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TRAINEE CLINICAL PSYCHOLOGISTS' EXPERIENCE OF PERSONAL PSYCHOTHERAPY IN THE CONTEXT OF PROFESSIONAL TRAINING.

by

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ABSTRACT:

Personal therapy for psychologists in training has been the subject of extensive debate but little systematic research. Only a few studies have explored the issue from the trainee's perspective. The aim of this study was to investigate trainee clinical psychologists' subjective experience of personal psychotherapy in the context of professional training. The participant sample was distinctive in that they had to undergo mandatory personal therapy as a training requirement. Qualitative data was collected through semi-structured interviews with nine intern clinical psychologists who had all done their psychodynamically oriented training at the same university. Thematic content analysis was used to generate salient themes relevant to the self-perceived impact of mandatory personal therapy on participants' personal and professional development. While some initial ambivalence and resistance to mandated treatment was evident, participants generally considered their personal therapy to have provided a valuable learning experience that complemented their professional training by deepening their understanding of the therapeutic process and the dynamics of psychotherapy. It was reported to increase empathy for their patients, to promote greater awareness of countertransference dynamics, and to serve a modelling function. Participants reported an increased appreciation of the value of personal therapy and eight of the nine participants endorsed mandatory personal therapy as a professional training requirement. Time, financial cost and the emotional strain of self-inquiry were mentioned as negative features of personal therapy.

TABLE OF CONTENTS

CHAPTER 1 INTRODUCTION 1
1.1 GENERAL INTRODUCTION 1
1.2 RESEARCH RATIONALE 2
1.3 RESEARCH AIMS 2
1.4 CHAPTER DIVISION 3

CHAPTER 2 LITERATURE REVIEW 4
2.1 INTRODUCTION 4
2.2 THE HISTORY OF PERSONAL THERAPY 5
2.2.1 1912-1918: The Origin of the Training Analysis 6
2.2.2 Budapest, 1918, to Bad Homburg, 1925 8
2.2.3 1925-1945: Institutionalization of the Training Analysis 9
2.2.4 1945 to the 1980's: Criticism of the Training Analysis 11
2.2.5 1990's to the Present: Developments and Regulations 14
2.3 RESEARCH ON PERSONAL THERAPY 17
2.3.1 Quantitative Surveys 18
2.3.2 Qualitative Studies 25
2.4 CONCLUSION 28

CHAPTER 3 RESEARCH METHOD AND PROCEDURE 29
3.1 INTRODUCTION 29
3.2 RESEARCH DESIGN 29
3.3 QUALITATIVE METHOD 30
3.4 SAMPLE 31
3.4.1 Sampling Strategy 31
3.4.2 Selection of Participants 31
3.5 DATA COLLECTION 33
3.6 DATA ANALYSIS 35
3.6.1 Step 1: Open Coding 36
3.6.2 Step 2: Axial Coding 37
3.6.3 Step 3: Selective Coding 38
3.7 QUALITATIVE VALIDITY 39
3.7.1 Credibility 39

3.7.2 Transferability 39
3.7.3 Dependability 40
3.7.4 Confirmability 40
3.8 ETHICAL CONSIDERATIONS 40
3.8.1 The Committee for Research on Human Subjects (CHRS) 40
3.8.2 Informed Consent 41
3.8.3 Anonymity and Confidentiality 41
3.8.4 Researcher Integrity and Reflexivity 42

CHAPTER 4 RESULTS AND DISCUSSION 44
4.1 THEME 1: PERSONAL THERAPY AS PART OF TRAINING 47
4.1.1 The Mandatory Requirement of Personal Therapy 47
4.1.2 The Importance of Personal Therapy as Part of Training 52
4.1.3 The Challenges of Personal Therapy Concurrent with Training . 56
4.1.4 Separating Personal Therapy from the Training 59
4.2 THEME 2: THE IMPACT OF PERSONAL THERAPY ON A PERSONAL LEVEL 62
4.2.1 Insight and Personal Growth 63
4.2.2 Impact on Close Relationships 66
4.2.3 Support and Containment 69
4.3 THEME 3: THE IMPACT OF PERSONAL THERAPY ON A PROFESSIONAL LEVEL 71
4.3.1 The Therapeutic Process 71
4.3.2 The Frame 73
4.3.3 Theory 74
4.3.4 Empathy 75
4.3.5 Modelling 77
4.3.6 Countertransference 79
4.3.7 Professional Growth 81
4.4 THEME 4: THE THERAPEUTIC APPROACH 81
4.5 THEME 5: INITIAL VERSUS LATER EXPERIENCES OF PERSONAL THERAPY 84
4.6 THEME 6: PERSONAL THERAPY AS SUPERVISION 86
4.7 THEME 7: FINANCIAL IMPLICATIONS 88
4.8 SUMMARY 89

CHAPTER 5 CONCLUSION, LIMITATIONS AND RECOMMENDATIONS 94

REFERENCES 96

APPENDIX A PARTICIPANT INFORMATION LETTER 107

APPENDIX B INTERVIEW CONSENT FORM 109

APPENDIX C CONFIDENTIALITY FORM 110

APPENDIX D GENERAL INTERVIEW GUIDE 111

CHAPTER 1 INTRODUCTION

1.1 GENERAL INTRODUCTION

Historically, one of the most firmly held beliefs among psychotherapists is that personal therapy is either a desirable or necessary prerequisite for conducting clinical work (Dryden & Spurling, 1989, p.232). In *Analysis Terminable and Interminable* (1937, p.246) Freud asks concerning the psychotherapist: “But where and how is the poor wretch to acquire the ideal qualifications which he will need in this profession? The answer is in an analysis of himself, with which his preparation for his future activity begins.” The desirability of personal therapy for therapists has since been the subject of much debate.

Today opinions on the benefit of personal therapy are split. On the one hand trainee psychologists (Macaskill, 1988; Macaskill & Macaskill, 1992 Murphy, 2005) and qualified clinical practitioners (Darongkamas *et al., 1*994; Grimmer & Tribe, 2001; Pope & Tabachnick, 1994) have found personal therapy to be a positive experience. On the other hand, some studies have found a lack of supporting evidence for the value of personal therapy as a training requirement (Macaskill, 1999).

While personal therapy is not a mandatory requirement of most professional psychology training programmes in the USA (Pope & Tabachnick, 1994), training institutions and registration bodies in the UK (e.g. the British Psychological Society) usually recommend or require personal therapy for psychotherapists and trainee psychologists (Darongkamas, Burton & Cushway, 1994; Grimmer & Tribe, 2001; Murphy, 2005).

In South Africa personal therapy is a mandatory course requirement at only one of the fourteen universities that offer programmes in clinical psychology, namely the University of the Witwatersrand (Wits). It is also not required for registration purposes by the official body that oversees the registration of psychologists, the Professional Board for Psychology. In fact, according to

Chapter 2, section 11 of the Rules of Conduct Pertaining Specifically to the Profession of Psychology (2006), in South Africa any psychotherapy client should be "aware of the voluntary nature of participation and has freely and without undue influence given his or her consent." This serves to further complicate the matter of mandating personal therapy for trainee psychologists.

1.2 RESEARCH RATIONALE

Personal therapy for therapists has been the subject of extensive debate but "little systematic investigation" (Macran & Shapiro, 1998) and very few studies have explored the issue from the trainee's perspective (Grimmer & Tribe, 2001; Murphy, 2005). In their review of the role of personal therapy for the therapist, Macran and Shapiro (1998) recommend that future studies concentrate on the experiences of, and the nature of the processes involved in, personal therapy. Ten years hence the existing research still does not capture the trainee's subjective experience of personal therapy.

The researcher could not find evidence of previous research done in South Africa on personal therapy in a training environment, much less on psychologist trainees' experiences of personal therapy. In light of research questioning the value of personal therapy in this context (Macaskill, 1999) it seems reasonable to explore trainees' perspectives on, and experience of, personal therapy.

1.3 RESEARCH AIMS

The primary purpose of this study is to explore, describe and interpret trainee clinical psychologists' subjective experience of personal psychotherapy in the context of professional training.

The secondary aim of the study is to generate information that could be used to inform training programmes at institutions involved in the training of clinical

psychologists. There is much debate, but little research about recommending or mandating personal therapy as part of training. It is hoped that this study will provide useful information on trainees' experiences and views of personal therapy, in order to better inform the decisions training institutions make on this aspect.

1.4 CHAPTER DIVISION

Chapter One provides an introduction, followed by the motivation and aims of the study.

