties that will be explored with a basic interpretive approach towards the question "What is the experience of therapist as client"? Both the positive and negative lessons learned through therapy will be explored allowing participants to expand our understanding of these important elements.

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Experimental studies found some support that therapists' therapy is beneficial for future clients. Peebles (1980) found that personal therapy hours improved the therapists' ability to display empathy and genuineness. Other studies illustrated that individual analysis improved empathy ratings (Strupp, 1973) and allowed for more appropriate responses towards clients by experienced therapists (Strupp, 1955). Contradictions were found regarding the hazards of therapy for clients of student therapists. Four studies (Katz, et al., 1958; Garfield & Bergin, 1971; Strupp, 1973; Dubovsky & Scully, 1990) suggested caution when student therapists participate in therapy. The researchers posited that individual therapy might pose a distraction from client problems when the therapist has less clinical experience. Whatever the reason therapists identify for entering therapy, "there is a clear distinction between dealing with personal issues and using it for a medium to learn" (Williams et al., 1999). As this distinction appears significant, my study focused on therapists that have had therapy for personal reasons rather than for training purposes. In other qualitative studies, this difference was not clarified and yet it is clearly an important element to consider.

Despite efforts to explore the impact of therapists' therapy on present functioning and future clients, Herron (1988) indicated that experimentally designed studies are limited because of the complexity in isolating all pertinent variables involved in the therapeutic process. In critiquing previous survey research, Macran et al. (1999) claimed "it is not clear what additional questions could be added to a structured survey in order to elicit a deeper understanding" (p. 420). Clearly both survey and experimental methods have only been able to explore specific aspects of

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therapists' experiences of therapy. Through the use of qualitative methods however psychologist practitioners are able to gain deeper knowledge that is directly applicable to their own work (McLeod, 1999). By discovering what is both effective and ineffective for therapists during the therapeutic process, suggestions can be made to reduce possible negative impacts of conducting therapy. Initially the therapist client will benefit through enhanced understanding of successful therapy. Future clients will also benefit due their therapists' enhanced understanding and appreciation of the therapeutic process.

Another gap in the literature was the limitation of qualitative studies on impairment and help-seeking in psychologists. Quantitative studies are numerous and have included primarily surveys of therapists. Thoreson et al. (1989) found that 9% of their sample dealt with alcohol problems ineffectively. Guy et al. (1989) found that 36.7% of their sample indicated that their own personal problems decreased their quality of care. Farber (2000) found concerns around confidentiality and professional credibility, as well as the need for self-sufficiency played a role in help-seeking behaviors in student clinicians. Deutsch (1985) found that the potential for dual relationships kept many therapists from participating in personal therapy. Several authors (Chernin, 1976; Deutsch, 1985; McCarley, 1975 and Millon et al., 1986) discussed the perceived double standard that exists for 'healers'. By exploring qualitatively the process of seeking help for therapists, suggestions could be made to address the barriers.

Qualitative studies provided considerable understanding of therapists' experiences as clients and the impact of their practice of therapy. Only one study by

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Wiseman and Shefler (2001) explored the experience of therapy separate from its interrelationship with the therapist's practice, however the researchers used a narrative method to explore this question. As part of the justification for their study of how personal therapy influenced a therapists' practice, Macran et al. (1999) claimed previous research had focused too narrowly. While the interrelationship between therapy and practice is a key aspect of the experience of therapist as clients, focusing more broadly will benefit our understanding of the overall process of therapy for therapists.

One other contribution of the present study stemmed from the assumptions put forth by Buckley et al. (1981) that participants who are highly educated about a process will be able to articulate important aspects of the phenomenon. Psychologists also hold valuable knowledge about the nuances of the therapeutic process. With this prior knowledge, I believe my interviews with psychologists will provide a more in-depth understanding of the experience of therapy for therapists.

A final gap in the literature was the limited number of qualitative studies exploring impairment and help-seeking behaviors in psychologists. Quantitative studies are numerous and have included primarily survey research. Thoreson et al. (1989) found that 9% of their sample dealt with alcohol problems ineffectively. Guy, et al. (1989) found that 36.7% of their sample indicated that their own personal problems decreased their quality of care. Farber (2000) found concerns around confidentiality and professional credibility, as well as the need for self-sufficiency played a role in help-seeking behaviors of student clinicians. Deutsch (1985) found that the potential for dual relationships kept many therapists from participating in

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personal therapy. Several authors (Chernin, 1976; Deutsch, 1985; McCarley, 1975; Millon, et al., 1986) discussed the perceived double standard that exists for healers.

Due to the nature of survey research, the depth of our understanding regarding help-seeking is limited to the questions posed by researchers. In order to explore the issues facing therapists prior to entering therapy, it is important for qualitative methods to allow therapists to discuss these issues freely. McLeod (1999) highlighted two of the advantages of qualitative research for practitioners. These were improving professional standards and can foster a richer understanding of ethical standards. By highlighting some of the ethical concerns raised by participants this study will also contribute to the improvement of professional standards and raise important ethical issues evident in therapists' therapy.

In summary, my study will help to fill several gaps that exist in understanding the complex issues that arise when therapists seek therapy. First, it will address some of the limitations inherent in quantitative literature in the areas discussed earlier. Focusing more broadly on the question of "What is the experience of therapist as client" rather than on the interrelationship with the therapists' practice will deepen previously achieved understandings. This research also adds to the limited amount of studies of both Canadian and American psychologists. Finally, this study also explored the important issue of help-seeking behaviors in psychologists, which will increase our understanding of ways to address impairment and the barriers facing therapists when accessing services. The understandings gleaned through the present study will contribute to the discipline of psychology by raising critical ethical issues and by offering potential solutions to the problems that currently exist.

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CHAPTER THREE

METHOD

In order to avoid confusion about the how and why of doing research, Crotty (1998) offered clarification of the terms method and methodology. Crotty described methodology as "the strategy, plan of action, process or design lying behind the choice and use of particular methods" (p. 3). In terms of the method chosen or the "techniques and procedures used to gather and analyze date" (Crotty, 1998, p. 3), a basic interpretative qualitative approach was selected because of its focus on "understanding how participants make meaning of a situation or phenomenon" (Merriam, 2002a, p. 6), which was consistent with the intent of the study. Merriam (2002a) posited that "the place to 'look' for a research problem is in your everyday experience-ask questions about it, be curious as to why things are as they are or how they might be better" (p. 11). The purpose of my study was to answer a question that arose through conversations with colleagues regarding "What is the experience of therapist as client?"

Previous studies have used qualitative methods however these studies focused on the therapists' experiences of the interrelationship between their own therapy and their practice of therapy. My study was designed to understand the meaning therapists give to their experiences as clients. Although in recalling their experiences therapists often made the link between what they learned in therapy and how they practiced therapy, this was not an implicit assumption in this research question.

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Presuppositions

In qualitative research, the concept of 'objectivity' is acknowledged as impossible to achieve. The researcher plays a primary role in both data collection and analysis. As a result, it is paramount that the researcher discusses any presuppositions or biases that might influence the research process and results. Peshkin (2000) claims that, "the important reason for reflecting on the development of an interpretation is to show the way a researcher's self, or identity in a situation, intertwines with his or her understanding of the object of the investigation" (p. 5). It is hoped that this transparency will allow readers to locate the researcher within the study and identify any inherent biases.

As is common in qualitative research, my desire to explore this question arose out of a conversation with colleagues. This conversation contained two main assumptions that I felt were problematic. First, that one could not truly understand the therapeutic process without having experienced it as a client. Second, that no therapist should conduct therapy without first experiencing the client role. As someone who has not yet experienced therapy as a client, I was curious about these assertions. I acknowledged the value of therapy but questioned the assumption that therapists need to undergo the process in order to be able to provide therapy.

As a graduate with a Bachelor of Arts in Anthropology, I am aware that there are many ways to experience healing. I am also cognizant that the majority of people in the world who overcome personal problems do so without the use of therapy as was defined earlier. Although therapy can benefit individuals who desire change, I do not believe therapy should be a prerequisite to providing therapy. By requiring therapists

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to have therapy, the dynamics of help seeking are altered. When layperson clients enter therapy, it is generally assumed that they have come of their own volition with the goal of achieving change or insight. I believe that when therapists are required to have therapy both their motivation for change and their overall results are negatively impacted.

Another belief I hold is that therapists' prior knowledge about the therapeutic process and human behavior will enhance their ability to articulate the subtle aspects of therapy. Although there is an abundance of research on the client's experience of therapy, I am particularly interested in how the therapists' prior exposure to the process will influence how they experience therapy. I am hopeful that their prior knowledge of the processes of therapy will allow for a deeper understanding to be elicited through interpretation of their experiences.

As a student therapist, I have witnessed the subtle and overt changes that occur with clients through the process of therapy. Despite these changes, I am also aware that therapy is not successful for everyone who seeks help. Therefore a final presupposition is that while therapy may be a beneficial process, there is no guarantee it will produce positive results. Success as defined by the client is dependent on a number of factors, including the client's readiness for change, therapeutic effectiveness, and the relationship between therapist and client.

It is hoped that discussing my presuppositions will allow readers to view the results of this research with my biases in mind. By acknowledging these biases I have engaged in researcher reflexivity, a process which enhances the trustworthiness of the

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data (Merriam, 2002b). I also engaged in reflection throughout the research process and utilized a journal in order to capture ongoing and emerging thoughts.

Participants

In order to enhance understanding of the experience of therapist as client, I chose participants based on their ability to "express thoughts, feelings, opinions that offer a perspective on the topic being studied" (Merriam, 1998, p. 85). Patton (1990) described this process as choosing information-rich cases "from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling" (p. 169).

In addition to willingness and the ability to articulate their experiences, there were several other parameters for participation in the research. Since I wanted to focus on psychologists' experiences of therapy, participants were either Masters' or Doctoral Level Registered (Chartered) or Licensed Psychologists. The difference between the two terms was the result of regional differences in the titles given psychologists in Alberta and California, two area where I have lived. Although several prior studies used samples of social workers and psychiatrists, my own interest was specifically in psychology, the profession in which I belong.

A second parameter for inclusion was that the experience of therapy to be discussed by participants must have occurred after becoming a provider of therapy. Therefore both experiences as student therapists and as professionals were included. I assumed that as individuals immerse themselves into the theory and practice of therapy their learning will change their experiences of therapy. Although a layperson

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would be able to articulate the experience of therapy, it was the therapists' experience of therapy that was pertinent to this discussion.

Another important parameter was that participants entered therapy for personal reasons rather than for training purposes. As discussed in my presuppositions, I believe that when therapy is required as a part of training, different dynamics occur. I am particularly interested in the dynamics that exist when therapists choose therapy of their own volition. A final important parameter of the therapeutic dynamic was that participants' therapy was individual rather than couple's or family therapy. I wanted to avoid the issue of confidentiality involved in asking participants to discuss therapy shared with other clients. I chose to focus on the unique dynamics created in individual therapy between the therapist client and therapist provider.

Parameters for participation were established and permission to proceed was granted by the Research Ethics Board of the Faculties of Education and Extension at the University of Alberta. A snowball or chain sampling technique (Patton, 1990) was used which involved asking a number of colleagues, professors and supervisors with whom to speak regarding my research question. Many of these individuals forwarded the names of interested parties or indicated their own desire to participate in the research. Merriam (1998) states that the number of participants in qualitative research depends upon "the questions being asked, the data being gathered, the analysis in progress and the resources you have to support the study" (p. 64). In this study, seven participants were interviewed in order to achieve an evocative understanding of the therapist's experience as a client. Using seven participants also allowed for a manageable amount of data as well as a variety of experiences from which to draw.

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Participants included six females and one male ranging in age from twenty-nine to fifty-five. I was acquainted with five of seven participants through school, work or conferences prior to the research. Reflecting back on the interviews with participants, familiarity both helped and hindered the process. For participants I knew personally, I felt our prior relationship allowed for the sharing of more personal information during the interviews. For the participants I knew professionally, our prior relationship may have inhibited the depth of the interview due to a possible need to avoid disclosing uncomfortable information about their therapy. I will reflect further on this issue in my discussion of ethical issues at the end of this chapter.

Participants worked in a variety of settings including private practice, non-profit agencies and university settings. Because of the small community of psychologists in the two cities, further clarification of demographic information was avoided in order to maintain anonymity for participants. No effort was made to interview therapists from different theoretical orientations. My decision to avoid identifying participants' theoretical information was due to the current trend towards eclectic practice and the general lack of adherence to one theoretical orientation.

Interview Procedure

When individuals initially indicated an interest in participating in the research, I discussed the nature of the study, the time required for their participation and their ability to withdraw from the study at any point. I reiterated the parameters for participation in order to clarify that the individuals qualified for the study prior to our meeting. I arranged with participants a mutually agreed upon time and location for our first interview. I suggested to participants that the location be comfortable for

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interviewing and private in order to maintain confidentiality and to minimize distractions. Five interviews were conducted in office settings, while two took place in home environments.

Prior to starting the interview, I gave participants a letter of introduction (see Appendix A) which explained the requirements for participation in detail. I requested participants also read the Consent to Participate Form (see Appendix B) which outlined ethical issues such as confidentiality and anonymity. Prior to starting the interview, further clarification questions were answered then I engaged participants in conversation for several minutes in order to establish rapport (Merriam, 1998 and Osborne, 1990). As a student therapist this was a comfortable process of engagement and helped to increase both my own and the participant's level of comfort. It also encouraged genuineness in the relationship and a basic level of trust which enhanced the interview process.

After permission was granted to begin taping, the recording device was turned on. The interviews lasted between 45 minutes and an hour and a half. Interviews were conducted in a semi-structured format and an interview guide (see Appendix C) was used in order to touch on aspects of the experiences of therapy that were not spontaneously raised by participants. The interview guide included general questions that I was curious about in the therapists' experiences of therapy and was also informed by the gaps identified in prior research. The advantages of an interview guide according to Patton (1990) are that it allows the researcher to make the best use of the time available and keeps the interview focused allowing the experience of participants to emerge. Similar to the process of therapy, I paid attention to subtle

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nuances of speech and non-verbal cues in order to enhance my understanding during analysis of the data. Interviews were audio taped and transcribed verbatim into text at a later stage of the process. All identifying information about the participants and other professionals were removed at this stage and pseudonyms were added to assure anonymity.

Data Analysis

Although my data analysis was initially influenced by Colazzi's (1978) well articulated method, following the first interview my analysis became less structured. Hein and Austin (2001) offered a more general approach to analysis which described three steps of analysis including immersion in the data, identification and thematization of relevant statements, and creating an exhaustive description of participants' experiences. In this study, data analysis was simultaneous with data collection (Merriam, 2002a) and was an ongoing process that started with the initial interaction with participants. Because interviews took place prior to, during and after my internship, they were spread over a period of a year and a half. This meant that a significant amount of time elapsed between interviews. Insights gained from analysis of the first interview led to further insights and clarification questions for the next interview. The accumulation of information permitted me to explore evolving themes and look for both commonalities and differences with the remaining participants.

Prior to transcribing the interviews, I listened to the recordings of the interviews in order to get an overall understanding of the information elicited. During transcription, attention was paid to the subtleties of speech including tone of voice, rates of speech and emotional content. I was careful to make note of these nuances in

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order to allow for deeper understandings to arise. Following transcription of the interviews, the next phase of analysis involved listening to the interviews several times while reading the transcriptions of the participant experiences for accuracy. Additional notes were added to the transcripts if necessary for elucidation.

Most of the ongoing contact with participants occurred over the internet. Therefore participants were sent transcriptions of their interviews and I asked for clarification or expansion of their experiences if necessary. With one participant in particular I have maintained an ongoing professional relationship which allowed for further reflections as the process evolved. This process demonstrated the benefits of qualitative methods in encouraging ongoing contact with research participants, which allowed for verification of the researcher's emerging understanding.

The next step involved extracting statements that illuminated aspects of the therapists' experiences of the phenomenon. I paraphrased these statements which required that I make inferences based on my understanding of the meaning behind the statements. Although this required insight on my part and a leap from the original data, I was careful to be true to the participants' words. I read over the paraphrased statements and grouped them into broad themes.

This same thematic analysis was completed for all participants. I then compared the themes that arose for the participants and looked for consistencies and inconsistencies among participants. A synthesis of each participant's experience was written and shared with the participants in order to allow for clarification and verification of their experiences. This process is called consensual validation (Hinck, 2004) and helps to establish trustworthiness of the data. There were four main themes

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identified in the data. These themes were discussed in a written synthesis of results, which identified each theme and used quotations from the participants to provide rich detail to support the themes.

Trustworthiness

One assumption in qualitative research is that all knowledge is perpectival (Osborne, 1990) therefore all knowledge is grounded in human experience (Polkinghorne, 1983). Although the question of "What is the experience of therapists as clients?" has not been addressed with a basic interpretive method in the literature, there have been similar studies connecting therapy with clinical practice with which to compare the resulting themes. Past research therefore will provide alternative perspectives of the phenomenon which will be added to the participants' voices in my study.