Chapter Two presents an overview of literature relevant to the study, with specific reference to research focusing on personal therapy in a professional training context.

Chapter Three comprises the research methodology. It includes a discussion of the qualitative research design, the thematic content analysis method of data collection and analysis, and the trustworthiness of the study. The chapter concludes with a discussion of the relevant ethical considerations.

Chapter Four presents the results. Each participant's response is analysed utilising thematic content analysis. The resulting themes are then presented and discussed.

Chapter Five provides an integration of the results with the existing literature. It summarises the conclusions drawn from the study and puts forth some recommendations for future research. Finally, the limitations of the study are also discussed.

CHAPTER 2 LITERATURE REVIEW

2.1 INTRODUCTION

This chapter opens with a discussion of the origin of personal therapy or, as it was initially known, “the training analysis”. The aim of discussing the history of the training analysis is to provide a context for the understanding of personal therapy today. It informs the reader of the original rationale for personal therapy, its development and the controversies around it.

The history is followed by a summary of some current regulations on personal therapy as a training requirement in South Africa and countries like the UK, USA and Australia. The summary of current regulations further serves to clarify the context of personal therapy today. The chapter then presents an overview of relevant research on personal therapy in a training and professional context. The existing research is mostly from the USA and the UK, but also includes studies from Sweden and Canada. The sample populations in the studies are therapists and trainee therapists from the fields of psychology, psychiatry and social work.

Relatively few studies were found on personal therapy in the context of training or even clinical practice. This is a fact also lamented by some of the authors of previous studies on this subject. Mackey and Mackey (1994) found that “although theory, experience and anecdotal evidence support the value of personal therapy for clinicians, relatively little research has been done on the subject” (p.97). Macran and Shapiro (1998) and Macaskill (1999) did a thorough review of the research literature on personal therapy and found it lacking in “methodologically sound research” (Macran & Shapiro, 1998, p.13). In more recent years the situation has not changed and personal therapy is still a neglected area of study.

The research literature that was found concerned itself with personal therapy for trainees and clinicians in the field of psychotherapy and includes studies that focused on aspects such as:

- the purposes and outcomes of personal therapy (Pollard, 2005);
- the value of personal therapy for psychotherapy trainees (Mace, 2001;
- the value of personal psychotherapy to clinical practice (Mackey & Mackey, 1993);
- the experience of personal therapy for trainees (Murphy, 2005);
- experiences, problems and beliefs around personal therapy (Pope & Tabachnick, 1994);
- the significance of personal therapy to the development of a professional self in students and therapists (Mackey & Mackey, 1994);
- the role of personal therapy for therapists (Macran & Shapiro, 1998)
- the value assigned to personal therapy by trainees (Weintraub, Dixon, Kohlhepp & Woolery, 1999);
- the relation between personal therapy in training and patient change (Sandell, Carlsson, Schubert, Grant, Lazar & Broberg, 2006);
- the personal versus the training analysis (Szecsody, 2003);
- perceptions of the impact of mandatory personal therapy on professional development (Grimmer & Tribe, 2001);
- the risks of personal therapy (McEwan, 1993);

2.2 THE HISTORY OF PERSONAL THERAPY

Personal therapy for the therapist was initially called a “training analysis”, but it was not considered important in the training of the first analysts. Many of the first analysts like Jung, Abraham and Rank were never analysed. Freud’s first students learned about psychoanalysis by reading his works and occasionally submitting their dreams and neurotic symptoms to him (Desmond, 2004). Freud treated his students like colleagues and he would discuss psychoanalytic theory, their patients and work, and the politics within the psychoanalytic circle with them. When and if he did analyse them, it was over a short period, typically a few weeks or months, during which he would

emphasize the workings of repression and dream formation (Desmond, 2004). This was referred to by Balint (1954) as the period of “demonstration”.

In 1954 Balint distinguished five periods in the history of the training analysis. He described the early metamorphosis of the training analysis as going from a period of “instruction” to “demonstration” to the “proper analysis”.
The period of instruction involved the acquisition of intellectual knowledge through reading Freud’s works. Balint refers to Freud’s regular walks with Eitingen in 1909 as an example of the second period of “demonstration”. Balint credits Ferenczi with initiating the third period, that of the “proper analysis”. Ferenczi was introduced to Freud by Jung in 1908 and he argued that it was unacceptable that patients were better analysed than their analysts and requested a thorough personal analysis from Freud. Ferenczi had what is considered to be the first ever training analysis with Freud in 1914 (Berman, 2004; Falzeder, 1994).

Ferenczi was also instrumental in ushering in the fourth period, the “fully completed analysis”, from about 1927. He “believed that training analyses should achieve more than therapeutic analyses” (Curtis & Qaiser, 2005, p.366) and energetically propagated his ideas on the matter. As a result the training analyses became longer and it was thought that analysts should be more fully analysed than other patients. Balint refers to the fifth period as “super-therapy” and explained that its aim was “to go beyond the Oedipus conflict into the pre-Oedipal states, which means that they [patients] must express in words mental experiences of a non-verbal or even pre-verbal period” (1954, p.159).

2.2.1 1912-1918: The Origin of the Training Analysis

The assumption that personal therapy had its origin with Freud has since been discredited by historians in the field of psychoanalysis and today it is accepted that the training analysis was originally the suggestion of Carl Jung (Falzeder, 1994, 1995, 1998; Kerr, 2004; Kirsch, 1984; Roazen, 2002b; and

Shamdasani, 2003). The historian of psychoanalysis Paul Roazen describes his “surprise in those days [the mid-1960’s] to come across a passage in one of Freud’s own papers where he explicitly credited Jung with the exact contribution” (Roazen, 2002b, p.73).

Freud’s first mention of the training analysis was in 1912 in *Recommendations to Physicians Practicing Psychoanalysis* (Freud, 1912). In this paper Freud discussed his belief that the patient’s unconscious processes resonated and reverberated with the therapist’s own unconscious. He considered personal analysis essential to make therapists aware of the unconscious forces within themselves that might interfere in their therapy with patients: “It may be insisted, rather, that he should have undergone a psychoanalytic purification and have become aware of those complexes of his own which would be apt to interfere with his grasp of what the patient tells him” (Freud, 1912, p.113). Roazen (2002b) and Shamdasani (2003) called attention to the fact that in this paper Freud commends Jung’s Zurich School of analysis on their emphasis of the personal analysis as a training requirement: “They have laid increased emphasis on this requirement, and have embodied it in the demand that everyone who wishes to carry out analyses on other people should first himself undergo an analysis with someone with expert knowledge. Anyone who takes up the work seriously should choose this course, which offers more than one advantage.” (Freud, 1912, p.116).

Shamdasani (2003) also established that it was Jung who proposed that every analyst had to have a training analysis: “In 1911 [Jung] wrote that psychoanalysis demanded a sacrifice beyond that of any other science: merciless self-knowledge, obtained through having a successful analysis” (Shamdasani, 2003, p.450). He refers to Jung’s 1912 lectures at Fordham University where Jung argued that success in analysis was related to the extent of the therapist’s own analysis. It is thought that he implicated Freud when he condemned analysts who thought that self-analysis was sufficient. Jung insisted that an analyst required a personal analysis, a “psychoanalytic training of his own personality” (quoted in Shamdasani, 2003, p. 450).

2.2.2 Budapest, 1918, to Bad Homburg, 1925

Falzeder (1998) noted that even though Freud commended the training analysis, he "was reluctant to make it a training requirement, like the Zurich School did, after the break between him and Jung in 1913" (p.129).

At the 1918 Congress of the International Psychoanalytical Association (IPA) in Budapest, Nunberg made the suggestion that every prospective analyst should be analysed themselves. But Freud's followers were fiercely loyal and rejected the idea put forward by Nunberg. Nunberg published his memoirs in 1960 and remembered the events at the Budapest Congress as follows (Kerr, 2004, p. 26):

> Practicing analysts were also encountering difficulties in the treatment of their own patients. During the course of their own analyses they had come to realize that these difficulties were due to "blind spots" that they themselves had, in relations to conflicts in their patients that coincided with their own. For this reason I suggested, at one meeting of the Society, that every analyst ought to be analysed.
>
> At the Congress in Budapest in 1918 Freud suddenly announced that I had an important statement to make. Taken by surprise, I had to improvise, and made the motion that every analyst be analysed. This was opposed by Rank and Tausk. I was puzzled by their opposition: the motives behind it still remained unknown to me. It was only in [1925], at the Congress in Bad Homburg, which was chaired by Karl Abraham, that this notion was carried. It was then that the training analysis was introduced. From then on, it became obligatory for anyone who wanted to carry out analytical treatment himself.