Merriam (2002b) discussed strategies for ensuring that a study was completed in a manner that was systematic and trustworthy, including member checks, peer review, reflexivity, adequate engagement in data collection, an audit trail and providing rich, thick descriptions. Member checks were achieved in my study by taking the material gleaned from the research interviews back to the participants in order to discover if they were plausible. Osborne (1990) described this process as checking for a 'goodness of fit'. Others have described the process as consensual validation (Hinck, 2004). On several occasions during the research, I either spoke directly to participants or through e-mail to allow for clarification of the information collected during the interviews. Participants read the verbatim transcriptions of their interviews and were later able to read over my interpretations of their experiences.

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Feedback was welcomed throughout the process and any clarification of information was added to my interpretation. Only on two occasions were clarification necessary and this involved sequential clarification of participants' experiences of therapy.

Peer review involved including others in the process of interpreting the findings. As Merriam (2002b) acknowledged, all graduate students are required to include feedback from their committees. I was assisted in my interpretation of the data by my supervisor on an ongoing basis. I was also offered feedback in my writing and analysis by other committee members.

The process of researcher reflexivity included bracketing my presuppositions about the research question and continuously exploring my own process as the study evolved. The process of engagement with the data is considered iterative not linear. Meadows & Morse (2001) claimed that "good studies use design and implementation processes that move back and forth between recruitment, sampling, data collection, analysis, and back again, and constantly validate nature and progress of the process and results" (p. 189). This process allowed for reflection, integration and insights to emerge.

An audit trail included a detailed description of the method used to collect and analyze data. This documentation allowed others to be aware of the processes and to be able to link the processes with the data collected. I also used a research journal to document ongoing insights and themes as they arose. Finally, providing rich descriptions relied on my ability to illuminate key aspects of therapists' experiences as clients. The results will hopefully resonate with others who have also experienced therapy thus demonstrating the trustworthiness of the process.

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Ethical Considerations

This study was reviewed and approved by the Research Ethics Board of the Faculties of Education and Extension at the University of Alberta. Safeguards to protect the rights of participants were considered prior to the start of research. Participants were given a study description (Appendix A) and asked questions of clarification prior to their involvement in the research. They were then asked to read and sign the Consent to Participate Form (see Appendix B) which explained the potential risks for their participation in the study. Every effort was made to assure anonymity to participants throughout the research process. Also due to limited number of therapists in the two locations, every effort was made to limit identifying information. Aliases were given to each participant to protect their identity and tapes from the interviews were stored in a secure place.

Due to the potential emotional impact of recalling their experiences of therapy, I was careful to clarify with participants their ability to withdraw from the study at any point. I also requested that participants only share information they felt comfortable sharing. I explained the process of data analysis and clarified their ongoing involvement in verifying my interpretations of their experiences. Merriam (1998) suggested, "most people who agree to be interviewed enjoy sharing their knowledge, opinions, or experiences. Some gain valuable self-knowledge; for others the interview may be therapeutic-which brings up the issue of researcher's stance" (p. 214).

Prior to the interviews I had cautioned participants about the potential emotional impact of their recollections of therapy. I was also aware however that my role as a researcher was not to be a therapist but to gather interview data on the

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research question. My priority therefore was to be respectful of the participants and to trust that they knew themselves well enough to share only what they felt comfortable sharing. As Merriam (1998) claimed, "the best a researcher can do is to be conscious of the ethical issues that pervade the research process and to examine his or her own philosophical orientation vis-à-vis these issues" (p. 219).

The subject of dual relationships was an interesting issue that arose both during the interviews and in the participants' recollections of therapy. Because of the small community of psychologists in the two cities, I knew that I would likely have a prior relationship with some of the participants that volunteered. Only two of the participants had no prior relationship with me while the other five were familiar to me through work, conferences or graduate school. This was an issue that should have been discussed with participants in more depth prior to the interview. In hindsight, prior relationships likely impacted the information participants were willing to share. For two participants, I felt their indirect supervisory role within the same agency I was working in may have inhibited the depth of our interviews due to their need to maintain a professional distance in their roles. For three other participants however, I felt that because of our prior relationship they were willing to share more with me than with someone who was unfamiliar to them. Also, for those participants familiar to me it allowed for more direct feedback regarding ongoing data analysis following the initial interview.

Summary

In summary, the question of "What is the experience of therapist as clients" was explored through a basic interpretive approach. Interviews were conducted with

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seven psychologists, three from Northern California and four from Alberta. The interviews were transcribed verbatim and served as the data for further analysis. A written synthesis was created based on the participants' shared experiences. These interpretations follow in Chapter Four. Chapter Five includes the themes derived from analysis of the participant interviews. These themes are supported through discussion and through the use of quotations drawn from the interviews. The final chapter offers an integration of the findings from my study with the research presented in the literature review.

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CHAPTER FOUR

THE PARTICIPANTS' EXPERIENCES

The following are my descriptions of the participants' experiences of therapy and are based on the verbatim transcriptions of the interviews. Participants were given the opportunity to review my description of their experiences and asked to provide feedback or clarification as necessary. Feedback was added to the written syntheses of participant experiences and involved two clarifications with respect to the sequence of therapy for two participants.

Lori's Experience

The precursor to Lori's initial experience of therapy occurred following a self-disclosure in her group therapy course, which was a part of her graduate program. As part of the group process, students were encouraged to share personal stories in order to allow for honest self-reflection. Despite having never shared aspects of her history, Lori chose to disclose to her classmates in the hopes that she could grow from the experience. Unfortunately, as she was telling her story, her professor exited the room. This left Lori feeling abandoned and unsafe due to its triggering of past insecurities and self-doubt. Lori was dismayed at her experience and disappointed that the dynamics with her classmates left her feeling alone in the process. The fact that Lori had finally chosen to share painful aspects of her childhood and was not supported through her experience created a barrier for her to overcome in future therapy.

Following the incident, Lori's professor suggested she would benefit from exploring some of her presenting issues in individual therapy and then offered to be the therapist. At the time, Lori felt she could use some support but said that she was

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unaware of the problems that could result from the overlapping relationship with her professor. Therefore she entered into a therapeutic relationship feeling uninformed. As a result of her transition into graduate school, Lori was experiencing significant stress due the combined pressures of home and academic life. In addition, Lori was experiencing depressive symptoms and was struggling to deal with family of origin issues. She described herself as feeling transparent or "paper thin", in her own words she felt "like someone could reach right through her". Lori felt that her professor's offer of help was a "life preserver in a storm" and she did not want to turn away the only person she felt could help.

Upon reflection, Lori recognized that the relationship became more complex as time passed. The overlapping roles and a lack of clarity in these roles created a difficult dynamic between Lori and her therapist. She was student, supervisee, client, friend, and at one point even briefly providing therapy to, her supervisor. Because her supervisor was in a position of power and had many years of experience, Lori trusted that their overlapping roles should not be of concern. She felt overwhelmed and viewed her therapist as her last resort. As a result she was careful not do anything to jeopardize this relationship which left Lori feeling complicit with what she described as her own "victimization". As she reflected however, Lori came to an understanding that it would have been difficult for her to control what happened and to be truly informed about the potential for negative ramifications in this dynamic.

The most problematic session in this therapy experience involved a physical release process which triggered past traumatic issues for Lori. Her therapist felt that she was holding back from sharing in therapy. She felt that a physical release, which

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was a popular technique at the time, would help Lori resolve her past trauma. The powerlessness Lori felt throughout her childhood was re-created when her therapist began the physical restraint in session. At the time, Lori recalled feeling unable to say or do anything to stop what was happening. The sense of powerlessness and betrayal she felt was further complicated by their overlapping roles.

It was clear that at a cognitive level, Lori felt like she had worked through her distress. During the interview however, the personal betrayal and unresolved emotions came to the surface as she recalled her experience. The most predominant emotion was anger. Lori's awareness shifted when she recognized that she was not responsible for what had occurred in her therapy. Because she was an adult at the time, she felt she had more control over the situation and could have avoided what happened. Lori's understanding of this experience seemed to shift as the interview progressed which allowed her to realize she was not to blame for what happened.

After her initial experience, Lori was referred to a second therapist in order to deal with the ongoing stress of providing therapy. She was working with families with multiple issues and was struggling to understand her own boundaries within the chaotic lives of her clients. Lori needed an objective view in order to understand and clarify her own and client issues. She also recognized that the therapy she had received had been damaging and that she needed to be able to work through lingering emotions. As in her first experience, Lori had a prior relationship with her therapist. He was able to overcome this dual relationship however by clarifying boundaries. This was an essential step in creating safety and trust in the therapeutic relationship. The therapist was honest about potential ethical issues and expressed that these issues should be

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dealt with in advance. As a result of her therapist's clarification of roles and responsibilities, Lori gained awareness about her own childhood issues. This allowed Lori to clarify the issue of responsibility from her childhood, and she was able to recognize that she was not to blame for her victimization.

Lori's second therapy experience was described as "profoundly healing" and the opposite of her first experience. With the support of the second therapist she was able to process why her first experience had been so damaging. Lori made the link between what had happened in her session with her childhood history of trauma. Not only was she able to process her first therapy experience but she was finally able to tell her story without feeling abandoned. She identified the therapist's lack of fear in facing her past as fundamental to moving through the pain from childhood and in finding a healthy resolution. The therapist's lack of fear and his connection with Lori allowed her to contain past trauma and the retriggering she experienced in her initial therapy.

One particular experience that she elaborated on in the interview was a session that focused on residual issues left by a client. Lori described a session with a client that dealt with an extensive trauma history. She was facilitating abreactive work with the client and during this process she felt an exchange of energy with the client. In a session with her therapist, Lori recognized that the negative energy she was carrying belonged to her client and was not her own physical manifestation of an illness. The therapist helped to facilitate a cleansing of the energy which she described as a "profoundly healing experience". During their session she opened her eyes and saw that the therapist had maintained his connection and had a single tear falling down his

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cheek. The therapist's ability to remain connected and to support her in re-telling her story was significant for Lori due to her prior experiences of abandonment.

Lori stressed the importance of feeling safe with her therapist, which led to a profound connection at a "deep soul level". Lori described their session as a profoundly spiritual experience where her therapist "absorbed the pain of the universe". She recognized that the therapist's acknowledgement of her difficulty in coming forward for help and in being honest during the therapy process was particularly important. Lori also expressed that the clarity in roles and the containment that was created as a result, allowed her to feel safe in exploring difficult issues. She was able to repair the wounds created in childhood and deepened in her first experience of therapy.

Lori described her experiences as creating a profound new respect for client vulnerability and their willingness to seek help. The experience allowed for a better understanding of the relationship she hoped to create with her clients and the type of therapist she wanted to be. The second therapist allowed her to process the guilt she felt from childhood. He also enabled her to weave her own story through his acknowledgment that despite all that she had faced, she was doing well. She stated that the experience allowed her to come to terms with the part of herself that felt responsible for what had occurred in childhood. The clarification of responsibility led to a rediscovery of her power. Lori felt she could confidently navigate the issue of responsibility and no longer feel like she was to blame for her traumatic past and for her initial experience of therapy.

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Lori felt that therapy provided both positive and negative experiences of how to nurture personal power. She used her positive therapy experiences as a model for how to supervise students. Her therapist's acknowledgement of her abilities allowed her confidence to grow as a young practitioner and allowed her to claim her personal power. She therefore used her experience to encourage students to recognize and not be afraid of their power. Lori tries to create an atmosphere where the student can flourish and be confident of their skills and abilities. She felt this was the gift that her second experience of therapy provided. She was able to experience both positive and negative examples of therapy and was sensitized to the issues of safety, trust and client vulnerability. Although Lori valued the experiences of therapy she felt that if not done well, therapy had the potential to be damaging to clients.

Jen's Experience

Jen initially experienced therapy during graduate school. As part of the requirements for her degree, Jen approached one of her past professors to provide supervision for her during her chartering hours. At the time, she was juggling the roles of wife, mother, graduate student and student therapist. She was also dealing with the legacy of a traumatic past, which proved to complicate the issue of boundaries. A past professor of Jen's had agreed to be her supervisor. Upon recommendation of her supervisor, but of her own accord, Jen entered therapy with him.

She felt this initial therapy experience was valuable in teaching her what never to do as a therapist. The most problematic issue for Jen was what she described as her therapist's violation of boundaries. She believed there were profound ethical violations and had contemplated consulting with professional organizations regarding the harm

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she felt she endured. She described her last session as damaging due to the therapist's pressure to disclose aspects of her past that she felt unsafe discussing. During his relentless barrage of questions, Jen felt as if she was being attacked and went into a frozen state. She was so upset following the session that she left his office and never returned. When her therapist did not follow up her sudden departure with a phone call, Jen felt abandoned and discarded. She expressed dismay that he had not been more accountable to her regarding the process and therefore she was unable to have closure.

Jen learned the harm of dual relationships when roles are not clarified at the beginning of therapy. She became aware of boundary violations within her therapy and felt she had been naïve regarding the appropriateness of therapy with her supervisor. During therapy there were no agreed upon boundaries regarding where information would or would not be shared. This lack of clarification led to humiliation when her supervisor disclosed personal information to her classmates during group supervision. She felt that he had misused the knowledge gained in individual therapy in group supervision, which left her feeling attacked and violated. Jen also felt the therapist had been confrontational, insensitive, and pressured her to disclose information that she did not feel safe discussing. This initial experience of therapy created shame and anger, which eventually led to the termination of their relationship.

Another harmful experience during therapy occurred when the therapist gave Jen a diagnosis of Borderline Personality Disorder. The diagnosis led to a tremendous amount of shame for Jen. She ended up keeping the information private for a long time before she was able to process it with others who knew her well and had had experiences with her therapist. Due to her experience of receiving a diagnosis, Jen

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used caution with her clients around this issue. Jen felt her own experience helped to sensitize her to the harm that can be done with a careless label.

Jen occasionally ran into her therapist at conferences but rather than confronting him, sought resolution with support from others in the therapeutic community. She identified feeling responsible for the dual relationship that existed with her therapist because of their initial roles as student and professor. She had some negative feelings towards him after her initial experience and recognized the inherent power imbalance in their relationship. Jen learned through this negative experience that for her it was too difficult to have overlapping roles as therapist and supervisor. Therefore she avoided this situation in her professional life. She is also clear with clients about the possibility of outside contact and how she intends on handling the situation in order to respect the client's confidentiality.

Jen's next therapy experience was substantially different from her first. In this experience, the friend who provided the referral cautioned Jen on the therapist's slow pace in sessions. Although initially frustrated with the slower pace of therapy, Jen realized this pace helped to create for her a sense of safety. The slower pace also facilitated her processing of the initial therapy experience and family of origin issues. She credited her therapist with being aware that her desire for a fast pace was a negative coping mechanism developed to avoid uncomfortable emotions. As a therapist, she learned that it was important to slow down the process of therapy in order to allow clients to experience emotions safely. This translated to her pacing sessions according to the needs and comfort level of her clients. She realized that a

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pace appropriate to her clients' needs helped to create a calming and soothing environment and allowed them to contain of their emotions.

Unfortunately the issue of dual relationships also arose in her second therapy experience when Jen discovered her supervisor was her therapist's friend. Jen had discussed difficulties with her supervisor in sessions and felt she should have known about the relationship prior to engaging in therapy. Jen felt she had been denied an opportunity to make an informed choice regarding continuing therapy. Based on her negative experience, she realized the importance of clarity with clients from the outset of therapy. She also recognized that clarity played a significant role in empowering the client during therapy and in creating safety and trust.

Jen used the opportunity to learn from what she viewed as the negative examples from her second therapist. She felt as if she led the agenda of many sessions, which resulted in sessions feeling random and unstructured. She felt it was important to help clients articulate their goals and keep them on track in achieving these goals. Jen claimed it was important to check with clients throughout therapy in order to verify whether the initial goals were still pertinent or whether new goals had arisen.

Prior to her initial experience of therapy, Jen felt she had deluded herself into thinking that therapy was not necessary for all therapists. Despite her early cynicism, she quickly learned about the importance of individual therapy to help deal with her past and to be an effective therapist for future clients. She viewed therapy as essential for anyone hoping to become a therapist in order to help differentiate client and therapist issues. The knowledge gained in her therapy helped Jen to clarify personal boundaries with clients. She also utilized her learning in supervision of students. Jen

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felt many of the students she supervised lacked self-awareness because they had not had therapy. She therefore encouraged students to have therapy in order to develop the awareness of their own issues, which in turn would benefit their clients.

As a result of her experiences Jen believed that therapy for therapists was essential to professional development. She recognized that it was difficult to understand personal boundaries without being able to explore these in therapy. Jen thought that many young therapists she supervised were naïve to underestimate the impact of conducting therapy. She doubted that any young therapist could successfully navigate all of the pertinent issues without assistance from a therapist.