The most influential group in the IPA, the Berlin psychoanalysts, led by Max Eitingon, Carl Müller-Braunschweig, and Sándor Radó, then started to establish training guidelines that included theoretical courses, a required analysis, and supervised analyses. In 1925 at the Congress of the IPA in Bad Homburg, the notion of a mandatory training analysis for all future analysts was finally accepted.

2.2.3 1925-1945: Institutionalization of the Training Analysis

From 1925 analysis for the analyst was considered imperative and most of the prominent psychotherapists underwent a training analysis, including Melanie Klein, Margaret Mahler, Erik Erikson, Harry Guntrip, Donald Winnicott, Albert Ellis, Michael Balint, Jacques Lacan, Otto Kernberg, John Bowlby and Wilfred Bion.

Training now had at its core the analysis of the trainee by a senior psychoanalyst, followed by the supervision of the trainee's clinical work, often by the same analyst. The training did not establish boundaries between theoretical training and the therapeutic relationship. The relationship between analyst and trainee was further compromised by the fact that the analyst reported back to the training institution on the progress of the trainee and on the suitability of the trainee to become an analyst.

Balint (1948, p. 170) compared analytic training to an "apostolic succession". Through the training analysis Freud's ideas and methods were handed down to his successors. Falzeder stated that

> "such training [was] also an important way by which the central theoretical ideas [were] transmitted, by 'experiencing' them rather than by learning them from books. Through the training analysis, each psychoanalyst becomes part of a genealogy that ultimately goes back to Sigmund Freud and a handful of early pioneers. Evidently, each training and supervising analyst has her or his own theoretical and practical preferences, with which the analysands are confronted and by which they are deeply influenced." (Falzeder, 1998, p.128)

Freud himself seemed to have valued the bond that was created through the training analysis. In 1912 Freud gave three reasons for therapists to have an analysis themselves:

> "Not only is one's aim of learning to know what is hidden in one's own mind far more rapidly attained and with less expense of affect, but impressions and convictions will be gained in relation to oneself which will be sought in vain from studying books and attending lectures. And lastly, we must not underestimate the advantage to be derived from the lasting mental contact

> that is as a rule established between the student and his guide" (1912, p.116-117).

Simplified, the first rationale refers to the attainment of self-knowledge, the second to the acquisition of professional knowledge, and the third to the closeness and loyalty that were established between Freud and those whom he analysed.

In *Analysis Terminable and Interminable* Freud wrote of the aims of the training analysis:

> "It has accomplished its purpose if it gives the learner a firm conviction of the unconscious, if it enables him, when repressed material emerges, to perceive in himself things, which would otherwise be incredible to him, and if it shows him a first sample of the technique which has proved to be the only effective one in analytic work…It's main object [is] to enable his teacher to make a judgement as to whether the candidate can be accepted for further training" (1937, p.248-249).

As a result of the formalization of analytical training, the first-hand experience of the training analysis and the expansion of psychoanalytic theory, the training analysis continued to develop, but was also criticized. One of the critical voices was, surprisingly, that of Anna Freud. In 1938 she wrote a paper called "The Problem of Training Analysis", on the shortcomings of the training analysis, but it was only published 12 years later in 1950. In this paper she stated that she considered the cause of the problem with the training analysis to be the fact that the training analyst reports back to the institution on the suitability of the trainee (Desmond, 2004). She pointed out that the training analysis appeared to commit mistakes that would be considered technical errors in a therapeutic analysis, with the consequence of "bad results in training analysis and unresolved transference relationships" (Desmond, 2004, p.36).

Another factor that had an impact on the training analysis was "the blurring of the boundaries between professional and sexual or familial relationships"

which was “the rule and not the exception” (Falzeder, 1998, p.127). Analysts would share details of their own lives and interests with their analysands, or freely discuss their thoughts on the analysis with them. Falzeder points out that “there were often repeated patterns of affect laden relationships, be they incestuous, hostile, erotic, or power relations, mixed with varying doses of analysis, leading to much confusion and suffering among those involved…there is evidence of many training analyses that were or became erotic relationships, or of erotic relationships that turned into analyses” (Falzeder, 1998, p.128). The early history of psychoanalysis is replete with such boundary violations.

2.2.4 1945 to the 1980’s: Criticism of the Training Analysis

Two decades after the institution of the training analysis the problems it generated could no longer be ignored, or the dissenting voices silenced. Apart from giving the trainee psychotherapist a self-experience of unconscious processes, the training analysis had also become an “instrument of power politics” and a “ritual of submission [and] indoctrination” (Cremerius, 1990, p.116) that promoted conformity, isolation and stagnation in the psychoanalytic training institutes.

After the Second World War the training analysis became openly criticised and this led to much disagreement and conflict within the psychoanalytic institutions and societies. Desmond (2004) pointed out that the “seed” of the theory wars and splits in psychoanalysis “were often sown in what is said to be the cornerstone of psychoanalytic training – the personal analysis of the analyst in training” (p.31). In the 1976 symposium on “The Identity of the Psychoanalyst”, organised by the IPA, Anna Freud stated:

> “The heart of the matter is that the problem doesn’t really seem to have changed much in the last forty-five years! But in listening to you here, I also got the impression that my colleagues who first advocated the introduction of training analysis - if they had known of all the dangers, of the positive and negative transferences, and splits, and hates, etc. would probably never have advocated it! They would have said, ‘Let them be as they are!’” (In Thomä, 1993, p.3)

Edward Glover in Britain in the 1940's and Jacques Lacan in France in the 1960's strongly opposed the way the training analysis was conducted. Glover was especially troubled by the politicization of the training analysis within the British Psychoanalytic Society (Roazen, 2002). Balint (1948) shared Glover's concern of the hidden power problems in psychoanalytic training. He considered it suspicious and a "grave warning sign that in over twenty-five-years one of the most important problems of psychoanalysis, the training, has not been discussed adequately" (p.163). In 1953 the first symposium on the problems of psychoanalytic training after the Second World War were held at the 18th International Psychoanalytic Congress in London (Thoma, 1993). It's main concern was the training analysis.

The critical papers that began to appear voiced some common concerns: the dichotomy between the therapeutic and training function of the training analysis, the inherent hierarchical and power problems, and the external relationship between the analyst and analysand in terms of corrupting transference and counter-transference. Bernfeld (1962) argued that the training analyst is not just a mere transference figure, as Freud suggested, but also a powerful part of the trainee's reality. The trainee wishes to follow the same profession as the analyst and this "influences the relationship and has consequences in the transference" (Thomä, 1993, p.3).

Desmond (2004) identified the pervasive theme in papers published on the training analysis between 1950 and the present: "...to the extent that an analysis is 'therapeutic', it stands a chance of being successful, to the extent that it is a 'training' analysis it is fraught with problems that might mitigate against the prospect of a meaningful analytic experience for the candidate" (p.38).

Nacht, Lebovici and Diatkine's (1960) critical paper on training analysis reported on the measures they had adopted in France, which aimed to reduce the analyst's influence on the training process, and further proposed separating the training analysis from the training (Thomä, 1993). This

suggestion has been repeated by many subsequent authors, including Kairys (1964), McLaughlin (1967), Kernberg (1986; 2000), Thomä (1993) and Denzler (1995).

Kairys (1964) argued for “major change” in the structure of psychoanalytic training. He identified the “crucial problem” of the training analysis as the dual role of the training analyst – conducting analysis as well as training. His solution was “to divorce the training analysis completely from the rest of the student’s training” (p.505). He called for a “non-reporting” analysis: students should still have an analysis with a recognised training analyst, but the analyst should only inform the training institute that the analysis has commenced and not report to the institute on the progress or any other aspect of the analysis.

McLaughlin (1967) echoed this recommendation and proclaimed that the analyst was the last person able to offer an objective judgment of his analysand. He wondered about the motives that made psychoanalytic institutions cling to the traditional format of the training analysis: “One cannot help but wonder if some of the unconscious factors concerned have to do with control, power and personal striving for prestige, and the promulgation of theoretical leanings. There must be strong unconscious motivation to allow us to continue with practices which we otherwise condemn” (p.231).

In 1986, while president of the IPA, Kernberg published an article on the institutional problems of psychoanalytic education in which he stated: “Psychoanalytic education today is all too often conducted in an atmosphere of indoctrination rather than of open scientific exploration.” (1986, p.799).