Carol's Experience

Near the end of her first year of graduate school, Carol started therapy voluntarily as a result of a break up with her boyfriend. She described herself as depressed with symptoms of disrupted sleeping and eating patterns. When a friend recommended a therapist in the area, Carol called the therapist to inquire about services. While reflecting about the impetus behind therapy, Carol realized that it was not simply the breakup with her boyfriend that was causing her distress. She also recognized that she was dealing with acculturation issues, and problems with self-esteem. Because of the nature of her presenting issues, Carol felt she would be more comfortable with a female therapist.

When thinking about the therapy process, Carol had ambivalent feelings regarding her therapist. On one hand she liked the therapist and felt they had a strong connection. This connection was due in part to her therapist's person-centered approach. On the other hand, Carol felt that the therapist was not challenging enough

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and that her therapy had been limited by this lack of confrontation. Carol reflected that she would have benefited from someone who was more "in her face", however when she felt confronted in session she interpreted it as her therapist's issues arising. When she did not feel confronted enough, Carol was critical of the therapist's laissez-faire approach.

Carol felt that a limitation of her therapist's self-knowledge had negatively impacted her experience of therapy. An example of her therapist's issues interfering occurred when Carol raised her concerns about getting older and shared the negative emotions that were brought up when thinking about aging. Her therapist responded defensively questioning Carol about why she felt the way she did and added her own belief that older people not be discarded. Carol surmised that the therapist's defensiveness was likely a reaction to her own insecurities around getting older. She felt that if she had been a layperson she might not have recognized that her therapist was triggered by her comments.

Following this session, Carol failed to return to therapy, feeling that her therapist had been confrontational in the session. She felt that the disadvantage of being a therapist-in-training was that it was difficult for her to face her therapist after the confrontation. She expressed a lack of closure because of the way the session ended and still thinks about it to this day wondering why she did not return. Carol acknowledged that many issues were coming to the surface for her at the time and she felt "raw" in her therapist's presence. Despite not currently living in the same city, she thinks about contacting her therapist and assuring her that therapy was a valuable

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experience. It was apparent that she felt a need to be liked by her therapist and the lack of closure was thought to have threatened the positive nature of their relationship.

Carol described her experience of therapy as a freedom not available in other relationships to explore issues. She valued the unconditional acceptance given by her therapist and the lack of need to explain herself. She described herself as generally open with friends and family. Therapy however, proved freeing because she no longer felt the need to apologize or explain her emotions. Nor did she need to feel responsible for other people's reactions. She valued hearing herself speak and having someone challenge her distorted thinking patterns and negative self-talk. Another important aspect of Carol's relationship with her therapist was that she felt liked by her therapist. She also valued her therapist's helpful wondering approach versus what she viewed as a more prescriptive approach.

Another awkward situation arose when Carol saw the diagnosis she had been given by her therapist on an insurance form. She felt that her therapist either should have used better precautions to safeguard the information or should have discussed the diagnosis with her ahead of time. Carol thought about the long-term impact of having a diagnosis on her records and questioned herself for not being more assertive about the diagnosis with her therapist. She finally discussed her concerns with her therapist who acknowledged regret about not handling the process with more sensitivity and care.

Carol's process of reflecting about her experience of therapy allowed for an interesting awareness to arise. While discussing what she thought were the therapist's limitations, she described characteristics that initially she felt would have benefited

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her more during therapy. As she spoke however, she realized that she really did not need to be challenged more directly or need someone to hold her accountable. She recognized that her therapist provided her with what she needed at the time, a safe and accepting space in which to process her emotions. The most powerful impact of her therapy experience was the unconditional acceptance and validation provided by her therapist. She described one session where her therapist reflected that despite all of the adversity and heartache Carol had endured that she was all right. This simple acknowledgement by her therapist proved to be powerful validation of Carol's strength and resiliency. She was also surprised at how much her therapist's validation empowered her in the process of healing.

Carol acknowledged the limitations of her therapist. Through her own experience she recognized the importance of structure and continuity between sessions as a way to ease anxiety for clients. Carol used this lesson with her own clients and was careful to structure sessions. Carol was aware that the commonalities she shared with her therapist led to a positive connection, however she also felt that many of the issues she brought to therapy were issues for her therapist. In her mind, this limited the depth of therapy because her therapist was unable to recognize and challenge Carol about the presenting issues due to her lack of self-knowledge. Carol believed it would have been helpful if her therapist had been transparent about issues that triggered her reactions.

Despite limitations, experiencing therapy while being a provider of therapy was acknowledged by Carol as incredibly valuable learning. It was not just the interpersonal exchange that helped her understand the process; she also valued the

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basic process of attending her sessions. From driving to the session and anticipating the upcoming exchange, to sitting in the waiting room, and leaving following the session in an emotional state. Carol found that these experiences helped her to tangibly understand the client experience. She felt that without this experience she would not have the same understanding or sensitivity for her clients.

Carol described two levels of processing that occurred simultaneously during therapy where she was both client and therapist-in-training. It was difficult to be the client without analyzing the purpose behind her therapist's questions, which interfered with her ability to be totally present in sessions. She struggled to separate her professional self from her personal self. She reflected that her way of dealing with emotion was to rationalize and explain it as she would in her role as a therapist. Her experience as a client was powerful in challenging her to experience her emotions and to be able to share with her therapist without feeling judged. Carol described this as feeling "raw" in her therapist's presence. Carol felt that she had not been able to experience the rawness in any other relationship. Therefore therapy allowed her to feel emotions no matter how difficult. This was an important lesson for Carol because she was so used to helping others process their emotions that she had denied much of what she felt about issues.

Rachel's Experience

Rachel participated in therapy on two occasions, once as a teenager and once during her graduate work in psychology. Reflecting upon the two experiences, the first experience was much more positive; however it did not occur while she was a provider of therapy and unfortunately did not meet the parameters for the research.

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Rachel's second experience occurred while in graduate school when she became concerned about depressive symptoms she was experiencing. She described her experience of depression as "feeling out-of-control and helpless". She recognized she was in need of assistance and began looking for resources at school and near her home.

Rachel's search led her to the university campus where the clinic offered a screening process for depression. She found the process informing at two levels, at the client level and at the therapist level. Her therapist-self appreciated the use of a checklist of symptoms that synthesized the information into a possible diagnosis. Her client-self appreciated the checklist's validation of the distress she was feeling. Rachel valued the understanding gained through the intake process and how it impacted clients. She also appreciated the awareness and sensitivity gained regarding the client's experience, which proved to significantly benefit her work as a therapist

Another aspect of the therapeutic experience that Rachel focused on was her process of finding a therapist. Initially Rachel felt that it would be helpful if the therapist matched her own spiritual beliefs. The matching process appeared to limit Rachel's choices at the agency closest to where she lived and she ended up dissatisfied with her decision. She gained a new understanding of the obstacles clients overcome in the process of seeking help. She also understood how difficult the process can be when clients lack information and resources in their search. Rachel was sensitized to how difficult it must be for clients to recognize they need help and to be patient when finding a therapist to match their needs.

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Her experience of finding a therapist allowed for a deeper understanding of the vulnerability felt by clients when seeking help. She acknowledged that the empathy created through her experience benefited her work with clients. Her experience of therapy helped her to understand what might be helpful for clients when working through problems. Rachel felt that the most beneficial characteristic of her therapist was his unconditional positive regard. She found her communication skills improved through the use of 'I' statements. She learned the importance of checking in with clients to make sure therapy is meeting their expectations and goals. Rachel also found therapy was a freeing process which allowed her to say what she felt and not apologize afterwards.

Like some participants, Rachel viewed her sessions as limited by the therapist's lack of activity within the sessions. She believed therapists benefited their clients when they were active, provoked further understanding and offered suggestions on how to deal with the presenting problems. Rachel felt the limitations her therapist demonstrated were ones she overcame with her own clients. She was also aware that financing therapy was difficult for many people, and that this could pose an obstacle for access to therapy.

Rachel tried to empower her clients in their choices. She also recognized how difficult this can be with someone who does not have the knowledge about resources or different therapeutic approaches. Rachel felt that even with her knowledge of the therapeutic process, she was unable to find the help she needed. Even when she asked her therapist for alternative suggestions and interventions she felt her requests were not honored, which led to her eventual termination of therapy.

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Tina's Experience

Tina entered therapy part way through her graduate career for support during her separation and divorce from her husband. Tina found that many issues were colliding as she transitioned from a career into school while also juggling the roles of wife, student and student therapist. She described her experience as generally positive and felt that the therapist had been a good role model for her professional development. At the time, she felt that her therapist was of most benefit in helping to clarify her boundaries. This skill was especially pertinent to Tina during her graduate career because of problems that developed with some of her supervisors.

Tina pointed out that she was twenty-nine when she entered graduate school and had been working in the human services field for several years. Her parents, who were both therapists, sensitized her to the importance of therapy for providers. Her graduate program also helped facilitate personal growth by creating a group for students to express concerns and explore their frailties. Her graduate program had encouraged students to have therapy and assisted Tina in her search for a therapist.

Tina chose three names of therapists she had received from friends. She called each therapist and interviewed them over the phone. She questioned potential candidates about their professional training, background, and philosophical approaches. Particularly appealing to Tina was her chosen therapist's prompt return of her phone call, his honesty, humility and sense of humor. She was clear to point out to her therapist that she wanted an active therapist that would tell her honestly what was on his mind rather than being a "blank slate". He assured her he was not the type of

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therapist to hold back his opinion. Tina acknowledged that he was extremely honest in his work with her and she valued his frankness and transparency.

Tina's therapy experience was most helpful in navigating what were the client's issues and what were her own reactions to the clients. She felt it was important for young therapists to look at everything as potentially their issue. She was also aware however, that there was a need to be able to set boundaries between self and client issues. The knowledge gained regarding boundaries was also beneficial in dealing with her professors because the power differences between her and her professors made it difficult to feel she had valid concerns.

Due to his role as a supervisor in her graduate program, Tina's therapist was able to provide her with personal impressions of some of the instructors with whom she was struggling. Tina did not feel that this crossed any ethical boundaries. She simply saw her therapist as validating her experience of the individuals that were causing her problems. She learned that she could continue to work with people with whom she had difficulties by acknowledging their limitations and focusing on what they offered. The lesson was something Tina tried to share with her clients by encouraging them to develop more positively assertive strategies within troubling relationships and to recognize what was useful to them.

When Tina used this example with clients, she referred to it as the internalized voice of her therapist, which tangibly demonstrated his impact on her. She entered graduate school at the age of twenty-nine, and felt that her program had created a disempowering process for her and her fellow students. She valued the assistance provided by her therapist in her transition from the working world to her role as

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student. Tina had been in the workforce for several years prior to entering graduate school. She felt that rather than increasing students' confidence in their new role as therapists, her professors decreased their self-esteem by questioning their abilities. This was particularly problematic in Tina's view because her clients viewed her as an "expert" and yet the instructors in the program constantly undermined her confidence. She was sensitized to the importance of empowering students in their roles and valued the learning for her future role as a supervisor in her graduate program. Through her own therapy she recognized the sense of duty she felt to the students she supervised to support their growth as young professionals.

Tina acknowledged that throughout her initial therapy experience she had been treated like an intelligent and competent adult. She found the respect provided to her by her therapist was extremely empowering. She realized the mutual respect achieved within her sessions led to both personal and professional growth, and contributed to an overall sense of calm. Tina recognized her therapist was a good match for her at that point in her career because he was ego building and therefore crucial to her development as a professional. She felt her therapy experience had resolved the rescue fantasy where the therapist assumes the role of rescuing clients. This also limited to some degree the pressure Tina felt in the role of "expert". Tina felt this role was demeaning to clients because it took away their ability to save themselves. She called this lesson "the most crucial gift" she received through her own therapy because she felt it was curative to recognize one's ability to heal oneself.

Tina felt the depth to which her own work with her therapist could go was hindered by several factors. She viewed the lack of depth as a result of her desire to

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appear worthy or competent to her therapist. She had great respect for him and his role as a supervisor in her program. She also recognized however, that her admiration for her therapist limited the issues that they could explore together. This limitation was a result of her need to appear worthy to her therapist. Although initially she appreciated his approach, she later felt that it inhibited the depth of her therapy. Tina referred to the deeper work as an uncovering process. She wished her therapist had challenged her on her glibness, which she recognized was a defense mechanism.

Tina characterized this experience as ego building and felt that this approach was what she needed at the time. This despite what she later acknowledged as limitations of her experience. She acknowledged that despite his training, her therapist did not contribute everything to "unconscious processes", which was in her opinion, an appealing strength of his work. She eventually terminated with her therapist when she felt stronger and when she thought therapy had reached its limit.

During her internship year, Tina saw another therapist who had been trained from a psychoanalytic perspective. Although she was comfortable with this perspective, she felt that it limited her therapist's ability to recognize the underlying issues. Her therapist tended to credit unconscious material for everything that was happening for her in her program. For example, Tina was attempting to work through issues with one of her supervisors whom she felt was being inappropriate with his boundaries and with her as a woman. Instead of addressing the pertinent issues of harassment, her therapist tried to explore her "father issues". Tina felt that partly due to his age, and also due to his theoretical orientation, her therapist was not able to understand her issues. She commented that she had "tested" her therapist and that he

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had failed her, which left Tina feeling unsafe. The lack of security and abandonment consequently triggered issues from her childhood when she did not feel protected by her parents. Instead of resolving the issues with her therapist, Tina turned to a female professor in her department who validated her concerns regarding the inappropriateness of her supervisor's behavior. She felt that was all she really needed from her therapist and yet he had failed to adequately address her expectations.

Tina's view of therapy is that it is never complete and that there are always things that a person can work on at different developmental stages in life. She did not believe that a person has therapy once and resolves all of the issues. Instead she believed that therapy was a lifelong process. She experienced therapy as a helpful resource she could turn to for support when needed. Tina described therapy as an objective, and empathic sounding board. Tina did not have any religious beliefs and viewed therapy as providing the type of support that religious faith provided to others. Tina acknowledged the imperfections in her therapy and in the therapeutic process however she also felt that she had learned even through the failures in therapy.

Tina's experience of therapy was a powerful learning tool for the type of therapist she wanted to be. Tina learned to appreciate the difficulty clients have feeling safe and trusting their therapists. Despite arriving in therapy with good coping skills, unlike many of her clients, Tina still found it difficult to build trust with her therapist. She acknowledged that some therapists might confuse this situational anxiety with a more serious anxiety disorder. She felt it was important not to pathologize clients for a normal reaction to a stressful situation. Another lesson for Tina was that clients are

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entitled to what they think they want from therapy and that may not always be consistent with what the therapist thinks they need.

Overall, Tina felt that the inherent power differences between client and therapist needed to be acknowledged at the outset of the therapeutic relationship. She also felt that it was important to be transparent and collaborative in the therapeutic process. Part of the transparency Tina appreciated involved her therapists acknowledging their own frailties and being respectful when exploring the client's frailties. Tina's experience also helped her to recognize the importance of encouraging clients to track their thoughts and feelings out loud in order to increase self-awareness. She learned that structuring sessions helped reduce anxiety for clients that resulted from the uncertainty in a new situation.

Tina discussed the difficulty she had "letting go", which resulted in many barriers within her sessions. She felt an added concern as a new therapist about feeling judged both personally and professionally. With her first therapist, she realized that their positive relationship in some ways inhibited the depth of her therapy. She valued his opinion of her and wanted to be worthy of his admiration. On the other hand, she was limited in her next experience of therapy by a lack of trust. A final limitation of therapy was her dual processing which required the therapist-client to explore emotional issues while at the same time learning cognitively about the process of therapy.

Jason's Experience

Jason entered therapy after graduation from his doctoral program. At the time, he was separated from his wife and was involved in a new relationship. Reflecting on

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the issues, he acknowledged that he and his wife had made a common mistake by focusing their energies exclusively on their children rather than on nurturing their relationship. Jason's initial contact with his therapist was through a men's group he had heard about through work. His involvement in the group led to individual sessions with the facilitator.

Jason very much enjoyed the therapeutic process. He noted that he especially enjoyed being the focus of attention and being listened to rather than listening to others. Jason viewed everything in therapy as positive, which reflected his lifelong love of learning. He felt that every experience in life, whether positive or negative, is an opportunity to learn. When questioned about any harmful aspects of his experience of therapy therefore, he simply explained what he had learned from the process. An example of Jason's learning through a negative experience was when his therapist made a critical comment about his father. He explained that despite exploring issues about his father in therapy, overall their relationship had been positive. The negative comments made by his therapist provided a learning opportunity to avoid criticizing his clients' relationships. He was more cautious after the experience of saying anything negative to clients regarding people in their lives that were causing problems. Instead he worked with the issues that were causing problems while avoiding the alienation that occurred in his experience of therapy.