The non-reporting analysis was initially not a popular measure in psychoanalytic circles and was only put into practice by a minority of institutions from the 1970’s (Thomä, 1993). It has only been in the past two decades that the non-reporting analysis had become more widely endorsed by psychoanalytic institutions.

2.2.5 1990's to the Present: Developments and Regulations

In 1997 the IPA Ad Hoc Committee on Evaluation of Different Training Models distributed two position papers to training institutes and societies (Szecsody, 1997). The one paper was titled "In favour of personal analysis" (Denzler, 1995) and proposed completely separating the analysis and the training process, discarding the term "training analysis" in favour of "personal therapy"; and leaving the choice of an experienced personal therapist to the trainee. The other paper, by Britton (1995), titled "In favour of training analysis and training analysts", called for an analysis concurrently with psychoanalytic training and until the completion of the training (In Szecsödy, 1997, p.47).

In their review of American and British research on personal therapy for therapists, Macran and Shapiro (1998) found that the support for personal therapy amongst therapists "vary according to personal belief and theoretical orientation", but "amongst practicing therapists (particularly those with a psychodynamic or insight-oriented approach), the prevalent view still is that personal therapy is an important, if not necessary, training requirement" (p.13).

After discussions with institutes and societies from all IPA regions, Thomä and Kachele (1999) published a "Memorandum of Reform of Psychoanalytic Education". The memorandum appealed for "a complete disconnection of the personal analysis from the main body of the psychoanalytic education", but they also stressed that it is "indispensable for an analytic therapist to experience for himself/herself the effects of unconscious processes on transferences and defences in an intersubjective exchange" (p.34). They therefore proposed a compromise between the personal rights of the trainee and the needs of the institution: "Psychoanalytic institutes are only entitled to request a strictly defined number of analytic sessions (say 200) with a training analyst. Afterwards candidates should be free to decide, without having to inform the training committee, whether and with whom they want to continue their therapeutic analysis" (p.34).

In 2000 Kernberg stated that the system of reporting the progress of the trainee to the training institute "inevitably stimulates non-analyzable submissive behaviour in the candidates, as well as varying degrees of dishonesty" (2000, p.99). In the "President's Column" of the first IPA Newsletter in of 2001, Kernberg shared "Some Thoughts Regarding Innovations in Psychoanalytic Education" (2001). It provided a summary of a variety of proposals on issues such as the status of the training analyst; frequency and duration of the training analysis; supervision; the selections of candidates; etc. The proposals expressed a broad spectrum of views and the consensus was that "with diverging models of psychoanalytic theories and technique, there exists a need for an ongoing evaluation of such divergences, and an ongoing effort to establish or re-establish a core common ground, while tolerating divergence and controversy in theory and technique" (Kernberg, 2001, p.9). "There were positive reactions regarding the advantages of separating the training analytic function from supervision and seminars," (p.10), but emphasis was put on being flexible on the one hand and maintaining standards of education on the other.

Kirsner's (2005) extensive research, for his book "Unfree Associations: Inside Psychoanalytic Institutes" (2000) included interviewing 150 analysts belonging to the American Psychoanalytic Association. He made the following recommendations on training: the trainee's analysis should be kept entirely separate from the training institution; the trainees should choose their own analyst; the training analyst should not have any association with the assessment of the trainee; and the analyst should not report to the institution on the trainee or the analysis.

In countries such as the United States, Canada, Australia, the United Kingdom and most of Western Europe, the requirement of personal therapy as part of a therapist's training currently depends on the training institution and the registration body the therapist wishes to register with. But there has been a definitive move away from the reporting analysis. This is a development of the training analysis in reaction to its limitations, but it is also due to increased ethical awareness resulting in ethics guidelines that, for

example, prohibit maintaining dual relationships with patients or analysands. Cresci (2002) stressed the importance of the ethical requirement to ensure the privacy and confidentiality of the trainee as patient and applauded the separation of the training analysis and supervision of cases “into two distinct functions and relationships…thus preserving the confidentiality of that experience for the analysand” (p.49). Even so, most institutes who have a nonreporting policy still request some information to be reported to them, such as: the name of the training analyst/personal therapist, confirmation that the analysis has begun, the termination date of the analysis, the frequency of the therapy, or the amount of hours of therapy completed (Desmond, 2004).

In the USA the requirement of personal therapy depends largely on the training institution and personal therapy is not generally required in the training of psychologists, but “among many professionals engaged in the practice of psychotherapy, personal treatment is highly valued” (Mackey & Mackey, 1993, p.97).

One of the main registration bodies for psychologists and psychoanalysts in the UK is the United Kingdom Council for Psychotherapy (UKCP). Their requirements for registration depend on the section the therapist intends to be registered with (Tudor, 2008), for example, the Psychoanalytic and Psychodynamic Section (PPS) of the UKCP requires twice weekly sessions throughout the duration of training, compared to the Behavioural and Cognitive Psychotherapy Section (B&CPS) which has no personal therapy requirement.

Another registration body, the British Association for Counselling and Psychotherapy (BACP) requires psychotherapists to complete 40 hours of personal therapy as a prerequisite for accreditation. Similarly, the division of counselling psychology of the British Psychological Society (BPS) requires 40 hours of personal therapy during training as necessary for chartered status (http://www.psychotherapy.org.uk). The BACP gives two reasons for requiring personal therapy for accreditation of therapists. The first is that self awareness is important to enable therapists to separate personal issues from those

relating to the therapeutic situation and, second, to help reduce “blind spots that could potentially lead to unethical practice” (Murphy, 2005, p.28).

2.3 RESEARCH ON PERSONAL THERAPY

It is evident from the previous section that there have been various motivations for personal therapy since its inception in the form of the training analysis: the experience of therapeutic technique, creating awareness of the unconscious, first-hand experience of transference, increased self-awareness and the acquisition of self-knowledge. Most of the rationales, benefits and aims of personal therapy can be summarised along the two dimensions of fostering personal health and growth and facilitating professional development.

There has, unfortunately, been little research on personal therapy in the professional training context (Bike, Norcross & Schatz, 2009; Craige, 2002; Curtis, 2005; Curtis, Field, Knaan-Kostman & Manix, 2004; Curtis & Qaiser, 2005; Macran & Shapiro, 1998; Norcross et al., 1988). The aim of existing research studies on personal therapy has mostly been to explore the proposed value of personal therapy, which often involves examining the question of whether the rationale that personal therapy has a positive impact on personal and professional development is supported by the research findings. Surveys have been the most popular methods of enquiry, but an increase in qualitative studies have appeared since the early nineties. The studies summarised below are either quantitative surveys or qualitative studies on trainee and qualified therapists’ experiences of, and opinions on, personal therapy.

2.3.1 Quantitative Surveys

2.3.1.1 Age and Gender Demographics

Darongkamas, *et al.* (1994) found that the experience of personal therapy was not associated with age or gender, but Pope and Tabachnik's (1994) study found that women were more likely to have been in personal therapy (89.6%) than were men (79.7%). Norcross, *et. al.* (1988) also found female therapists more likely than male therapists to undertake personal therapy, but a replication of the Norcross study in 2009 by Bike, Norcross and Schatz (2009) found men and women psychotherapists to be equally likely to undertake personal therapy.

Norcross, *et al.* (1988) found that "most therapists undergo personal therapy when they are training or at the start of their careers." The Pope and Tabachnick study (1994) confirmed that younger therapists were significantly more likely to enter therapy: only 7% of the respondents in the study who were under 40 had never been in therapy compared to 19% of the respondents over 50.

2.3.1.2 Incidence of Personal Therapy

Surveys reveal high incidence rates of personal therapy for therapists and trainees. Macran and Shapiro (1998) published a literature review of survey studies conducted in the USA and the UK since the 1960's. They found personal therapy to be overwhelmingly popular with between two-thirds and three-quarters of all therapists entering into some form of therapy.

A comprehensive US study by Norcross, Strausser and Faltus (1988) found that 71% of a sample of 509 psychotherapists (234 doctoral level psychologists, 104 psychiatrists, and 171 clinical social workers) had undertaken personal therapy at least once. In a replication and extension of the Norcross study 20 years later, Bike, Norcross and Schatz (2009)

presented questionnaire data from 602 psychotherapists and found the incidence of personal therapy to have risen to 85%.

In Canada, McEwan & Duncan (1993) surveyed 400 qualified clinical and counselling psychologists of the British Columbia Psychological Association about their opinions on, and experiences of, personal therapy as a part of professional training. Of the 185 respondents, 41% had undergone personal therapy as part of their clinical training; and of those, 46% reported that their therapy was mandatory.

A UK study by Pope and Tabachnick (1994) surveyed 800 registered psychologists and found that the overwhelming majority, 84% of the 476 respondents, have undertaken therapy. They found a significant association between orientation and incidence of personal therapy with substantially higher incidences of therapy among psychodynamic and eclectic therapists compared to cognitive-behavioural therapists.

Darongkamas, Burton and Cushway (1994) published another UK study in the same year. They surveyed 496 NHS clinical psychologists and found that 41% of the 321 respondents have had personal therapy and 41% of the respondents who have not had therapy reported that they have considered it in the past. This figure is considerably lower than the other UK study and a possible reason for the lower incidence of personal therapy is that the sample was skewed towards therapists with a cognitive-behavioural orientation (41% of respondents) compared to the Pope and Tabachnick (1994) sample.

Norcross, *et al.* (1988) also found that clinical psychologists and psychodynamic or insight-oriented therapists were most likely to have therapy. Their study found that the incidence of personal therapy related to theoretical orientation in the following way: 93% of existential, 88% of psychoanalytic, 85% of systems, 82% of psychodynamic, 69% of cognitive, 67% of client-centered, 62% of eclectic and 47% of behaviour therapists had undertaken personal therapy.

2.3.1.3 Type of Personal Therapy Chosen

The majority of personal therapy chosen tends to be psychodynamic, relatively few individuals choose cognitive or behavioural, even if that is their own orientation (Norcross, *et al*., 1988, Norcross, 1990, Darongkamas, *et al*., 1994). Darongkamas, *et al.* found that 80% of the respondents from a cognitive-behavioural orientation had not undertaken personal therapy.

Therapists also tend to choose psychoanalytic and psychodynamic psychotherapy for themselves. The Norcross study (1988) showed that the majority of therapists and trainees undertook personal therapy with psychoanalytic (41%) or psychodynamic (18%) therapists. Even behavioural therapists seek out non-behavioural therapists for their personal therapy (Norcross, *et al*., 1988, Darongkamas, *et al*., 1994). Less than one in ten behaviour therapists chose a behavioural therapist for personal therapy (Norcross, *et al*., 1988).

2.3.1.4 Reasons for Personal Therapy

The reasons for entering personal therapy are diverse. For trainees it is usually a training requirement or recommendation. Qualified therapists mostly cite personal growth, resolving personal problems, and reducing symptoms (Mackaskill & Mackaskill, 1992) as reasons for having personal therapy. Bike, *et al*. (2009) listed the top reasons for seeking personal therapy as: marital-couple difficulties (20%), depression (13%), need for self-understanding (12%), and anxiety-stress (10%). Pope and Tabachnick (1994) listed the main reasons for being in personal therapy as: depression/unhappiness (25%), marriage/divorce (20%), relationship (14%), self-esteem/self-confidence (12%), anxiety (12%), career/studies (9%), family of origin (8%), loss or abandonment (4%), and stress (3%).

2.3.1.5 Positive and Negative Experience of Personal Therapy

All the studies found that the majority of therapists feel positive about their therapy. Shapiro's (1976) survey of 121 graduates of the Psychoanalytic Centre for Training and Research of Columbia University, found that 6 out of every 7 respondents were satisfied with the outcome of their training analysis, despite the fact that it was a reporting analysis. Macaskill and Macaskill (1992) revealed that 87% of respondents reported that personal therapy had a moderate to very positive effect on their work with patients and their personal lives – the reported positive effects included: increased self-awareness, increased self-esteem and reduction in symptoms. McEwan and Duncan's (1993) Canadian study found that 88% of participants saw at least one benefit, and 83 % at least one risk in having personal therapy. In their survey of the 216 members of the American Psychoanalytic Association, Martinez and Hoppe (1998) found that 78% of respondents reported that they derived "very much" or "tremendous" benefit from their training analysis, and 70% had "loving, warm" feelings toward their training analyst. More than 90% of therapists reported positive outcomes in the Bike, *et al*. (2009) study.

All the survey studies discussed here agreed that only a minority of therapists report negatively about their experiences in personal therapy. Unsatisfactory results were reported by 14% of respondents in the Shapiro study (1976), 17% in the Darongkamas, Burton and Cushway study (1994), 22% in the Martinez and Hoppe study (1998), and 28% in the Craige study (2002). Mackaskill and Mackaskill (1992) found that 39% of respondents reported some negative effects, which included depression, psychological and relationship stress, and becoming too reflective. A possible explanation for the increased reflectiveness of therapists was given by Macran & Shapiro (1998), who pointed out that it may be possible that therapeutic training and practice "intensify an existing tendency to be more psychologically minded (e.g. reflective, self-aware and insightful) which characterizes individuals who choose therapy as a career" (p.17).

When the respondents in the Pope & Tabachnick (1994) study were asked to indicate how “harmful” personal therapy was to them, 77.6% reported that the experience was “not at all harmful” and only 2% of the respondents found therapy to be “very” or “exceptionally harmful”. Reported causes of harm included: therapist’s sexual acts or attempted sexual acts with the participant; therapist’s perceived incompetence; an emotionally abusive therapist; therapist’s failure to understand the participant; boundary violations; an inattentive or uncaring therapist; a narcissistic or self-centered therapist; and poorly handled termination. Of the respondents in the Darongkamas (1994) study, 46% found personal therapy moderately stressful; 26% a little stressful; 16% very stressful; and 8% not stressful at all.

2.3.1.6 The Value of Personal Therapy

The vast majority of therapists felt that personal therapy has been valuable to them on a personal and or professional level (Bike, *et al.*, 2009; Curtis, *et al.*, 2004; Darongkamas, *et al.*, 1994; Mackaskill & Mackaskill, 1992; Macran & Shapiro, 1998; Norcross, *et al.*, 1988; and Pope & Tabachnick, 1994). Some of the reported benefits include increased awareness of the importance of the relationship between client and therapist, experience of transference, and increased empathy, patience, and tolerance (Norcross, *et. al*., 1988).

Darongkamas, *et al.* (1994) found that 79% of the respondents reported that personal therapy influenced their clinical work positively, and 80% reported that personal therapy reduced the stress involved in clinical work. Respondents reported personal therapy to substantially improve self-esteem (42.7%), work function (41.2%), symptoms (32.3%), character (26.7%), and social and sex life (15.3%). Benefits to their professional work were reported as: “enhanced working relationship with patients, increased therapeutic skill, increased appreciation of the patient’s viewpoint, clarification of the therapist’s own issues” (1994, p.169).

The main benefits of personal therapy indicated by the respondents in the Pope and Tabachnick (1994) study included: increased self-awareness or self-understanding (28%), increased self-esteem or self-confidence (21%), improved skills as a therapist (16%), support (4%), acceptance of feelings (4%), better understanding/relationship with family of origin (4%), improvement in relationships (3%), management of depression and or anxiety (2%), and personal growth (2%). Pope and Tabachnick concluded that the belief among the majority of respondents (70%) that personal therapy should be a mandatory requirement of training reflected the participants' views that increased self-awareness and self-understanding "may enable therapists to better handle self-disclosure, self-expression, boundary issues, sexual dynamics, and other frequently mentioned aspects of therapy" (p.25).

A survey of 75 psychoanalysts of the William Alanson White Institute in New York and the Institutt for Psykoterapi in Oslo (Curtis, *et al*., 2004) found that therapy led to significant positive change in therapists. The areas in which analysts noted the most positive change in themselves were related to their capacity for intimacy, their concerns with being rejected, their ability to link past and present experiences, the perception of a wider range of options for themselves, increased comfort with their own power, increased ability to put feelings into words, and having fewer self-doubts.

2.3.1.7 Personal Therapy as Part of Training

Some studies found that personal therapy in combination with training was experienced as a substantial burden (Mackaskill, 1988, McEwan & Duncan, 1993). Macran and Shapiro (1998) concluded from in their literature review that "what is apparent from the literature is that, despite its positive qualities, personal therapy imposes a major burden, particularly for therapists undergoing training" (p.16). McEwan & Duncan (1993) stressed the benefits of personal therapy as part of training, namely: developing empathy; the opportunity to learn from a role model; the personal growth of the individual; and the gaining of "practical know-how" relating to the professional

development of the therapist. Most of the risks identified by McEwan and Duncan were related to ethical issues. Potential risks were seen to be the dual relationship, therapeutic and educational, between trainee and therapist (listed by 32% of respondents); having a “poor” therapist, the usual risks inherent to any therapy, and risks to the confidentiality of the client. Mackaskill & Mackaskill (1992) found that half of their sample of trainee therapists reported that financial costs and time constraints were a significant stressor.