Jason had experiences with several therapists throughout his career. His choice of therapists was based on their reputation in the community and his own interactions with them through work and professional seminars. For one particular therapist, Jason knew when he met him that he would be a good match. He relied on his intuition and

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initial impressions when making a decision to approach the therapist for therapy. He felt another benefit of therapy was seeing a well-respected therapist at work. He described getting "two bangs for his buck" because he was able to benefit from the person's experience while also benefiting professionally by witnessing the therapist at work.

Jason valued a counselling approach rather than a clinical approach to therapy. He thought Clinical Psychologists generally were trained from a diagnostic perspective, which pathologized clients rather than focusing on strengths and building relationships. He also had experience with Counselling Psychologists and found they focused on the therapeutic relationship, which he valued. Despite his perspective about the training background of therapists, he felt that the most important factor in choosing a therapist was what type of person they were. Jason mentioned several characteristics that he valued in his therapists beyond the perspective from which they were trained. He stated that he did not want his therapist to be pedantic or arrogant and think that they knew him better than he knew himself. He felt it was important that therapists were honest and real about what they could do to help clients. He also stressed the value of a collaborative approach rather than a prescriptive approach in order to empower clients.

Jason discussed the same dual level of processing that other participants discussed however, he felt that he was able to "in the moment" experience the emotions necessary to do the work. He focused on trying to be present and responding to his therapist's facilitating questions. It was later when he went home that he found

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time to reflect on what he had learned as a therapist, and he made notes following many of the sessions of things he had learned.

Another experience of therapy occurred when Jason was having difficulties dealing with the unsettled relationship between his girlfriend and his daughter. He felt caught in the middle, wanting to be supportive of his partner yet not wanting to alienate his daughter. His therapist helped to negotiate this awkward position and seek a resolution. For Jason it was illustrative of the helpfulness of the therapeutic process in setting boundaries in relationships whether they were personal or professional.

An example of Jason's learning from a negative experience arose when he was explaining to his therapist his job as a father. The therapist thought his comparison was peculiar and did not understand how being a father could be viewed as an occupation. Despite his therapist's inability to understand his comparison, being able to talk about his convictions to another person helped clarify his own beliefs. An example of a realization he had following this session was that he strongly felt being a parent was a job that needed preparation and education. This experience transferred to his role as a therapist when he suggested to parents that they read books or articles that would help them to increase their skills as parents.

Jason also mentioned how he transferred what he learned in therapy to his role as a supervisor. He felt that it was important for his students to ask their clients about previous therapy experiences and evaluate what was helpful or unhelpful in those experiences. Jason was a proponent of therapists having therapy and when advocating this belief to students he compared it to the use of psychometric tests on oneself in order to learn about the process.

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Jason had several experiences with different therapists and was able to comment on the differences he saw between male and female therapists. He felt more comfortable talking with male therapists about sexual issues however, he also enjoyed the nurturing environment created by his female therapists. He believed that women were generally better at creating relationships because this skill came more naturally to them. He experienced a vastly different environment in male and female therapists' offices. The male therapists had more austere environments and masculine tastes, while the female therapists created a nurturing environment. Just like in other situations, Jason appeared to enjoy the learning that occurred and did not value one experience over the other.

Jason had many theories about therapy that he had developed over the years. He felt that therapy was a person's chance to share his or her feelings and not be judged or evaluated for whatever came up. It appeared that the lack of judgment by the therapist was one element of his experience that he highly valued. He also valued therapists who were not presumptuous about what was best for the client. He preferred the therapist facilitate the process for the client and let the person discover what was needed. Jason could not understand why therapists avoided their own therapy because he believed it was an excellent opportunity for personal growth and self-discovery.

Ashton's Experience

Although Ashton had been in therapy on more than one occasion, the experience that met the parameters for this research occurred two weeks after separation from her husband. Ashton described this experience of therapy as being the most significant and life altering of any of her therapy experiences. Ashton was in the

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process of completing her Master's degree and was working full-time, and therefore was experiencing significant stress in addition to her separation. She described herself as feeling physically ill due to the impact of her relationship ending. She knew that she would have to redefine everything about herself, which led to a sense of aloneness for which she felt unprepared and ill equipped.

Ashton was aware that this situation was unique and during this difficult time she would have to rely on others for support. Ashton described the difficulty she had in acknowledging that she needed help because of her usual role as the listener. She felt that everyone had expectations of her as the strong one who supported others. As a result, it seemed her family and friends were not sure how to help with her distress. Ashton acknowledged that it was difficult to overcome the expectations she had of herself, that she did not need others to be able to handle difficult times. She described therapy as "an escape route" out of this pattern and a chance for her to "spend my time with me".

Because Ashton had been in therapy in the past, she felt she knew what she wanted and needed from her therapist. Ashton's previous experiences of therapy had primarily been with men, and she had felt a "sense of betrayal and abuse of power within these relationships". This led her to a preference for a female therapist with a feminist approach to therapy, who could understand at a deeper level what Ashton's experiences were as a woman. She expressed that the therapist's honesty and willingness to share parts of self was one way to reduce the inherent power differences in their relationship. Another valued characteristic was that it was important to Ashton to know that her therapist understood what it was like at some level to be vulnerable,

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whether that be through her own experience of therapy or other life experience. Ashton wanted to know that she had no prior professional contact with her therapist. She was looking for work at the time, which made her cognizant of potential overlapping roles. She also needed to feel safe going to her therapist, which meant that she wanted the office to be in a discreet location where she would not be seen by other professionals.

Despite her prior experiences of therapy, Ashton was hopeful there were therapists who could be what she wanted. She described this belief as part of her need to renew her faith in her profession. Ashton received a referral from a professor she respected in her department and called the therapist to inquire about services. Ashton specified several qualities that were important in her selection of therapist, such as openness, honesty, and transparency. Another important factor because of her student status was the therapist's willingness to be flexible with fees.

When she first met the therapist, Ashton intuitively knew that she would be a good match. The therapist had a warm, nurturing, and motherly presence, which Ashton experienced as grounding. Ashton explained that the sense of intuition she relied on to find an appropriate therapist was similar to the connection she felt with certain clients. She called this connection, "a sacred space", and knew that if she felt this connection with her therapist she had found the right person. Because of the type of person she was, Ashton felt it was important for her therapist to be open to different ways of working, such as journaling, drawing and photography. Another quality she appreciated was that the therapist was non-directive and allowed Ashton to be wherever she needed to be in session.

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Upon her first visit to see the therapist, Ashton felt the office was appealing in its discreet location. The office was a nurturing space that was quiet and created an immediate sense of safety. She described the set up of her therapist's office as predictable, which enhanced the sense of safety she felt. Ashton explained that she and her therapist always sat in the same chairs, which led to a comfortable safety. Despite the emotion in the intake session, Ashton felt that the therapist was able to complete a thorough interview and had been careful to review the limits of confidentiality. Her therapist was aware early on that Ashton was a therapist-in-training and reviewed the standard procedures regarding overlapping relationships. The therapist was also able to acknowledge what Ashton described as "the inherent power imbalance in the therapeutic process", which had been a problem in her past experiences of therapy. This led Ashton to feel like they were two colleagues, one older and one younger.

There were many helpful things that her therapist was able to convey to Ashton during the process of therapy. Ashton described her therapist as being able to tolerate silences indicating that she was sensitive to the pace Ashton needed to process her presenting issues. Ashton was feeling a sense of aloneness that was complicated by feelings of grief and anxiety. Her therapist did not try to rush her through these uncomfortable emotions rather she was encouraged to remain in the discomfort and silence. Ashton recognized that it was in the silence that she found what she needed to achieve understanding. She felt it was invaluable to be completely honest in her sessions and to feel that she would not be judged. She appreciated her therapist's appropriate boundaries in that she always started and ended sessions on time. Ashton could not remember having a cancellation by her therapist, which also enhanced the

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sense of predictability. Another element of her therapist's predictability was that she did what she said she would, which left Ashton feeling like she could rely on her therapist for whatever she needed.

A key understanding that arose through her therapy experience was that she could ask for what she needed and feel safe doing so. Another helpful part of her therapy was when her therapist confidently labeled some of the problematic dynamics within Ashton's marriage and helped her name her experience. Ashton claimed that she had always tried to be fair to her husband and was more focused on his needs rather than her own. This led to her minimizing his behaviors and the traumatic impact they were having. Her therapist encouraged Ashton to focus her language on her own needs, which allowed a shift in her understanding of an unhealthy dynamic.

Ashton explained one particular session which was demonstrably important to her because of the emotions that arose as she spoke about it. She described herself as feeling very vulnerable and depressed. She also recognized that at the time she had begun to isolate herself from family and friends. Her therapist was able to recognize her level of distress and despite previous firm boundaries around session length, she did not hesitate to extend the session to allow Ashton time to process her emotions. The session played an important part in validating the level of distress she was experiencing. Ashton was aware of her therapist's exception to the rule and appreciated that she was sensitive enough to know when flexibility was warranted. This led to a feeling of genuine caring by her therapist and an important healing experience.

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Ashton did not recall anything that was harmful about her experience of therapy however, one element that she wished her therapist had explored was the impact of family of origin issues. In the intake interview, her therapist took a detailed account of her family dynamics however it was not something that was ever used in her sessions. Ashton felt that it could have benefited her understanding of the origin of some of her presenting issues. Despite this small limitation, Ashton felt she would not hesitate to return to see her therapist whenever issues arose in the future.

Not only did her therapist help her as a psychologist, but she also became a mentor when issues arose with her supervisor. Ashton related one occasion when she consulted with her therapist regarding an ethical issue that was confronting her. She recognized that this was outside of the therapeutic role but felt that her therapist had been helpful and respectful nevertheless. Ashton felt that her therapist modeled the power of the feminine, which had played a role in her belief in her own capabilities. Because of the relationship that developed with her therapist, Ashton had a strong desire to be a mentor for other young women, like her therapist was for her.

Ashton described that early in her therapy she was more conscious of her role as a therapist-in-training and was therefore worried about feeling judged as unworthy. She questioned her own abilities as a therapist and wondered whether her therapist would doubt her abilities to be a therapist. Ashton felt that her therapist was able to acknowledge her own vulnerabilities regarding her professional role. She also assured Ashton that being vulnerable was part of being an authentic person and that it was important as a therapist to demonstrate integrity.

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One of the greatest lessons of her therapy was the increased awareness of client vulnerability in therapy. She felt it was important to experience what it meant to be vulnerable. Although she was appreciative of her experiential learning, she also recognized others could learn in different ways. She was careful to acknowledge her client's vulnerability and to pay close attention to the issue of safety within sessions. Ashton felt that she had internalized the voice of her therapist and would often ask herself, "What would my therapist say?" when struggling with issues. There were several instances when Ashton journalled about her session and what had been helpful so that she would be able to reflect on them and use them in her own work with clients.

An important realization for Ashton in her therapy experience was the recognition that therapy was an extremely valuable process. She described it as one of the best things she had done for herself. The experience had increased her self-worth and made her recognize and assert her needs more effectively than before. Ashton's therapist was careful to acknowledge her progress, which helped her realize how capable she was to overcome future obstacles. Ashton stated that she knew that if she had overcome what she did, that she could overcome anything. She described her own therapy as a journey that she wished everyone could partake in.

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CHAPTER FIVE

RESULTS

This chapter is a presentation of the themes identified in the interviews with the seven participants. Many commonalities as well as unique experiences were revealed in the analysis of the transcripts. In this chapter, those themes common to participants' experiences will be identified. Some are reflective of the actual process of therapy, including "Boundaries", "Connection" and "Dual Processing". Another theme, "Learning Through Experience" relates to the way participants transferred their experience of therapy into their personal and professional selves.

Participants indicated that they sought therapy for a variety of reasons. The participants were in transition points in their lives, which added new stressors. Lori and Jen returned to graduate school with the added responsibilities of partners and children. Tina and Ashton were in graduate school and were separating from their husbands. Jason was at a later stage in his career but was also separating from his wife. In addition to the end of her relationship, Carol was dealing with acculturation and self-esteem issues, while at the same time adapting to the pressures of her role as a graduate student. Finally, Rachel was struggling with symptoms of anxiety and depression, which she felt related to struggles with her faith. Despite different reasons for attending therapy, commonalities existed in the themes based on participants' experiences.

Boundaries

Boundaries in therapeutic relationships refer to one's ability to differentiate between self and other, including personal and professional responsibilities and roles.

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Participants identified both positive and negative experiences with boundary issues within therapy. Positive experiences facilitated the development of safety that was required for containing past trauma. Consistent modelling of boundaries in therapy helped participants recognize responsibility in both personal and professional relationships. The internalization of boundaries within sessions helped participants recognize and differentiate between their issues and the issues of others.

Negative experiences occurred when therapists were not able to set clear boundaries in their relationship with participants, which in some cases of past trauma exacerbated presenting issues. Two of the participants had negative experiences due to a lack of clarified boundaries in overlapping roles. Upon reflection, these participants felt that because of their inexperience and the inherent imbalance of power in their roles in therapy, they were unable to establish clear boundaries. Other examples of negative experiences occurred due to lack of safety in the therapeutic relationship. The absence of safety was related to the perceived lack of structure, and unanticipated responses from therapists which resulted in participants' doubting therapists' abilities.

Positive Examples of Boundaries

"Boundaries" appeared to be a key issue in the success or failure of the participants' therapy. For some participants who shared their history of trauma, appropriate boundaries were essential to a positive experience of therapy. For other participants, positive examples of boundaries allowed them to navigate responsibility in their relationships, which included an enhanced ability to understand the in-session processes with their own clients. Timely clarification of boundaries allowed Lori to overcome her initial negative example of therapy and experience profound healing.

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Tina, Jen and Lori all expressed how their therapy helped them understand, at a tangible level, the issue of responsibility in personal and professional relationships. Jen and Ashton discussed their positive experiences when their therapists slowed the pace of therapy in order to help contain difficult emotions. Another way that boundaries positively benefited participants was in the predictability and structure of sessions.

Role Clarification

Role clarification involved the delineation of overlapping or dual relationships by the therapists. Lori realized that her past issues were being reactivated by the trauma in the families with whom she worked and therefore she struggled to clearly differentiate between client issues and her own. Lori experienced a lack of containment to properly deal with her emotional distress and described her situation this way:

> I was doing so much trauma work that my own history came up fast and furious. There was no containment for that at the time and I think I was pretty depressed. The image that stuck with me was that you could have reached right through me, that I was somehow just paper.

Her new therapist also had overlapping roles with her but he was quick to clarify these roles and discuss potential issues. Lori indicated that he "really got it and understood what was happening at some level and approached it very directly". She felt the early clarification of boundaries and roles created safety and allowed for what she described as a "profound healing experience". She appreciated her therapist's frankness and felt

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that the clarity in roles compared to her previous experience of counselling allowed for a feeling of normalcy to develop.

> Our roles never overlapped in that same kind of way, although we travelled together and worked in various groups together but it was always very clear what the roles were under what circumstances. That in part was him, he was just very clear about those things and very upfront about it...I knew that I still needed some personal support around some issues so it was a lot clearer and actually that was a profound healing experience for me at many levels.

Not only did the clarification of roles help create a sense of safety but it also normalized the process for Lori. This allowed her to feel less responsible for childhood issues and helped to integrate childhood memories with a better understanding of responsibility. By setting appropriate boundaries in therapy, her therapist allowed Lori to contain childhood memories in a way that was empowering both personally and professionally. When comparing her initial negative experience with her next experience, Lori stated:

> The first time I think that only increased my sense of guilt and responsibility, so it kind of feeds off that omnipotent child part of you when that happens. It took awhile for me to really incorporate a sense of powerfulness as opposed to powerlessness and inadequacy...I really had this profound sense of guilt that I carried and they just put it in perspective. They didn't dismiss it, they just put it in perspective...It was a non-judgmental, integrative approach as opposed to a dismissive approach and I think that in relationship to both of them I was able to get a better handle on my own personal power and what that can do.

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Recognizing Responsibility

Another way that appropriate modelling of boundaries helped participants was by increasing their ability to recognize responsibility in relationships. By experiencing clear boundaries in their therapeutic relationships, Tina and Lori were able to recognize both personal and professional responsibilities in their interactions with others.

As well as helping to contain and contextualize childhood memories, Lori's therapist was able to assist her in recognizing when an issue was hers and when it was her client's. She felt that through the process of creating boundaries in their professional relationship, other boundaries were created which helped her to deal with her past safely and work more effectively with clients. This was an excellent example of how setting appropriate boundaries within the therapeutic relationship created an impact outside of the context of therapy.

Although the types of issues Tina was exploring with her therapist were different from Lori's, she also felt her therapist helped her to identify responsibility in relationships. Tina's experience of boundaries was different in that she found her therapist helpful in navigating issues present in her graduate program. Because her therapist was also a supervisor in the program, Tina was able to rely on his knowledge of the supervisors with whom she was struggling. His insight and validation of Tina's concerns helped her to clearly define her situation.

Especially helpful for Tina was the therapist's sense of humor when looking at her issues with other supervisors in the program. She received honest feedback about the supervisors based on his experiences with them. Tina felt her supervisor's level of

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sharing was appropriate and it helped her gain a healthier perspective of an unhealthy dynamic. She credited her therapist's candor with promoting her professional growth. Tina felt his feedback around the behaviors of other supervisors was helpful in navigating the power imbalances that existed between staff and students. She also credited him with strengthening her ability to set appropriate boundaries in future professional relationships.

As in Lori's experience, Tina's therapist acknowledged that she did not need to take responsibility for the inappropriate behaviors of others. She also recognized that there were things to learn in every relationship and that it was important to not negate this due to problematic dynamics. This lesson was helpful for Tina because at that point in her professional development, she felt that she should look at everything as her issue. Tina's learning also impacted her personal life. She explained,

> I recognize that as a therapist-in-training that I should look at everything as potentially my issue, but you have to have somebody navigate that with you and say, "No, that's not your issue, that's the other person's issue."...So I think he was really helpful. That was absolutely crucial for me as a student, as a developing therapist and paralleled what had gone on in my marriage in which I was unable to stand up for certain things that I needed.

Through the process of identifying responsibility in her relationships, Tina was able to recognize the healthy aspects of her relationships and not negate what was available to her. She found this was a valuable skill which she tried to nurture in her client's problematic relationships.

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Jen was also able to identify responsibility in relationships. She was a strong proponent of individual therapy because she felt it allowed her to differentiate client issues from her own issues. She believed that therapy was beneficial in getting to know one's self and one's boundaries which she saw as an essential component of being a mental health provider.

> I mean I think that when you're a therapist you have to get your own sense of self and your own sense of place in order before you can help somebody else. In order for you to have your boundaries up, you have to actually know what your issues are and test them and see what they look like. You can't help other people with their boundaries if you haven't got a clue what your own are and I think a lot of beginning therapists go into therapy not really having a clue.

Containment

Another positive example of boundaries was the creation of a safe and emotionally contained environment. Following her initial negative experience of therapy, Lori recognized that she needed further work to help contain past trauma and to deal with the harm she felt resulted from her interactions with her first therapist. For Jen and Ashton, their therapist's pacing of sessions empowered them to deal with their presenting issues. Jen initially reacted negatively to her therapist's slow pace in sessions. She later realized that her history of trauma made a faster pace more comfortable because it allowed her to avoid uncomfortable emotions. The slower pace of sessions helped to create a safe and contained space in which to process her emotions. In a similar manner, Ashton's therapist encouraged her to sit with her

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uncomfortable emotions in order to discover how to work through them rather than running from them.

> She would encourage me to keep staying in that space, to really listen to my own voice and what I knew in my body to be real. So it was interesting that I went out of anxiety of being alone and then was encouraged and supported to stay in touch with that and what it was telling me. In the end, that told me what I needed. Had I just run away from it, I would probably still be running. (Ashton)

Their therapists' appropriate use of pacing allowed Jen and Ashton to reconnect with parts of themselves that they had previously run from and to work through their presenting anxiety. Despite their clients' initial discomfort, it was clear that the therapists knew that a slower pace would help contain the presenting issues. The importance of pacing to help the client contain their emotions was essential to Ashton and Jen in moving through their presenting issues.

Modelling

Positive modelling of boundaries was demonstrated for Ashton through her therapist's appropriate level of self-disclosure. Ashton felt that her therapist shared personal information only when it validated her presenting concerns. The therapist's self-knowledge allowed her to recognize when self-disclosure would be helpful to the client in dealing with presenting issues. Another important way that her therapist modeled boundaries was through her reliability and professionalism. Ashton could not recall any cancellations and felt that her therapist always followed through on what

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she promised. The therapist's reliability eased anxiety which allowed Ashton to feel safe releasing her emotions in session.

> I knew I could really depend upon her. That's, I think, what made it really safe too. She was always very predictable and reliable. We'd always start sessions on time, she rarely made me wait. She never had to cancel a session in the entire couple of years that I had seen her. Just always being there and doing what she said she would do.

The positive experience of boundaries was helpful both personally and professionally for Tina. Professionally it played a role in how she supervised students. She described the process as "the internalized voice of her therapist" coming through during supervision. She felt she was playing an essential role for the new students by helping them recognize their boundaries and empowering them as young therapists. As part of the process of therapy, Tina felt her work had allowed her to internalize the boundary between self and other which led to a more positive understanding of relationships.

Summary

Clearly, there were many positive examples of boundaries in the participants' experiences of therapy. Therapists helped participants contain problematic emotions in therapy through clarification of overlapping roles. Therapists also empowered participants by helping them to define responsibility in both personal and professional relationships. Through pacing according to the needs of clients, therapists modeled how to help clients contain difficult emotions. Finally, predictability and structure

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throughout therapy allowed participants to feel safety within the therapeutic relationship.

Negative Examples of Boundaries

For some participants, difficult situations arose when the client and therapist roles were complicated by prior relationships. As mentioned, it was helpful when therapists acknowledged overlapping roles prior to the start of therapy. When inherent power differences were not addressed, problematic dynamics developed. These dynamics led to intense emotional reactions and negative impacts on participants. Although participants were able to have reparative therapeutic relationships following their initial experiences, it was clear from the emotions that arose during the interviews that the negative impact had been significant. Finally, when participants felt their therapists did not provide enough structure during sessions, the lack of structure led to increased anxiety by participants and an overall sense of responsibility for the content of sessions.

Lack of Role Clarity

Just as the positive examples of boundaries helped to contain past trauma, negative examples exacerbated symptoms in those participants with a trauma history. For Lori and Jen, their initial experiences of therapy involved a number of overlapping roles with their supervisors/therapists. At no point however, did their therapists clarify boundaries. The lack of clarified boundaries was especially difficult for these two participants because of their past histories of trauma. The women felt they were not in informed positions with respect to consenting for therapy. Instead, they trusted the therapists' judgments of what were appropriate relationships. During therapy Lori and

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Jen recognized that the lack of clarified boundaries were problematic however, they felt helpless to ameliorate the situations. Lori recalled, "There was a client role and a friend role and a therapist role and when it got to that point I realized...that was not a good thing".

Upon reflection Lori realized that she viewed her supervisor as her last source of help. It was clear that to confront the issue of overlapping boundaries would have been extremely difficult at the time.

> I was so overwhelmed and so afraid of losing what I saw was my last resource, the person that was holding the glue together, that I think I made an uninformed decision and agreed to the friendship...So there was so many layers of crap...It's that being so misunderstood and misread and forced to do things. It's not like I was forced to do things, I mean there was a negotiation around it but I wasn't in an informed position to negotiate. I think that is the whole problem with that relationship was that it was impossible for me to be in a position of informed consent to do anything.

It was the lack of confrontation regarding the inappropriate boundaries and the impact of a physical release session that led to the buildup of anger and resentment for Lori. Her next experiences of therapy allowed her to process this session as well as make the connections with her traumatic past.

When Lori and Jen spoke of their therapy in the interview, they expressed anger as well as sadness as they recounted their experiences. These experiences involved their therapists' interventions to process traumatic memories. Although the techniques were different, both were poorly timed and intrusive. At the end of the

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sessions, the women were left feeling further traumatized and angered by the therapeutic process. Lori described her experience this way:

> It absolutely became a struggle in which I recognized even at the time that I refused to express anything. I mean she could have literally driven a nail through my head and I wouldn't have cared. It became this really weird physical dynamic that happened in that session and that was in part what my anger is about.

Jen felt that because of her vulnerable position she was unable to recognize the problematic dynamics that existed with her supervisor. In one particular session, her supervisor/therapist pushed Jen to disclose information about her past abuse. Jen felt that he had been aggressive in pursuit of details that she was not willing to share. In addition to an inappropriate intervention, her supervisor/therapist also demonstrated poor boundaries in breaking confidentiality. During group supervision, he shared personal information gained in her individual therapy with Jen's classmates. She explained:

> I still think that a lot of it comes back to boundaries. I think if he didn't have access to me as a student when I was a client or a client when I was a student, I think some of that stuff wouldn't have happened. There seemed to me a real blatant boundary crossing. Someone shouldn't have access to both persons. That's for me to process and for me to figure out, not for someone else to do.

The women trusted their therapists would make appropriate decisions regarding the dual relationships that existed. In part because of their histories of trauma, the women felt especially vulnerable to boundary violations and betrayals of trust.

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In Jen's next therapy experience, the issue of dual relationships arose again despite her overall positive experience. After several sessions with her therapist, Jen discovered that the therapist had a very close relationship with her clinical supervisor whom she had discussed in sessions. This unexpected dual relationship led to a sense of betrayal and her eventual termination of therapy. This example reiterated to Jen the importance of clarity in relationships and how transparency needs to happen when an issue arises in therapy.

In several instances, the standard procedure for clarifying dual relationships and boundaries, typically explained to lay clients at the onset of therapy, was neglected. Some participants felt their therapists had neglected to discuss the potential risks of dual relationships and to gain informed consent. The negative impact on these participants provided a tangible reminder of the importance of obtaining informed consent and of exploring the potential risks of dual relationships. This information is no less important for therapist clients who have had prior experience of this process with their own clients. Only by discussing dual relationships and the limitations to confidentiality can clients be empowered within sessions to set boundaries.

The participants indicated that these omissions could have resulted from therapists' assumptions that the participants knew the ramifications of dual relationships. Unfortunately, despite prior knowledge, these young therapists did not fully recognize the potential difficulties that can arise when there are overlapping roles. Entering into therapy, they trusted their more experienced counterparts to practice ethically and to warn them of any potential problems of dual relationships.

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The lesson learned through the negative examples of boundaries will also be discussed in "Learning Through Experience" in terms of the impact on participants' practice of therapy.

Lack of Safety

In later reparative work, Jen and Lori were able to deal with their initial negative experiences because of the safety and containment provided by their subsequent therapists. The women gave examples of how the dynamics of their prior therapeutic experiences created environments that felt unsafe and inhibited them from asserting themselves. Lori's description, in particular, illustrated the impact of therapist disregard for client readiness. There was little that she could do however, to extricate herself from the situation. Lori felt she had to comply in order to get the help she needed despite the fact that her emotional state worsened as a result of this experience of therapy. This sense of complicity served to increase the guilt and responsibility that stemmed from what she called her "omnipotent child". She stated:

> As a learning therapist I feel so much guilt in relationship to that whole thing that somehow there was no way of negotiating a clearer relationship in it and it wasn't really until I got out of that and until I put an end to it that I was able to see. So I ended up feeling complicit in my own victimization if you will.

Jen had a similar experience. Following relentless pressure in therapy to discuss her past traumatic experiences, her immediate reaction was to freeze and run. She described her reaction as one of needing to escape.

> I felt that he attacked me in session where he would ask me a question about past sexual abuse...and I found it really abusive. Actually I remember going

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> into a really frozen state and just walked out at the end of session without paying. I just couldn't get out of there fast enough.

Jen felt abandoned by her therapist when she did not receive a follow-up call or referral to other services. She felt that if she had been a layperson, there would have been an attempt by her therapist to make sure that she was okay following the session.

> He knew how upset I was when I left that day and he never followed up with a phone call or anything. He just sent me a bill. That was that. If you're going to work with someone who is struggling with some past issues, I don't think that ethically you send them out into the community unless you know they have some resources out there or you know that they're okay or you have some kind of contact. You don't just muck with people in your office and send them on their way. That's absolutely what he did!

Through their negative experiences, Lori and Jen recognized they still had work to do on their initial traumas. They knew that in order to benefit themselves and future clients a more positive experience of therapy would be needed.

Lack of safety led to feelings of powerlessness, complicity, abandonment and a breech of trust. As the interviews progressed, it was clear that the opportunity to further process their experiences proved therapeutic for both Lori and Jen. In ongoing communication with participants, Lori acknowledged that the interview had allowed some closure with what occurred in her therapy. She stated:

> I feel no emotional attachment to the story, other than a sense that I'm really glad I'm cleared of it. Telling that story, I think, was the final clearing of a bunch of stuff about that time in my life as well as a really negative sense of

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myself from that time. So I thank you for the opportunity to complete that piece of work.

Lack of safety was also triggered by unexpected therapist reactions. Carol's negative experience resulted from what she felt was her therapist's lack of self-knowledge. She discussed a session that triggered a problematic reaction from her therapist. Carol felt that as she discussed her own struggles with aging, the therapist over-identified with her issue which led to a confrontation about beliefs. She concluded that her therapist must have been struggling with her own feelings of self-worth as she aged and that she personalized what Carol shared in session.

Carol reflected on the confrontation as a limitation of her therapist's self-knowledge and felt that the therapist should have been more aware of the impact of her response on her client. Although she was a younger, less experienced clinician, her recognition of the triggering of her therapist was confusing to Carol. At one level, she seemed to be sympathetic about what she felt were her therapist's issues. At another level she was disappointed with what she perceived to be the therapist's lack of self-knowledge. Carol reflected:

> I guess in that situation if I was the layperson I would have thought, "Well, she's confronting me and I need that" or whatever. But being the therapist I thought, "What is that bringing up for her automatically?" And I thought, "Is she having some countertransference issues?"

Carol and her therapist were never able to fully process the confrontation. When her therapist brought it up the next session, Carol minimized its impact and was unable to be honest about how she really felt about the confrontation. Because she felt

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frustrated and unsafe to share her thoughts and feelings, Carol did not return to therapy. Her apprehension about returning was due to vulnerability she felt in her therapist's presence and her need to be liked by her therapist. Therefore she was unable to acknowledge the extent to which her therapists' response had offended her. Despite her overall positive recollection of the therapeutic process, Carol struggled with this one aspect that felt unfinished. Carol valued closure and the fact that she was unable to achieve closure with her therapist still bothers her.

Lack of Structure

Another negative example of boundaries occurred for some participants when they felt that the therapist lacked sufficient structure in therapy which created anxiety. Carol expressed ambivalence regarding the lack of structure provided by her therapist. Although she appreciated the freedom it provided, she also expressed a desire for more structure in order to reduce anxiety. Carol stated:

> I think I would want someone who would challenge me more, who would be much more, "Okay, let's come up with a plan. So let's help you be more patient and less sarcastic". So somebody who would really come up with a plan, hold me accountable…I guess much more CBTish. Yeah, much more goal oriented and really challenges my cognitions 'cause I can take the best of me to help me with my anxiety.

She felt that her therapist could have offered more concrete solutions for her presenting problems and helped to establish clear goals for therapy. She would have felt more "accountable to the process of therapy" if her therapist provided more direction.

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Similarly, Rachel wanted more structure and suggestions from her therapist. Upon reflection, she felt that a Cognitive Behavioral Therapist (CBT) would have been more beneficial in dealing with her depression. Rachel wanted the type of therapist that offered tangible solutions with a client-centered perspective. Rachel stated:

> I think therapists work better by doing more than just listening but by kind of provoking other ideas within the client or suggesting things that are active and not just passively listening. So I think from my experience and that's partly who I am too, I'm much more active, but for the type of client that would be anything like me who already is thinking a lot about their issues, reciting them to someone else isn't really helpful.

Tina also recognized the difficulties that arose when therapists lacked structure in their sessions. She felt that therapy was an anxiety producing process and that often times this anxiety was mistaken for more serious issues.

Summary

The most harmful aspect of participant experiences arose due to lack of role clarification or overlapping roles with their therapists. The participants who were in the same life stage described their experiences from both personal and professional perspectives. Because six of seven participants discussed therapy experiences that occurred when they were students, they may not have been as assertive or aware of what was appropriate in terms of boundaries.

The participants internalized boundaries on many levels. In some examples, the participants became aware of inappropriate boundaries by their therapists through

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overlapping roles, inappropriate sharing of information, or problematic use of interventions. Other negative impacts resulted from what participants felt was therapists' lack of self-knowledge. In more positive examples, therapists modeled strong boundaries which contained the emotions experienced in therapy and served as an example of how to be in relationship with clients. Proper containment within sessions also allowed participants to have clarity in terms of their responsibility in other relationships.

Connection

The theme of "Connection" captured the moments in therapy when participants felt a strong relationship with their therapists and a feeling of being genuinely cared for. Participants mentioned that they felt "safe", "empowered" and "understood". They also felt empathy and lack of judgment from their therapists, which allowed them to tell their stories without fear. The theme of "Connection" also involved the participants' recognition of healing, or an awareness that something had shifted in their prior understandings. Ashton described the connection she felt as "sacred".

> I think part of it came from my own experiences with clients knowing when there's an energy or a connection you can't really explain. It's like a different presence when you know there is work being done and I was hoping I would feel that from the other side. I don't know if it's something I can articulate, it's just sort of energy, an acceptance, a space that's sacred somehow.