McEwan and Duncan (1993) found that of the trainees who had therapy as part of their training, it was “required” (mandatory) in 46% of the cases, “optional and recommended” for 23%, and “optional but not recommended” for 28%. Participants were given justification for mandatory therapy in the following way: “no justification” for 18% of respondents, “minimal justification” for 40%, and “explained completely” for 37% (p.186). They found that all the respondents agreed that therapy should be separate from trainee therapists’ academic work.

2.3.1.8 Opinion on the Importance of Personal Therapy

When McEwan and Duncan (1993) asked respondents how important it is for trainees to experience therapy, 30% rated it as “quite important”, and 36% as “essential”. And those who received personal therapy as part of their training rated it higher than the respondents who did not. Opinion was divided on whether personal therapy should be part of training, and specifically, whether therapy as part of training should be mandatory. Comments ranged from: “you don’t put a plaster cast on a healthy leg”, to “please make personal therapy mandatory for at least two years”, to “mandatory therapy is unethical and ineffective” (McEwan & Duncan, 1993, p.190).

Darongkamas, *et al*. (1994) found that respondents who had experienced personal therapy were more likely to recommend it to other clinical psychologists and for trainees. Respondents ranked personal therapy second in importance after clinical experience in relevance to clinical work, and 82%

rated it as important to them as individuals, with psychodynamic and eclectic therapists rating its importance higher than cognitive-behavioural therapists.

Pope and Tabachnick (1994) found that a substantial majority (70%) of their respondents was of the opinion that graduate and professional schools in psychology should “probably” or “absolutely” require therapy for trainee therapists. A smaller majority (54%) indicated that personal therapy should “probably” be a requirement for licensure. The participants who had undertaken personal therapy themselves were significantly more likely to favour mandating therapy as a training requirement.

2.3.2 Qualitative Studies

Mackey and Mackey (1993) explored the value of personal therapy to the clinical practice of 15 master’s students in social work and 15 qualified clinical social workers. All of the respondents were in personal therapy at the time of the study, 87% of them with psychodynamic oriented therapists. Reasons for undertaking personal therapy included: an intrapersonal conflict of some or other nature, often accompanied by anxiety or depression (50%), interpersonal relationship difficulties (23%), stress associated with studies or career (10%), and substance abuse, usually alcohol (10%).

Coding the data produced five themes (Mackey & Mackey, 1993, 1994). Both students and practitioners mentioned the following three themes: the therapist as model; enhanced empathy; and greater understanding of the therapeutic process. With regards to the third theme, comments most often referred to the dynamics of the therapeutic relationship, transference, countertransference and technique. A theme that was only mentioned by the students was personal therapy as a complement to their training: how it helped to integrate theoretical concepts in a meaningful way and served as a complement to supervision. Practitioners reflected upon a fifth theme of self awareness and how therapy was an investment in integrating themselves and their

professional identity. Half of the respondents were in favour of mandatory personal therapy as part of training and half were opposed to such a measure.

Mackey and Mackey (1993) concluded that their "findings supported the hypothesis that personal therapy may be a valuable resource in becoming a competent clinical social worker." (p.108) They further concluded that the primary benefit of personal therapy would still be to ameliorate personal conflict, but that it may also complement and enhance professional practice by nurturing knowledge, values and skills through the model of the therapist; and by providing a "vehicle" for cognitive and emotional understanding of the therapeutic process and the dynamics of psychotherapy.

Grimmer & Tribe's (2001) UK study explored the opinions of seven recently qualified and seven trainee counselling psychologists on the impact of mandatory personal therapy on their professional development. All the participants had completed the required 40 hours of personal therapy for purposes of registration.

The study found that mandatory personal therapy lead to perceived positive outcomes for the participants in terms of their professional development. The outcomes included: "developing reflexivity as a result of being in the role of client; socialization into a professional role through validational and normative experiences; emotional support during times of crisis; developed understanding of the impact of clinical techniques through the modelling of good and bad practice; and, personal development that leads to an improved ability to distinguish between personal issues and those of the client" (p.296).

Participants believed that they obtained a better understanding of the therapeutic process through being in the role of the client themselves and reflecting on the process and the content of their own therapy. They also reported increased empathy and appreciation for the importance of the therapeutic relationship to change. Participants described socialization experiences such as the modelling of professional conduct; and the validation of the belief in therapy as a mechanism for psychological change.

Interestingly, participants also reported learning from negative personal therapy experiences what they would like to avoid as therapists. Examples of negative therapist behaviours participants experienced included: overuse of cliché, lack of therapist awareness of non-verbal behaviour, use of insensitive or inaccurate diagnostic labels, inaccurate empathy, intrusive probing, and an interrogatory style.

A more recent UK study is that of Murphy (2006), comprising data from five participants who were MA students in Counselling Psychology and who had completed at least 40 hours of mandatory personal therapy as a requirement for their training. The constant comparative method was used to analyse the data obtained from a semi-structured group interview. Four key phases associated with personal treatment emerged from the data, namely: reflexivity, growth, an authentication phase and a prolongation phase.

The phase of reflexivity involves a realisation that personal issues emerged during training, often affecting counselling practice, and that personal therapy could be used to work through this unresolved material. The phase of growth refers to the development of empathy, positive self-regard and self awareness through personal therapy. During the phase of authentication, validation was obtained of the self as an "acceptable tool for practice" (Murphy, 2006, p.31), and of the therapeutic approach as an effective intervention for psychological change. The final phase of prolongation represents the opinion that more or longer term personal therapy is a useful part of continued professional development.

Kaslow & Friedman (1984) were interested in the interface of personal therapy and clinical training for psychotherapist trainees. Their study involved fourteen clinical psychology students in Ph.D. programmes in the United States who had personal therapy concurrent with their training.

The reported positive impact of personal therapy on clinical work included: growth in respect for their patients' struggles in therapy; enhanced ability to

just ‘be with’ the patient instead of feeling the need to ‘do for’ the patient; “enhanced capacity to differentiate their own affective states from that of their patients” (p.42); the development of a more realistic perspective of treatment processes and goals; and an increased ability to attend to reflect on countertransference. On a personal level, therapy was found to promote personal growth, self-discovery and self-knowledge, to increase accurate perspectives of their own pathology and to increase the trainee’s investment in personal treatment. Negative aspects were listed as: overidentification with the patient role, despair regarding their own ability as a therapist, an inability to attend well to their own patients due to the “flooding effects” of newly freed up material in their own therapy, and the stress of graduate school in combination with personal therapy.

2.4 CONCLUSION

It seems that the literature on the value of personal therapy is fairly consistent. Most studies report that respondents feel that they have benefited personally and or professionally from the experience. Most therapists consider personal therapy to be a desirable, if not necessary, experience for psychotherapy trainees and qualified psychotherapists. Second only to practical experience, personal psychotherapy is cited by therapists as “the most important contributor to their professional development” (Norcross, *et. al.,* 1988, p.53).

It is only recently that qualitative research has focused on the actual experience of trainees (e.g. Grimmer & Tribe, 2001; Murphy, 2005). Before this, studies that did investigate the trainee’s perspective (e.g. Macaskill, 1988; Macaskill, 1999) seem to have been only quantitative. In light of the limitations of the existing literature, and lack of research on this subject in South Africa, it seems reasonable to explore trainees’ perspectives on, and experience of, personal therapy both in terms of potential positive and negative implications.

CHAPTER 3 RESEARCH METHOD AND PROCEDURE

3.1 INTRODUCTION

This chapter describes the research method and process. First the qualitative research design and method will be explained. The sample and sampling procedure is then presented and the data collection and analysis detailed. The chapter concludes with discussions of the trustworthiness and ethical considerations of the study.

3.2 RESEARCH DESIGN

The research design provides a plan of how the research is going to be executed along the four dimensions of purpose, paradigm, context and technique (Terre Blanche & Durrheim, 1999).