Trust and Safety

Six of the seven participants discussed how their strong connection with their therapists led to positive results in therapy. Two important elements of the connection

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were trust and safety. It appeared that one could not exist without the other. Participants touched on either their therapists' ability to create safety and trust or the reasons why they did not feel these elements were achieved in sessions.

For one participant in particular, the connection with her therapist developed despite an initial negative therapeutic experience. When Lori approached her second therapist, he was able to clarify their overlapping roles prior to the beginning of their therapeutic work. The role clarity not only allowed Lori to contain emotions but also enhanced her initial connection with her therapist. The safety and trust created as a result of their connection helped heal the abandonment she experienced when she initially talked about her history in front of her classmates. The "profound healing" Lori described would not likely have been possible without the connection she experienced with her therapist.

Carol trusted and valued her therapist's unconditional positive regard and her ability to empathize despite not having shared the same life experiences. She was surprised how well her therapist empathized with her presenting issues despite their different backgrounds.

> She was very empathic and I could tell that she didn't experience what I did obviously but she could definitely feel my pain. She could reflect it in a way that I didn't expect her to and I thought, "Wow, she really does care!"

Carol felt the connection with her therapist led to a level of trust she had not experienced in other relationships. The therapist allowed her to express feelings, "no matter how ugly." Carol described her open expression of emotions as feeling "raw" in her therapist's presence. She viewed herself as the type of person who was a good

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listener but who was rarely able to express her emotions without feeling like she needed to apologize for them. Ashton expressed a similar sentiment that she had always taken on a care-giving role with family and friends that did not allow her space to express how she felt. Because of her connection with her therapist, Ashton felt she could say anything and not feel judged. For both participants the opportunity to step out of their roles as listeners and to share painful emotions was the result of their connection with their therapists.

Jason and Ashton both spoke of an intuitive knowing when they met their therapists that there was a connection. Jason acknowledged how his therapist's lack of judgment allowed him to freely express his thoughts in therapy. He stated, "I think as a client, just not being judged is a powerful kind of thing and just feeling so comfortable with the person that you can tell them anything, virtually anything." Ashton discussed a similar freedom to express what she needed to in order to benefit from therapy. In the past she felt she had typically taken on the role as listener in other relationships. As a result of the safety and trust she felt with her therapist, Ashton was able to acknowledge that she needed help.

> I think there are certain expectations that come with you being a therapist as well. So it was nice to be able to go to someone in the profession who would understand that there are maybe not a lot of people that I would trust with what I was going through.

Part of not feeling judged was the ability to feel vulnerable in the therapist's presence. Ashton's prior experiences of helping others made it difficult for her to allow herself to be vulnerable but in the end this was a key benefit of therapy. Ashton

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felt a similar validation when her therapist was able to reflect back the progress she had made and acknowledge the strength it took to overcome her issues. Her therapist's support allowed Ashton to gain confidence in her ability to overcome future obstacles.

Empowerment

Experiencing trust and safety in a therapeutic context helped Tina and Lori to believe in their own abilities. Prior to their successful therapy experiences, Tina and Lori discussed how they felt disempowered in their new roles as students. They were in similar life circumstances having returned to graduate school after getting married. They felt their graduate school experience had undermined their confidence in their own abilities. Lori's initial experience of therapy left her paradoxically feeling omnipotent and disempowered. She left her first therapy experience feeling vulnerable and betrayed. The safety created by Lori's next therapist helped her to define the issue of responsibility. This connection allowed her to move forward and tell her story without needing to protect others.

Lori's, Tina's and Carol's therapists acknowledged and validated their capabilities as young therapists which proved to be extremely empowering for the women. One of the most valuable aspects of their therapy was being treated as intelligent women. They felt the basic respect provided by their therapists allowed them to feel confident of their abilities thereby empowering their work with clients. Tina felt that her therapist recognized the importance of empowering students in order to make them more effective clinicians and was able to sufficiently build Tina's confidence at a time when she had begun questioning herself due to problematic

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interactions with supervisors. "He treated me like an intelligent adult and that was not only unbelievably calming, but helpful personally and professionally".

Carol felt a connection with her therapist because of what she viewed as the commonalities they shared and her belief that her therapist genuinely "liked her". Carol felt empowered through a simple acknowledgement by her therapist that despite all of the difficulties she had faced she was actually doing well. The validation had a profound impact on Carol's belief in her ability to deal with her presenting problems.

> One of the most powerful experiences for me was that she acknowledged something that I keep telling myself but don't truly believe that despite a lot of heartache I've endured over the years through childhood and family, I really turned out okay. And I think that it was pretty powerful for me to hear that from her.

The final element of connection experienced by Lori was her therapist's acknowledgement of the negative impact of her previous experience of therapy and the barriers she overcame to seek help a second time. She appreciated that her therapist was sensitive enough to realize how difficult her initial experience of therapy had been and her vulnerability in coming forward again. He also was able to make her aware that however she needed to do the work, he would be there with her. In describing the impact of her therapist's acknowledgement, Lori stated,

> I think why that resonated so well for me, and what made it safe for me to work with him was that he understood what it meant for me to open myself up and that whatever I would feel in response to doing that was okay with him.

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Because her therapist had been so sensitive to her vulnerability, Lori learned a valuable lesson about the vulnerability, courage, and empowerment of clients. She also recognized the importance of validating the client's willingness to come forward for help, which strengthened the connection with her therapist.

Summary

The connection that participants felt toward their therapists was created in a variety of ways, but most importantly involved a relationship based upon trust, safety, and feeling empowered. Therapists demonstrated their understanding of what it was like to feel vulnerable. Participants felt validated by the therapists' lack of judgment that allowed them to tell their story and believe that they were being heard. For some participants, the role as healer in their relationships had prevented them from exploring their emotions and being vulnerable to others. To be able to do this in a safe and contained manner resulted in a deep sense of gratitude to their therapists. It also created an increased awareness of the ways in which therapists can enhance their connection with clients.

Dual Processing

The theme of "Dual Processing" describes what participants viewed as common in their experiences of therapy. Participants identified two levels of processing as therapist clients. The first level involved the therapist-self witnessing experienced therapists at work and evaluating the therapist's approach. The second level of the processing involved their client-selves using therapy to resolve personal problems. Some participants discussed how this dual level of experiencing limited the depth of therapy due to the interference it caused. Another reason that dual processing

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limited and complicated participant experiences was due to fear of judgment by the therapist.

Therapist as Apprentice

One aspect of therapists' therapy that distinguishes it from layperson therapy was described by participants as the constant fluctuation between cognitive and emotional processing. This was the result of the participants wanting to experience therapy to resolve personal problems but also inevitably learning from the examples provided by their therapists. Although six of seven participants had therapy as students, each participant discussed what they had learned from their therapy that changed how they practiced therapy. Lori, Ashton, Carol, and Tina discussed the dual processing that they identified as unique to therapists' therapy. Lori described the experience:

> In some ways there are always two layers going on when you're a therapist and you're already working. You're always looking to see what is better for you and makes you feel good and also the learning that you take back into your office.

Lori and Ashton also explored the unique fear of judgment that student therapists felt in therapy, the unspoken pressure to be mentally healthy. Lori commented:

> I think we develop therapeutic selves that are separate from ourselves but are connected. So I think that's a different issue in working with therapists as clients. I mean not everyone is afraid that you're going to judge them as crazy but I think it's specifically different within your own profession and I don't think there's any profession like that.

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Tina and Carol also felt their dual roles as client and student therapist inhibited the depth of their therapy. Tina felt that because she viewed her therapist as a mentor, she censored what she said in therapy. She discussed her need to appear competent and worthy of his respect. Tina felt that the depth of her therapy was limited because of her admiration for her therapist. In her first experience of therapy, she connected well with her therapist and cared about what he felt about her. This was helpful because she was able to trust him and felt supported in her therapy. Tina speculated however, that her desire to appear worthy as a young therapist to her own therapist limited the depth of therapy.

> I think that there's, not a drive that was conscious, but to be seen as worthy of being a therapist myself by him and seeing him as a mentor and that inhibited my ability to let it all hang out which I think is how you get to the deeper stuff.

Tina felt that because of her role as student therapist and also because her therapist was a supervisor in the program, she was unable to deepen her process. She felt her therapist's sense of humor and humility was beneficial. In the end however, his lack of recognition of her defenses also limited what they were able to accomplish in therapy. She speculated, "I never really brought up those sort of, maybe I was shy...or intimidated about saying, 'I think you are failing me here. Why are you failing me?"

Carol was also aware of her need to be liked by her therapist and felt her dual processing limited her ability to remain the client. As part of the dual processing, she discussed her struggle to avoid thinking that everything her therapist said was a result of her own issues. Carol felt that she was not able to fully enjoy the process of therapy

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due to her constant analysis of her therapist's motivation behind questions. She felt this would not have been an issue for a layperson client and speculated that if she had therapy prior to graduate school it might have allowed her to more freely be the client. She discussed her struggle to "stay out of her head" and experience the feelings that were arising through the process of therapy.

Therapist as Client

The split role of a therapist in therapy was made more difficult by the struggle to separate personal and professional selves. Carol wondered whether she was an inherently analytical person or whether her graduate training had taught her to think analytically. She described the process this way:

> I would have allowed myself to be the patient more had I not been in graduate school...It's hard for me to know what part of it is my personality and it would have been so regardless of the fact that I was in graduate school or not.

Although Carol's student role created some interference, she indicated that the depth of her counselling experience was impacted most strongly by her personality. Carol was aware that therapy was a place that she could discuss these experiences however, she struggled with her own vulnerability in her therapist's presence. For Carol, the advantage of feeling liked by her therapist became a disadvantage when she felt inhibited in therapy to be honest and forthright.

Jason saw nothing but benefits from dual processing as therapist and client. He felt his therapy was an opportunity to learn. He explained, "I always think that as a therapist going for therapy you get two bangs for your buck 'cause you're learning."

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He was not bothered by dual processing during therapy; rather he commented on his ability to separate what he needed to process emotionally and cognitively. He achieved this by journaling after sessions about what he thought was valuable which, he felt, allowed him to experience the emotions in session.

For the participants, the theme of "Dual Processing" was common at some level to their experiences of therapy, whether it had a positive or negative impact. Lori and Ashton felt that it was a unique experience for therapists to go for therapy because of the expectation to be healthy and the vulnerability created when they acknowledged the need for help. Carol and Tina felt that the dual processing that resulted from their roles as therapist and client had inhibited the depth of their therapy. This inhibition was the result of their difficulty stepping out of the therapist's perspective and their desire to appear worthy to their therapists. Jason was unique among participants in that he did not struggle with the dual processing mentioned by other participants. He could not understand therapists who were self-conscious about being in therapy, rather he appreciated the opportunity to put his therapist-self aside and be listened to by his therapist.

Summary

The theme of "Dual Processing" was common for participants and highlighted the inherent difference between the therapy of therapists and laypersons. For the therapist-client, there was an extra level of processing which involved their past knowledge impacting their experience in sessions. Participants saw themselves processing both cognitively as therapists and emotionally as clients. For one, the dual processing added "two bangs for the buck". Others felt it inhibited their ability to "let

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it all hang out" because of the participants' fear of being judged by their therapists as unworthy or inadequate.

Learning Through Experience

All seven participants provided examples of what they learned in their therapy and how they applied it in their personal and professional lives. Despite positive and/or negative experiences, all were viewed as providing learning about the content, delivery and focus of therapy. It was common for participants to take what they could, even from their negative experiences, in order to make them more effective therapists. The experience of therapy also added to the participant's understanding of self and the type of therapist he or she wanted to be. Additionally participants discussed how their therapy experiences impacted the type of supervisor they wanted to be for their students.

The lessons learned through their own therapy included the importance of: structuring sessions, empowering the client, empathy, avoiding criticism of client relationships, role clarification, and avoiding harm. Another example of learning through therapy involved increased sensitivity to client vulnerability. This included understanding the difficulty clients had feeling safe and trusting the therapist. All of the participants valued their experiences of therapy and felt that it was an important process for therapists. It was clear that despite what would be perceived as negative events, participants chose to learn from their experiences.

Providing Supervision

Tina's and Lori's experiences of therapy were closely intertwined with their later supervision experiences with students in their program. Lori and Tina felt

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graduate students were not encouraged to embrace their own power which resulted in them questioning their abilities. Through their own positive experiences of therapy, Lori and Tina transferred their learning to their supervision of students. Lori explained:

> There are students that are unbelievably good therapists and have lots of personal power but nobody believes they can actually do the work. So how to create a learning environment in which people can come to own their own power and be really effective with it. Because what happens otherwise is if it gets crushed down and they become afraid of it they become useless therapists.

In supervision therefore, Lori acknowledged and validated her students' unique skills and accomplishments in order to build their confidence. Tina viewed her role as helping students to navigate responsibility with their clients and with other supervisors. Tina achieved this goal by helping students recognize what they were and were not responsible for in relationships. She used the same approach with clients in order to help them navigate problematic relationships.

Jason also discussed how he felt his experiences of therapy had influenced both his practice of therapy and his supervision of students. He valued what he learned in therapy with respect to how it improved his supervision of students. As a result of his positive experiences, he encouraged students to learn experientially and to undergo therapy.

Client Vulnerability

Another aspect of participants' learning through experience was gaining an understanding of client vulnerability in coming for therapy. Lori and Ashton's therapy

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experiences increased their awareness of client vulnerability. The participants also recognized the courage clients needed to ask for help.

> It gave me a huge awareness of the vulnerability of clients for starters and a profound respect for their willingness to come forward...I think it is really important and it gave me in many ways a much clearer view of what it was that I wanted to do and how I wanted to be in the relationship. (Lori)

Understanding the bravery of clients helped the participants clarify the type of relationship they hoped to have with their clients due to their realization of the difficulty feeling safe in the therapeutic relationship.

Carol and Ashton were sensitized to the client experience by paying attention to the entire process of therapy. They discussed their memories about the practical aspects of attending therapy, including driving to the session, sitting in the waiting room and noticing the placement of chairs within the office. Carol said:

> I guess knowing what it feels like to go to the therapist's office. I mean just the physical driving there and parking my car and waiting in the waiting room and having the receptionist look at me and know why I am there.

These memories played an important role in sensitizing the participants to what clients experience as part of therapy. For Ashton, it played an important role in her understanding of client vulnerability and of what is required for clients to feel comfortable in therapy.

Rachel, Tina and Ashton acknowledged the difficulty they had stepping forward for help despite multiple coping skills and knowledge of the therapeutic process. Rachel empathized with clients who started therapy in a vulnerable and

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disempowered position. She understood the courage involved to allow a client to come forward for help. Rachel described the process this way:

> What it's like to try to find a therapist. The uncertainty of who would fit? How do I know this person is going to be good? How frustrating that must be. There are so many therapists out there and you know to pick and choose. From my experience because I know that I can be empowered to tell my therapist that I'm not getting something from this...but for people that don't have that assertiveness or understanding that they can be empowered to ask for their own treatment. It must be really frustrating.

Rachel was able to discover the type of therapist she wanted to be, which included her belief that the client feel empowered in setting goals. She also felt that there should be "no false buy ins" when clarifying these goals.

Jen, Tina, and Carol mentioned that their experiences of therapy taught them about the importance of providing structure to therapy sessions in order to alleviate anxiety for the client. Jen felt too much responsibility for her sessions with her second therapist and through her experience she altered her own style to keep sessions structured by focusing on the client's initial goals. Carol commented on how the lack of structure led to increased anxiety because she felt somehow responsible for the sessions. Tina appeared to be the most sensitive to how the therapeutic process created anxiety for clients. As a result of her own therapy experiences she tried to normalize client anxiety during the process of therapy. She gained awareness of how difficult it was for her to feel safe and to trust despite all of her positive coping strategies, resources and knowledge of the therapeutic process. Tina explained,

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> It's an anxiety producing process and that's always something I am mindful of as a therapist and try not to contribute people's natural anxiety about being in such a vulnerable position to some sort of personality problem or some defense.

Because Tina had been sensitized to the client experience she was careful not to pathologize the situational anxiety clients initially display at the beginning of therapy.

Validation

Tina acknowledged the importance of providing clients what they ask for unless there was the potential for harm. Respecting that clients know what they need, Tina felt that she should validate her clients' personal strengths and empower them as much as possible. In order to assist the therapeutic process, Tina and Ashton discussed the importance of transparency and collaboration within therapy. Their roles as clients sensitized them to the value of a non-judgmental approach towards their own clients. Tina recognized the importance of avoiding the role of rescuer with clients in order to allow them to own their successes.

> It helped me to resolve the early issues of rescue fantasies and how demeaning that is to the patient. It sort of crystallized that for me. When you see yourself as having to rescue them (clients), you're not giving them the respect and the ability to rescue themselves and feel powerful that way and capable, which is curative in and of itself. I think that was the most crucial gift he gave me.

Ashton learned a powerful lesson of the importance of honesty when labeling abusive behaviors. Ashton felt that she had minimized her husband's behaviors and that when her therapist reflected back to her that the behaviors were emotionally

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abusive, her distress was validated. From this experience, Ashton learned to be honest with clients when she recognized abusive patterns in their relationships.

> I think it had a very big impact specifically in the area that I am working in, trauma. It's given me a new understanding because I think that I was minimizing my experience at the time in terms of the traumatic impact it might have had because it was mostly emotional abuse and control issues and she didn't let me do that. So it's impacted the way I work with clients now in that I am very much aware of power dynamics that they might have in their relationships and I probably speak up more than I would previously because I feel it myself. I know that, I've been there and I've had it validated by somebody else where I can say this is abusive and just label it.

Through Ashton's experience of therapy, she was able to develop a voice which she did not have previously. Her experience taught her that sometimes clients needed to have problematic behaviors named.

Avoiding Harm

The section, 'Boundaries: Negative Examples' identified several participants' perspectives on the experiences of personal harm that resulted from the therapeutic encounter. As a result of her experiences, Lori felt that the most significant lesson from her therapy was to avoid harming the client. Similarly, Jen and Carol agreed and framed it in the light of protecting clients from insensitively applied diagnoses. The women felt the stigma attached to diagnosis might impact future opportunities. Jen was given a diagnosis by her therapist, which led to shame and lingering self-doubt. Following a diagnosis of Borderline Personality Disorder, Jen struggled to understand

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her therapist's impressions. She was able to counter her self-doubt through discussions with friends.

> He also put some labels on me. He took the opportunity to diagnose me as a Borderline Personality. Well it was quite horrible and there was actually a lot of shame around it. I had that to myself and really didn't do anything with it. It was a long time before I told anybody about that piece.

In the end, Jen felt that her therapist had been insensitive and careless in his diagnosis. As a result of her experience she was able to recognize the powerful impact that a diagnosis can have on clients which transformed how she applied diagnosis with clients.

Carol also discussed the hurt she felt when she received a diagnosis. In her opinion the therapist was careless and insensitive regarding the process of diagnosis. Not only did she not discuss the diagnosis with Carol, but she gave Carol the form to send in to her insurance company. Carol disagreed with the diagnosis but felt disempowered in the process. She was not provided the information in advance, yet was expected to accept the therapist's impressions. Although Carol was able to discuss the diagnosis with her therapist at a later date, she felt that she should have fought harder to avoid having it as part of her records. Carol described her frustration this way:

> She gave me an OCD diagnosis…I think it was an inaccurate diagnosis and I still kind of think to myself, "Gosh darnit, I should have never allowed that". And I think that's going to be a diagnosis that's going to stay in my records forever.

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For both women, the diagnoses were harmful in that they caused them to question themselves. Jen and Carol felt excluded by their therapists, which left them feeling disempowered and doubting that they could trust their therapists. The process of diagnosis left the women with an understanding about the importance of collaboration with the client and being sensitive to the potential impact of diagnosis. They felt that diagnosis was an extremely powerful tool that needed to be used with the respect and dignity of the client in mind. Through their experiences, the participants no longer took for granted the process of diagnosis and were keenly aware of the potential impact on their clients.

Summary

The experiences of therapy as clients taught participants valuable lessons about the therapy relationship as well as the type of therapists they wanted to be. Participants tangibly experienced the vulnerability of the client role and gained empathy through their experiences. It seemed that in addition to their formal training, the participants' experiences of therapy allowed a deeper understanding of the client role. Further examples included avoiding harm to clients and how to empower clients in the therapeutic process. Through positive and negative examples participants learned about the importance of tailoring the sessions to the individual needs of clients. Overall, participants valued their therapy despite some negative experiences. They felt every experience improved their skills as therapists. Each participant acknowledged that their own therapy was a key part of their development as professionals and as individuals.

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Summary of Themes

While it is clear that participants had different experiences of therapy, there were many commonalities shared. Because six of seven participants had therapy early in their careers, it seemed that the awareness of personal and professional boundaries was not yet fully developed. This led to two participants having therapy with a supervisor, which created problematic dynamics and harm to the clients. Participants learned from both positive and negative examples of boundaries with their therapists. As a result of positive examples of boundaries, participants were able to contain and process traumatic memories and understand at a deeper level the issue responsibility. Unfortunately negative examples of boundaries led to a perceived lack of safety and increased guilt and shame regarding past issues.

Participants also shared moments in their therapy when they experienced "profound healing" within a "sacred space" with their therapists. Participants felt that the "Connection" with their therapists led to experiences of safety and trust in the therapeutic relationship. Other words used to describe their relationships were feeling empowered, understood and free from judgment. Because some participants saw themselves in a caretaking role in their personal relationships, they also appreciated the opportunity to be vulnerable in the presence of their therapists.

The participants' experiences of therapy were unique when compared to other clients due to the "Dual Processing" that existed. The "Dual Processing" was a result of participants' prior exposure to the therapeutic process either as students or as professionals. Some participants discussed how they felt prior knowledge had inhibited the depth of their therapy. This was partly because they were afraid of

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feeling judged. Also they felt it was difficult to be the client rather than intellectually process the experience as a therapist in training.

A final theme in the participant experiences was what they felt they learned from therapy that transferred to their work as therapists. Several participants discussed the impact of their therapy experiences on their supervision of students. Others emphasized that through their experiences they were able to empathize with the vulnerability of clients that led to belief in empowering clients throughout the therapeutic process. Other learning involved increased sensitivity to the difficulty clients have establishing safety and trust in the therapeutic relationship and the importance of avoiding harm.

Overall there were many commonalities in participants' experiences of therapy. All discussed both positive and negative impacts of therapy, and despite their experiences, were strong proponents of engaging in therapy. The most important reason acknowledged by participants was the increased ability to empathize with clients and the deeper understanding this created of their clients. Participants used their negative experiences to learn about what not to do with clients. Their positive experiences led to both personal and professional growth.

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CHAPTER SIX

DISCUSSION

The findings of this study have added to and complemented prior findings regarding the experiences of therapists as clients. One finding that emerged from this study was that despite prior knowledge of the therapy process, participants often sought therapy for similar reasons and struggled with the same kinds of issues as layperson clients. Another finding was that participants' experiences of therapy were impacted by prior knowledge of the therapeutic process and by their own expectations of themselves as professionals. Most prior qualitative studies connected the therapists' experiences of therapy with how it had impacted their practice of therapy. By posing the open question "What is the experience of therapist as client?" participants were able to discuss whatever they felt was important in their experiences. It appears that this was an important distinction as it allowed participants to expand beyond previous studies, into unexplored areas. This led to a deeper understanding of both the positive and negative aspects of therapists' therapy.

The themes that were identified in this study included "Boundaries", Connection', "Dual Processing", and "Learning Through Experience". Participants raised the important issue of "Boundaries" and how their experiences of therapy had been both positively and negatively impacted by their therapists' examples. "Connection" explored what participants felt was important about how therapists built the therapeutic relationship. It was interesting that the connecting factors of therapists' therapy did not differ significantly from those generally identified by layperson clients. Participants discussed that their therapist's ability to empathize helped to

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create safety and trust in the therapeutic relationship. Participants also explored the unique phenomenon of "Dual Processing" which involved therapists' simultaneously experiencing therapy for personal as well as professional growth. Finally, as in prior studies, participants highlighted what they had learned from their own therapy that would apply to their work with clients.

The overall findings in this study are generally consistent with similar qualitative studies (Macran et al., 1999; Mackey & Mackey, 1994; Wiseman & Shefler, 2001) regarding the issues facing therapists when they access therapy. Past qualitative studies have found that therapist clients' overall experiences of therapy have generally been positive (Macran et al., 1999; Mackey & Mackey, 1994; Wiseman & Shefler, 2001). Another common finding was that therapist's own therapy played a key role in enhancing understanding about the subtle aspects of therapy (Macran et al., 1999; Mackey & Mackey, 1994; Wiseman & Shefler, 2001). Most importantly it involved increased empathy for the client role. Other findings indicated that therapist clients had an increased understanding of theory and the therapeutic process (Molitor, 1984; Mackey & Mackey, 1993; Mackey & Mackey, 1994). Therapists also showed an increased self-awareness and the development of a professional self (Mackey & Mackey, 1993; Mackey & Mackey, 1994; and Wiseman & Shefler, 2001). Finally therapy enhanced the participants' understanding of how to differentiate between client and therapist issues (Macran et al., 1999; and Wiseman & Shefler, 2001).

The main finding of this study is best described as a paradox which is apparent at two levels. On the first level, therapist clients are at once similar and dissimilar to layperson clients. Therapist clients are similar in terms of the context of therapy and

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the problems that lead them to therapy. They are dissimilar however in terms of their dual processing and their unique vulnerability with respect to boundaries. The second level of the paradox is that therapists' prior exposure to theory and interventions both simplified and complicated their experiences. As Geller (2005) claimed therapists' therapy was simplified due to their "greater awareness of the customs, conventions and language" (p. 381) of the process. He added however that they are also more likely to "detect those moments when therapists deviate from accepted practices and when they are not good patients" (p. 381). Therefore prior knowledge of the therapeutic process did not always enhance the experience of therapy. In fact, prior knowledge often interfered with participants' ability to benefit fully from therapy. In addition, despite participants' prior knowledge of therapy, they were not guaranteed an empowered presence in therapy.

What was not unique to the therapist-as-client dynamic was that therapists above all else are people with the same types of problems as layperson clients. In their research, Norcross and Connor (2005) found the common presenting problems of therapist clients were anxiety, depression, and marital conflict. These problems paralleled the issues found in layperson clients. Likewise, the participants in this study sought therapy due to distress stemming from relationship difficulties, depression and other problems associated with common life transitions. The similarity in presenting issues is an important piece of the overall resemblance of therapist clients to layperson clients and a reminder of the common factors that weave together the experiences of 'healer' and client.

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Norcross and Guy (2005) capture this part of the paradox by stating, "It is apparent that psychotherapists struggle with the same psychological conflicts, life transitions, and existential questions as the clients they serve. Perhaps this is not only inevitable but as it should be" (p. 174). What makes this similarity difficult is that many therapists struggle to be positive examples of mental health in their professional lives, while at the same time being unavoidably human in their personal lives. As a therapist, one may be expected to be able to rise above what others toil over. This expectation creates an impossible standard, yet it is encouraged both subtly and overtly throughout one's professional development.

Despite the similarities with layperson clients, therapist clients' issues are complicated because their personal and professional selves are so strongly intertwined. In this study, all of the participants except one sought therapy during their graduate work. According to participants' accounts, the transition into graduate school involved shifting responsibilities and a re-evaluation of priorities. There are several reasons why this period of transition is particularly difficult for therapy students. In addition to the regular graduate school responsibilities and pressures, student therapists have the expectation to be mentally competent and to deal with the competing pressures of work, school and family, in order to work effectively with clients (Looney, et al. 1980).

Due to the reflective nature of psychology and the need to know the self, graduate students often re-examine their relationships with family and significant others during this period. The nature of therapy also requires student therapists to be present with their clients and be aware of the impact of client issues on their own

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functioning. It is not surprising therefore, this period of transition and redefinition is often when therapists access therapy. As discussed in the literature review (Farber, 1983; Glass, 1986 and Dubovsky & Scully, 1990) times of transition and developmental change can prove extremely stressful for individuals whether they are layperson clients or therapist clients. For newer therapists, the distinction between their personal and professional selves is not yet fully developed making personal therapy extremely challenging.

Another challenge facing therapist clients is their desire to learn both personally and professionally from their experiences of therapy. This desire for both personal and professional growth was captured in the theme "Dual Processing" . On one hand, dual processing simplified therapy because knowledge of the therapeutic process enhanced therapist clients' understanding of their therapy. Conversely, prior knowledge also complicated therapy because therapist clients' simultaneously processed intellectual and emotional material. That is, participants acknowledged the difficulty of attending to their emotional processes while cognitively integrating information about the therapeutic process. Therefore the goal of understanding the therapeutic process to achieve professional growth interfered with the goal of experiencing the process for personal growth. The relationship between these goals, although symbiotic, proved complicated because of therapist clients' tendency to intellectualize as part of their professional role as well as personal style. As a result of the dual processing, participants struggled to be transparent. This was due to their fear of being judged by their therapists, as well as the self-imposed judgment some participants described.

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The factor that was unique in the therapist-as-client dynamic and appeared to have to the most significant impact on the overall experience of therapy for participants was the boundaries demonstrated by therapist providers. When therapists clarified boundaries participants experienced safety and trust in the therapeutic relationship. Positive modelling of boundaries by therapists also led to increased understanding of responsibility in relationships for participants. Problems that resulted from negative modelling of boundaries by therapists included a decreased feeling of safety and trust in the therapeutic relationship. Unfortunately, negative experiences of boundaries also had the potential to impact the participants' future clients. Because of the overall importance of this theme to the experience of therapy further expansion and discussion is warranted.

Boundaries

The theme of "Boundaries" was chosen for further elaboration due to the importance given by participants to the issue throughout the interviews. When participants identified positive examples of boundaries, they appeared to better understand their own responsibility which allowed for a healthier understanding of relationships. Conversely, negative examples exacerbated previous problems and led to harm for some participants. The unique vulnerability that resulted from the participants' roles and prior knowledge of the process made them impressionable to both positive and negative experiences with their therapists. Their experiences demonstrated the importance of the early clarification of boundaries between therapist providers and therapist clients. The examples that were discussed involved personal and professional boundaries which included clarification of roles and overlapping

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relationships, differentiating client and therapist issues, as well as containing past trauma. A very important finding of serious concern to the profession that emerged from this research was that some therapists offering therapy to student therapists did not demonstrate a professional respect for boundaries in their relationship with their clients.

In discussing his experiences of therapy, well-known British therapist Dryden (2005) claimed that none of the three therapists he saw had elicited informed consent. Only one of the therapists in the present study mentioned whether there had been a discussion regarding the limitations of confidentiality. Other participants chose not to elaborate or felt that adequate discussion of the pertinent issues was lacking. Clarifications of boundaries, reviewing the limits of confidentiality and the creation of a therapeutic contract with therapist clients were important but overlooked components of the establishment of a solid therapeutic foundation.

Also consistent with the results of this study, Lichtenberg (2005) felt that critical elements in dealing with boundary issues were openness, directness, avoiding exploitation and mutual respect. As discussed by participants, when therapists were direct and transparent about the existing hierarchy and the likelihood of dual relationships, safety and trust increased. When therapists normalized the client's need for help and acknowledged the courage required to seek therapy, clients felt empowered and validated. Appropriate boundaries in the professional relationship allowed for safety and containment within the therapeutic relationship, thereby ensuring the therapist's attention to responsible caring.

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This study shows that despite therapists clients' prior knowledge of the importance of boundaries in the therapeutic relationship, they remain vulnerable due to the implicit power differences between therapist and client. Brown (2005) felt that therapist clients were willing to give up too much power and needed to be more active within sessions to model boundaries. This lack of assertiveness was evident in the present study, especially when there were overlapping relationships, for example when supervisors or professors provided therapy for their students. Problems that resulted from overlapping roles and lack of clarified boundaries were decreased safety and trust in the therapeutic relationship, as well as the re-triggering of past trauma.

For some participants, dual roles were manageable when their therapist clarified and modeled appropriate boundaries. When therapists clarified overlapping relationships, it allowed participants to safely explore their own vulnerabilities and more effectively contain past issues. In turn, they developed healthier boundaries with their own clients and in their personal relationships. This is echoed by Wittine (2005) who wrote: "With a safe, containing therapist, the inner search unfolds with greater freedom and ease; without the therapist's presence, searching is difficult if not impossible" (p. 125).

Consistent with the results of this study, Pearlman and MacIan (1995) and Pinsof (2005) noted an additional vulnerability for therapist clients with a prior history of trauma. When therapist's past history of trauma is not sufficiently processed, the potential impact on their clients is significant. Two of the participants felt they were unable to object to inappropriate interventions offered by their therapists because of their personal histories of having been traumatized. This was especially difficult

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within an overlapping or dual relationship where implicit power differences were apparent. For clients that already have a history of abuse or other trauma the resulting boundaries violations by their therapists are much more hurtful and damaging.

Research exploring the harmful aspects of therapy with therapists is limited. Buckley et al. (1981) and Williams et al. (1999) found that 27% and 21% respectively of psychologists surveyed found some aspect of their therapy harmful. According to Grunebaum (1986), therapists who experienced harm in their therapy wanted to share "their experiences in order that a discipline which they cared deeply about might learn from the experience." (p. 174). While participants in this study were open to sharing negative experiences, it appeared that the participants made every attempt to be fair to their therapists in recounting their stories. One benefit of this research was that it allowed for further processing of the events and, for one participant in particular, allowed a sense of closure that had not been achieved prior to her interview.