The purpose of this study is to explore the participants' subjective experience of psychotherapy in the context of the professional training of clinical psychologists in South Africa. The study is explorative in that it attempts to investigate an area of research that is relatively unknown. To the knowledge of the researcher, there have not been any studies that have explored trainee clinical psychologists' experiences of personal therapy. In line with exploratory research, the study was "designed as an open and flexible investigation"; the researcher adopted an inductive approach and began by exploring genuinely open-ended questions and "patching" the responses together to form "general, but speculative hypotheses" (Terre Blanche & Durheim, 1999, p.40).

The research paradigm of this study is interpretive as the researcher believes that the object of investigation is the participants' subjective experience of their personal therapy. As the study relies on making meaning of this experience in the context of an interview relationship between the researcher

and subject, its *methodology* is qualitative. The particular method chosen was thematic content analysis.

The techniques/methods used for sampling (purposive sampling); data collection (semi-structured interviews); and data analysis (thematic content analysis) are discussed below.

3.3 QUALITATIVE METHOD

This study is located within the methodological tradition of qualitative research. Qualitative research attempts to explore and capture aspects of the social world for which it is difficult to develop precise statistical measures (Neuman, 1997). It argues for the importance of discovering the meaning of experience as interpreted through the eyes of the particular participants and researchers. It calls for "a sensitivity to the complexities of behaviour and meaning in the contexts where they 'naturally' occur" (Henwood, 1996, p.32). The study endeavours to produce in-depth, detailed, contextually sensitive and meaningful research.

The study's theme of inquiry can be described as "inductive". Patton (1990, p.40) explains that an inductive approach implies that the researcher will immerse herself in the details of the data to "discover important categories, dimensions and interrelationships;" and explore genuinely open questions, rather than test "theoretically derived (deductive) hypotheses."

Giorgi (1997) describes five basic steps that qualitative research generally follows: (1) collection of verbal data, (2) reading of the data, (3) breaking of the data into some kind of units, (4) organization and expression of the data from a disciplinary perspective, and (5) synthesis or summary of the data for purposes of communication to the scholarly community. Step one will be addressed in section 3.5 (*Data Collection*); steps two and three will be explicated in section 3.6 (*Data Analysis*); step four will be presented in chapter

four (*Results and Discussion*); and step five will be addressed in chapter five (*Conclusion, Limitations and Recommendations*).

3.4 SAMPLE

3.4.1 Sampling Strategy

The researcher made use of purposive sampling, i.e. expert knowledge about a certain population is used to select participants who represent that population (Berg, 1995; Trochim, 2001). A purposive selection method was appropriate as the study aims to render rich, sophisticated material and focuses in-depth on a particular context.

3.4.2 Selection of Participants

Small samples are characteristic of qualitative research and the aim was to gather a small sample of between eight and ten participants. The final sample size was nine. The first criterion for participant selection was that the participants were master's degree students in clinical psychology. In South Africa clinical psychology masters students are required to complete a year of structured academic training, a second year of internship training at an accredited institution, and a third year of community service before being eligible for registration as independent practitioners.

The study aimed to explore trainee clinical psychologists' experience of mandatory psychotherapy. Since the only clinical psychology students in South Africa required to have regular psychotherapy as part of their master's course are those at the University of the Witwatersrand (Wits), the study was limited to select students from that population. At Wits the students studying toward their master's degree in clinical psychology are mandated to commence weekly psychotherapy for the duration of their two-year training. Therapists do not report on the trainees' personal therapy, and trainees are

obliged only to notify the course coordinator that they have commenced personal therapy and to provide the name of the therapist concerned. Given that personal therapy requires a financial commitment, an arrangement with psychodynamically oriented local therapists to provide trainees with therapy at substantially reduced fees enables even poor students to receive treatment.

The second criterion was that the participants had completed a minimum of one year of weekly psychotherapy during their training. This ensured that the participants would have sufficient experience of personal therapy to be able to discuss their experience of it.

The sample consisted of nine trainees in their internship year (2nd year of masters training). The demographic characteristics of the participants were as follows: seven of the participants were female and two male; five were white, two black, one asian and one coloured. Four were in the age group 21-25; two in the age group 26-30 and one each in the age groups 31-35, 36-40, and 41-45. All of the participants had spent between 11 and 16 months in personal therapy as part of their training. Seven of them were still continuing with personal therapy.

The Wits master's course has a psychodynamic orientation and the university recommends that students choose therapists that follow a similar approach, although this is not enforced. The therapists of eight of the participants were psychodynamically oriented clinical psychologists, while one of the participants consulted a Rogerian educational psychologist.

The participants were interviewed in English, their language of tuition. English is the home language of six of the participants and the second language of the remaining three (as well as the researcher). All the English second language speakers were fluent in English and could express themselves in a sophisticated and nuanced way.

Names and contact details of potential participants were obtained from the psychology office at the School of Human and Community Development at

Wits. Invitations to participate (see Appendix A) were distributed via e-mail to 14 students and ten agreed to be interviewed. Participants were telephoned to make appointments for the interviews. One participant withdrew due to time constraints.

3.5 DATA COLLECTION

The study used semi-structured interviews as means of data collection. The purpose of an interview is to enter a person's world and perspective and to find out from them, in their own words, the things that we cannot directly observe (Patton, 1990). This type of interview was chosen because its open-ended structure was conducive to exploring participants' experiences and the meanings they attach to them. It allowed participants to provide nuanced and detailed descriptions of their experiences.

The semi-structured interview is limited in that it depends on the participants' ability to express themselves in a rich and sophisticated way. It may also be limited if the interviewer fails to establish rapport with interviewees, who may then be reluctant to share their experiences. The participants in this study were all able to eloquently speak about, and reflect on, their experiences. Rapport was easily established with all participants, most probably due to the fact that the researcher had much in common with them, being a master's student herself.

The researcher personally conducted semi-structured interviews with the nine research participants. Interviews were conducted individually, over the course of two weeks and in each participant's office at work, with the exception of one interview that was conducted in a counselling room on the Wits campus. Each interview lasted about an hour. Videotaped recordings of the interviews were made and subsequently transcribed. A video recorder was available to the researcher as it was felt that seeing a visual image of the interview would aid the analysis, especially when coding for feelings and meanings.

An approach to focused interviewing called the “General Interview Guide” was followed (Patton, 1990). It was felt that the General Interview Guide-approach was most suitable to the study as this comprised open-ended questions related to the topic focus that were explored during the interview. It allowed the participants to freely expand on the topic and explore their subjective feelings, thoughts and views and to bring their own experiences, in their own words, to the interview. This is in line with the inductive approach that requires the interviewer to be open to any material the participant may introduce to the study.

The researcher commenced the interview by restating the title and aims of the study and explaining the exploratory nature of the research. Participants were then encouraged to discuss their experience of personal therapy. The researcher attempted to let the participants lead the discussion and to avoid leading questions. The researcher used the Interview Guide (Appendix E) as a checklist to make sure all relevant issues were covered during the interview. At the end of the interview the researcher surveyed the list to see which themes were omitted during the interview. The participants were then asked about their experiences relating to these, but the researcher did not attempt to force a uniformity of content or response across the interviews. To structure the interviews in such a way would have been contrary to the nature of the study and inhibited the spontaneous discussions that the interviews produced. The researcher found that “by making use of a variety of participants, the possibility of finding underlying constants or themes in the many forms of expression the experience takes [was] greatly increased. Similarly, a participant may concentrate on one particular area and fail to describe other aspects of personal experience.” (Kruger, 1988, p.152).

The open-ended questions selected for the Interview Guide were formulated by carefully identifying relevant themes through the literature study. The Interview Guide (Appendix E) listed the following open-ended questions for discussion:

- How did the participant subjectively experience his/her personal therapy?

- What were the initial and later experiences of personal therapy during the training?
- How did the personal therapy impact on the participant's own professional and personal development, if at all?
- How did the personal therapy impact on participants' relationships (romantic, friendships and/or familial relationships), if at all?
- What, if any, was the impact of their personal therapy on the participant's therapy with their own clients?
- What are participants' attitudes toward the desirability versus necessity of personal therapy as part of training?
- What are participants' views on the value of personal therapy during training (advantages and disadvantages)?
- How did the participants experience the type (psychodynamic, cognitive, etc.) of personal therapy received?
- How did the participants experience the mandatory nature of the required personal therapy?

3.6 DATA ANALYSIS

Thematic content analysis was used to analyse and interpret the interview data. Thematic content analysis is the "scoring of messages for content, style, or both for the purpose of assessing the characteristics or experiences of persons" (Neuendorf, K.A., 2002, p.192).