A suggestion arising from this study is that it is essential that therapists are proactive in addressing the difficulties that arise in therapists' therapy. One way to alleviate this problem for future therapists is to educate students about these issues when they seek therapy. In this way, they would be more prepared to challenge situations that create discomfort and know the appropriate channels to seek. Suggestions to address the problems discussed in this study are offered in the following section for therapy programs, therapist clients and therapist providers.

Implication for Mental Health Professionals

Based on the findings of this research I will offer some reflections for mental health professionals on the implications of this and other research for those seeking or

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providing therapy for colleagues. It is hoped that these suggestions will contribute to raising the awareness of therapy programs, therapist providers, and therapist clients. By addressing the issues at three levels increased understanding of both the benefits and risks inherent in therapy for the therapist will be achieved.

Therapy Training Programs

Despite the fact that their programs had not mandated therapy, participants consistently commented that they felt one's own therapy was important in one's professional development. They did not necessarily however support the idea of mandating therapy. Today many graduate programs in psychology have already made a choice about whether or not to mandate therapy for students. One argument in support of mandated therapy is its usefulness in addressing student impairment. Another reason programs mandate therapy is that it is viewed as an important step in one's professional development. While programs have the best intentions in mind when encouraging therapy there is little doubt that by requiring therapy, a problematic dynamic is created. When programs become involved in whether or not their students choose to receive therapy, it is difficult to anticipate the impact of their involvement and the inherent risks.

Despite the overall support in favor of therapy for the therapist, some have pointed out that therapy other than for relief of symptoms changes the dynamic of therapy. In his discussion of the role of personal therapy in the formation of an analyst, Kirsch (2005) wrote:

> The person who enters analysis with the idea of becoming an analyst had a definite aim or goal beyond his or her therapy. This person wishes to have the

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analysis serve the ego aim of becoming an analyst...Such an aim is clearly different from that of a person who comes for the relief of symptoms (p. 30).

Kirsch concludes that a person's reasons for attending therapy impact the dynamics of therapy. When one has therapy as an expectation of training, there is a focus on mastering the techniques and nuances of the profession. When one has therapy to deal with personal problems the objective is individual growth. If we use the metaphor of therapy as a journey, perhaps this difference will become clearer. When a person is instructed to pay attention to the architecture they pass on their journey, their experience of the journey is different than a person who does not have prior instructions. Perhaps they notice similar things along the way, but creating an expectation of learning prior to the experience cues the individual towards certain parts of the experience. The same can be argued for therapists who are expected to have therapy as part of their training; their experiences are altered when they are expected to attend to cues in the therapy process.

McEwan and Duncan (1993) discussed the problems created by mandating therapy for students. These included: lack of choice of their therapists, inadequate warning of the harm of dual relationships and inappropriate follow-up care by their therapists. Clearly, several questions need to be addressed prior to programs' involvement in the process. What can a graduate program do to encourage yet not interfere with students in the process of seeking therapy? For programs that choose not to require therapy, how can they implement policies that will encourage their students to be healthy enough to overcome the various personal and professional challenges

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that the discipline requires? What is a program's obligation to ensure, as much as possible, the well being of its graduates?

One option to mandating therapy would be to focus more on the training of young therapists to help them recognize signs of impairment. Suran and Sheridan (1985) offered several suggestions for graduate programs in psychology. One example was to have a series of courses or information sessions with the goal of educating students about impairment, professional development issues, burnout, and self-care. Another suggestion was the need to balance performance demands on graduate students with the need for personal growth. It is important that suggestions target both students and professors because of their combined ethical duty to address the needs of clients.

As mentioned, six of seven participants in this study accessed therapy during graduate school. These participants commented about the unique stressors at this point in their careers despite identifying other issues as their main impetuses behind therapy. What each participant demonstrated was an awareness of the importance of understanding their own issues prior to helping clients with their problems. A good reminder therefore for student therapists is the importance of self-reflection and an understanding of the signs and symptoms of impairment.

While it is important for supervisors and professors to monitor the functioning of students, it is also important that they acknowledge the vulnerability and stress that students are under as they enter graduate school and a new profession. Rather than mandated therapy, a more pertinent intervention may be to make therapy more accessible and more ethical in its implementation. As Glass (1986) suggested, one part

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of the solution would be to have programs compile a list of practitioners, their area of specialty, and whether they are willing to see students at a reduced rate. Programs could also consider options that offer students either formal or informal support while avoiding the feelings of inferiority and vulnerability.

Participants in this study found it difficult to recognize when they were in crisis and to be assertive about the desired characteristics for a therapist. As preparation for future therapists therefore, student training could also include an exploration of therapist characteristics viewed as valuable to the individual. Although it may be difficult to anticipate what will be needed from a therapist, students can begin to ponder decisions that must be made prior to therapy. Through phone calls and consultation with professionals in the community, students could narrow their choices of therapists should need arise. By putting students through a mock search, they would be supported and encouraged in the process. Another benefit of the exercise would be that students become sensitized to the obstacles facing their clients in the search for a therapist, thus enhancing empathy for the client role.

Another option mentioned by one participant was a peer support group offered in her program. This group was composed of graduate students and was operated as an informal process group in which they could freely discuss issues of concern to them. This type of group offers advantages to students because they are able to discuss the issues of concern without feeling evaluated in the process. These suggestions will help programs achieve a more open and supportive atmosphere that prioritizes self-care and avoids pathologizing the need for help. It will be important that programs are sensitive about how to best support students while empowering them through the process.

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Although an argument could be made that programs should not be responsible for private aspects of their students' lives, I suggest that it is in the best interest of all concerned that programs do their best to address impairment prior to the students' entrance into the profession.

Therapist Clients

Therapists seeking therapy may want to consider several issues before proceeding. It is important for therapist clients to have an idea of the qualities they find desirable in a therapist and that they be assertive in their search for assistance. As part of the search process it will be important to solicit information regarding their options from trusted mentors in the community. It may be helpful to create a list of questions and interview several therapists before making a decision. Therapist clients need to clarify their expectations and goals for therapy so that they will know who is qualified to meet their needs. It is also important that they increase their awareness of the pertinent issues facing therapists in therapy with a focus on boundaries and dual processing.

After locating a therapist, therapist clients must be empowered in the process of informed consent and express any dissatisfaction or need for clarification of issues. In the creation of a therapeutic contract, it is recommended that therapist clients explore whether their therapists have had experience addressing the presenting issue and how they conceptualize treatment. This information will help clients to decide whether the therapist is competent to address their concerns or whether they should ask for other referrals. Dryden (2005) agreed it is important for clients to know what the therapist is offering in order to decide whether they want services.

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In order to increase understanding about therapy for therapists, therapist clients should be informed about the inevitable dual-processing that occurs in sessions. It is important that they understand the likelihood that their professional experiences will influence their experiences as clients. One strategy used by a participant to assist him in remaining present while in session was the use of a journal following sessions to record thoughts about what was learned during the session. Another suggestion is for therapist clients to be open and honest with their therapists about how they are processing the session. In this manner, they will be able to explore assertiveness within the safety of the therapeutic relationship.

Finally, therapist clients are encouraged to allow themselves to be vulnerable in the therapeutic process. Through open and honest reflection they will be more fully aware of their own processes. Although initially this may not be a comfortable position for therapist clients, with a safe and containing therapist their own transparency will permit deeper and more meaningful work. In turn, the increased self-awareness that will result from therapy will also benefit their future clients.

Therapist Providers

An interesting question raised in recent research (Geller, Norcross & Orlinsky, 2005) is "What qualifies a therapist to provide therapy to other therapists?" It would seem that in order to be a therapists' therapist one would want to have some awareness of the unique issues and challenges of working with colleagues. As noted in the literature review, there is an abundance of quantitative research on this special population (Shapiro, 1976; Grunenbaum, 1983; Norcross et al., 1988a; and Bridges, 1983). There has, however, been very little attempt to understand what therapist

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providers do or should do to prepare for the process. It is important that therapists have specialized training concerning the issues that arise due to the unique challenge of providing therapy to other therapists. I would recommend that a discussion with the client occur early in therapy which highlights potential areas of concern and creates an open forum for future problems.

Participants discussed the characteristics they valued in their therapists. Qualities such as openness, empathy, a non-judgmental attitude, warmth, respectfulness and competence were mentioned by participants and supported by prior studies (Grunenbaum, 1983; Orlinsky & Ronnestad, 2005; and Norcross et al., 2005). Other important characteristics discussed by participants were a sense of humour, a non-pedantic approach and an ability to empower clients. Participants' reactions to their therapists depended on how well they were matched, whether that included theoretical orientation, gender, or age. There was no perfect therapist's therapist. Instead, choice of therapists was based on personal preference and on the client's presenting issues.

While the above qualities are important, it is also essential for therapist providers to be aware of potential problem areas when the client is also a therapist. The most significant issue is the potential for overlapping relationships, which can cause significant distress for both client and therapist. Brown (2005) suggested that dual relationships can lead to more limited social and professional involvement in the therapeutic community, for example not attending conferences or meetings that include their clients. If this is not possible, clarity of roles is essential in order to protect both therapist and client. Another important recognition is the therapist's

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ethical duty to be competent to treat the client's presenting issues. Although prior treatment of therapists may be advantageous, it does not create competence with the next therapist, who may present with different issues. Therapists must therefore be willing to refer clients on to other professionals who may be better qualified to address the clients' particular issues.

As mentioned earlier, therapist providers must also acknowledge the inherent power differences within the therapeutic relationship and work collaboratively to address this dynamic. Their clients may see the therapist providers as mentors which Brown (2005) felt was addressed by making this a conscious part of the therapy. Another important therapeutic issue for providers to recognize is the vulnerability of therapist clients, which includes the potential shame regarding the need for help and fear around losing credibility with the therapist.

As part of the acknowledgement of dual roles, therapist and client should plan accordingly regarding how to deal with outside contact. Early and ongoing clarification of roles is essential because of the likelihood of overlapping roles for therapist provider and therapist client. Therapist providers should take precautions in order to safeguard the confidential nature of the therapeutic relationship. In order to alleviate any concerns by therapist clients, an ongoing discussion about what is being done to maintain confidentiality is recommended. Therapist providers should therefore use discretion in supervisory meetings, case conferences and during consultations with other therapists. Not only does this protect the therapist, it also helps to ensure safety for the client by clarifying the parameters and expectations inherent in the relationship.

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Finally, it is also important for the provider to be cognizant of the relevant issues to therapist clients at different points in their careers. Therapists accessing therapy during training will likely be more vulnerable to boundary violations and therefore strong clarification of these issues is advised for this group. Therapists later in their careers may have greater difficulty being vulnerable and admitting these vulnerabilities in session. As well, they may also feel more sensitive to judgment if they seek help later in their careers.

Considerations of the Present Study

The first consideration resulting from this study involved the narrowness of the group of participants chosen for interviews. A snowball sampling technique was used which relied on word-of-mouth to spread the information regarding my area of interest. Once the criteria for participation were developed, I discussed the topic with friends, supervisors, professors and acquaintances in the field. Through this process, seven participants were interviewed. A consideration when reading the results therefore is that only certain psychologists were informed of my study which limited the participants to a narrow group. Although participants shared both negative and positive experiences of therapy, overall they felt that therapy was an important part of the professional development of young therapists. It is likely not all therapists have this same view of the process. In relation to sampling considerations, it is also important to acknowledge that six of seven participants were female and were students during their experiences of therapy. This likely impacted how they experienced therapy when compared to the more experienced male participant.

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A second factor to be considered is that the data was gathered through retrospective accounts and human memory is highly fallible. Although the researcher can often interpret beyond words, the research is influenced by the participant's ability to remember and translate their memory into a verbal account of the therapy experience. The time that elapses between the experience and retelling of the experience therefore may impact the breadth and depth of participants' reflections. An

Directions for Future Research

Geller et al. (2005) in their recent study of therapy with therapists discussed several questions that remain despite present research. How do we ensure that the services provided to therapist patients fulfill the ethical requirement of working within one's area of competence? Does competence in working with adult non-therapist patients automatically qualify one to treat therapist patients? The resolution of these questions is even more important when we acknowledge the dual burden placed on therapists' therapists because of the likelihood that they will be viewed as role models. Also the impact of therapists' therapy is twofold because the lessons learned by therapist clients are also passed on to their clients. As the researchers suggested, there may be a place for the provision of information regarding treatment of this special population within training institutions.

Due to the limitations posed by studies based on retrospective accounts of the therapists' therapy, another possibility for future research could be the use of narrative accounts of therapists' therapy as it is unfolding. Through the use of journals, writings and other creative means of expression, the current understandings gained through the

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process of therapy could be shared with readers. In this way, the passing of time will not interfere with their ability to recall impactful moments in therapy.

Final Reflections

I feel fortunate to have undertaken this research project. I have felt honored that the participants allowed me into their "sacred spaces" and were able to share their more vulnerable selves. In the process, I learned both about the positive and negative elements of receiving therapy as a therapist. The negative elements served as a caution to me about the dangers that can occur when the inherent power differences in therapy are not respected. Negative impacts also provided a tangible reminder of the importance of clarifying boundaries with clients. At the same time, the positive impact of therapy served to increase my hope and belief in my chosen profession and to remind me of the valuable work that can be achieved within a trusting and supportive environment. I feel confident that this study has contributed to the developing picture of what the experience of receiving therapy as a client is to therapists. This is an important area of research and one in which much research remains to be done.

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Appendix A

Letter of Introduction/Purpose of Study

The Experience of Therapists as Clients

My name is Karen Dushinski and I am a Doctoral student in counselling in Educational Psychology at the University of Alberta. I am undertaking research in an attempt to gain a clearer understanding of the experience of therapists as clients. My interest in this topic stems from discussions with psychologists regarding the importance of having their own therapy as part of the learning process.

Your participation in the study will include an interview and debriefing. I would like you to take some time to think about your experiences in therapy as a client. I would like you to be able to discuss your experience as freely as possible and that you only share what you are comfortable sharing with me. The interview will last approximately sixty to ninety minutes and will be tape recorded for later analysis.

The final interview will occur after I have analyzed the information gained during out interview. This will allow for an opportunity to correct any misunderstandings or misrepresentations of your experience and for me to share my understanding of our interview.

All of the information obtained about you will be kept confidential. I will choose a false name for use in the information in order to maintain this confidentiality, and I will remove any information that could identify you to others. I will keep the information gained from the interview in a secure place

Your participation in the study is entirely voluntary and you have the right to withdraw at any point. If you decide that you do not want to participate in the study, any information about you will be destroyed.

Thank you in advance for your time and willingness to share your experiences with me. If you have further questions about the process please feel free to call me at (780)-431-2169, or you can call my supervisor, Dr. Robin Everall at 492-1163.

Yours Truly,

Karen Dushinski

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Appendix B

Consent to Participate

I, _____, am aware that the purpose of this study is to try to understand the experience of therapists as clients. I understand that this process will include an introductory interview, taped 60 to 90 minute interview and a final corroborative interview. I understand that I will be asked to describe my experiences in as much detail as I am able. I also understand that Karen Dushinski is conducting this research for the purpose of a doctoral dissertation under the supervision of Dr. Robin Everall of the Educational Psychology Department at the University of Alberta.

I agree to participate in the study and I am willing to share as much as I feel comfortable sharing with Karen. I am aware that the interviews conducted require tape recordings in order to allow for transcription and further analysis. I am aware that my participation in this research is voluntary and that I am able to withdraw from the study at any point. If I choose to withdraw from the study, any information about my experiences or me will be destroyed. I am also aware that if discussion of my experiences raises any concerns for me that I wish to discuss with a therapist, Karen will recommend individuals that I may contact.

I am aware that all information associated with this study is strictly confidential and that my identity, or that of any persons that I mention, will be known only to the researcher and not be revealed at any point. When transcribing the interview recording, the researcher will not use my name or the name of any individuals that I may mention. False names will be provided and will be altered to ensure anonymity. As well, the researcher and her supervisor will be the only individuals with access to the tape recordings or interview transcripts, and these will be stored in a secure place.

I am aware that the information obtained from the interview(s) will be used solely for research purposes (dissertation, articles, and/or presentations), and that by signing this consent form it in no way releases the researcher from her professional or legal obligations. This study has been reviewed and approved by the Research Ethics Board of the Faculties of Education and Extension at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the Research Ethics Board at (780)-492-3751.

Signature _____
Date _____
Witness _____

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Appendix C

Interview Guide

Could you please tell me about your experience of therapy?

Could you discuss any aspects of therapy that were helpful?

Could you discuss any aspects of your therapy that were harmful?

Could you describe elements of your decision-making process before entering therapy?

What were the criteria you used in order to make your choice of therapist?

How would you characterize the experience of having therapy?

What have you taken away from your experience?

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