Thematic content analysis required the researcher to systematically sift through the data with the aim of identifying the themes and categories that emerged from it. The "theme" is the basic unit of analysis in this study and the researcher coded for explicit as well as implicit themes. The process of sifting through, dissembling and reassembling the data, is called "coding" (Ezzy, 2002). Coding simply means identifying themes or concepts in the data. The researcher distilled these common themes from the text in order to give expression to the commonality of the participants' voices (Anderson, 2004).

Throughout the process of data gathering the researcher developed ideas and theories and, by the time the researcher commenced with the analysis, she already had a preliminary idea of the themes that were present. These themes and categories were induced from the data and were not decided upon prior to coding the data. Ezzy (2002) explains that "while the general issues that are of interest are determined prior to the analysis, the specific nature of the categories and themes to be explored are not predetermined", although they "do not emerge from the data uninfluenced by pre-existing theory" (p. 88).

The researcher followed Ezzy's (2002) three step process of coding in thematic analysis, namely open coding, axial coding and selective coding.

3.6.1 Step 1: Open Coding

Open coding involves initially exploring the data and looking for themes. This step required the researcher to become familiar with the text by immersing herself in it.

The researcher printed out the nine interview transcripts with a wide margin on the right hand side. She read through each transcript line by line, marking with a highlighter all the words and descriptions that were relevant to the topic of enquiry. This implied all words that described the participants' experiences of and thoughts on personal therapy and training. This criterion was used in a very broad and inclusive way and the researcher ended up highlighting phrases in almost every line of the participants' dialogue. Examples of phrases that were highlighted from one paragraph are:
"I think it is good to be reminded of what it feels like to be in the other chair…and to experience that"; "I think it's very different to be the therapist and to be the client…it's a very different experience…", etc.

From the highlighted areas the researcher then identified distinct units of meaning. Meaning units are identified and separated "by a break or change in

meaning" (Anderson, 2007, p.2). These meaning units were marked by brackets in the right hand margin, as illustrated above. The researcher aimed to identify as many meaning units as possible and then to name (code) the themes of the meaning units. For example, after experimenting with different codes, the researcher ended up coding the above: (personal therapy provides) "experience of being a client"; (personal therapy as) "supportive place"; and (personal therapy has) "therapeutic value". The researcher limited her own interpretations of the participant's responses at this stage, and tried to use the participant's own words as far as possible in coding.

The same process was followed with the other the transcripts. They were carefully read and relevant words and phrases were highlighted, after which meaning units were identified. Themes were then discerned from the meaning units and coded in the margins of the transcripts. The researcher ended up with between 38 and 53 codes for each transcript. Each transcript's codes were typed and printed out. The list of codes for Transcript 1 included: "personal therapy important aspect of training"; "felt pressurized to have personal therapy"; "grateful for personal therapy"; "mixed experience of personal therapy"; "personal therapy compulsory"; "master's training stressful"; "training influenced experience of personal therapy"; "experience of therapist"; "expectations of therapist"; "learning about the process of therapy"; "understanding of the frame"; "the financial aspect"; etc.

3.6.2 Step 2: Axial Coding

The next step was to categorise the codes. Ezzy describes the aim of axial coding as "to integrate codes around the axes of central categories" (2002, p.91).

The typed codes were compared, contrasted and reflected upon. The researcher drew diagrams, linked codes, grouped codes together and created tentative categories. The researcher explored the properties and dimensions of the codes, e.g. codes that referred to "the approach of the therapist" had

the properties of “psychodynamic”; “Rogerian”; “supportive”, etc. For each of these approaches, participants’ experiences differed along a dimension. This led to some codes being divided into separate codes, or multiple codes unified into one category. The researcher revisited the text throughout this process and experimented with coding words, lines, sentences, paragraphs and even pages. The researcher finally ended up with about 25-30 categories for each transcript. Some of the categories overlapped, some did not.

Next the researcher combined the categories/themes for all the interview transcripts. The researcher carefully considered whether categories were too large or too small and whether there were too many or too few. The categories were re-labelled, subdivided and collapsed as appropriate and were reworked to 12 themes and 11 sub-themes.

3.6.3 Step 3: Selective Coding

Selective coding requires identifying the core code or story in the analysis. Two core themes were identified from the data, around which all the other codes fitted, namely “The impact of personal therapy on personal development” and “The impact of personal therapy on professional development”.

The themes and categories that emerged from the data analysis were finally also linked to pre-existing themes that were identified in the literature study.
The themes from the data and the pre-existing themes overlapped considerably. The process of integrating the literature and data analysis involved “negotiating between categories that emerge through the data analysis and knowledge of categorical schemes utilised in relevant literature and theory. The aim is to avoid the knowledge of existing [literature] forcing the analysis of the data into these pre-existing categories” (Ezzy, 2002, p.94). Ezzy explains that by comparing the categories from the data with the existing categories, a “new and more sophisticated understanding of the experience can be developed” (2002, p.94).

3.7 QUALITATIVE VALIDITY

Guba and Lincoln (1985) suggested four criteria of sound qualitative research, namely: credibility, transferability, dependability and confirmability (Trochim, 2001; Terre Blanche & Durrheim, 2005).

3.7.1 Credibility

The primary concern of internal validity is the degree to which the research conclusions are true. In qualitative research this is referred to as “credibility” and it can only legitimately be judged by the participants as it asks whether the results are credible from the perspective of the participants in the research (Terre Blanche & Durrheim, 2005). To establish credibility for this study the researcher emailed the results chapter of the study to all nine participants and asked for feedback before finalising the conclusions. The questions put to the participants were be: “do you find these results credible?” and “are these results a true representation and interpretation of what you meant?” The researcher received valuable feedback from the participants, which she summarised and refer to in the conclusions.

3.7.2 Transferability

Transferability refers to the degree to which the results can be generalised to other contexts. The researcher would like to make clear that the context of this research is the professional training of clinical psychologists in South Africa and that eight of the nine participants were in psychodynamic psychotherapy. The results are therefore limited by these conditions, and the researcher does not propose that these be generalized to other populations or settings, without mentioning the specific context of the research.

3.7.3 Dependability

Studies of the interpretive paradigm do not “assume that they are investigating a stable or unchanging reality and therefore do not expect to find the same results repeatedly” (Terre Blanche & Durrheim, 2001, p.64). Dependability in qualitative research accounts for the continuously changing context of the research, rather than for the replicability of results, as in the case of quantitative research. Each participant had a different therapist and a different experience of r therapy, clinical training, and the effect the therapy had on their personal and professional lives. The researcher did not approach this study to find generalizable results , but rather to determine what each participant’s experience was in their given context, and to see if common themes emerged from these different experiences. But it should be noted that though common themes like “the experience of personal growth” emerged, the participants’ experiences of each theme differed quite markedly. Each participant defined and experienced “personal growth” in a unique way.

3.7.4 Confirmability

Confirmability indicates “the degree to which the results could be confirmed or corroborated by others” (Trochim, 1995, p.163). The researcher submitted her research results to her supervisor prior to finalizing the report. The supervisor scrutinised the data analysis, critically interrogated the findings, and provided relevant feedback in this regard.

3.8 ETHICAL CONSIDERATIONS

3.8.1 The Committee for Research on Human Subjects (CHRS)

Since this research involves human subjects, the research proposal was submitted to the University’s Committee for Research on Human Subjects (Humanities) in October 2006 for ethical clearance, which was duly granted. The role of the committee is to monitor the ethics of research protocols, i.e.

the risks and benefits to the informant or subject. Its role is to ensure that the research respects the rights of individuals and that:

- Informed consent was obtained without coercion;
- Confidential matters are handled circumspectly;
- The privacy and wishes of participants are respected;
- The participants are informed as fully as possible as to the aims and possible implications of the research.

3.8.2 Informed Consent

Participants were informed of the aims and purpose of the study in the initial informative letter (see Appendix A). Participation was voluntary and participants were informed of the option to withdraw from the study at any point (see Appendix A). The researcher obtained written informed consent for the interviews and the recording, transcription and usage of all data (see Appendices A, B and C). The researcher provided participants with her contact details and assured them that she would be available to answer any questions they may have during the study. Participants were informed that the results would be made available to them upon completion of the study.

3.8.3 Anonymity and Confidentiality

Participants' and their therapists' identities have not been identified and participant numbers were used instead of names. The transcriber was required to sign an agreement of confidentiality (Appendix D). Video recorded interviews are being kept safe by the researcher and will be destroyed once the research report has been assessed and passed.

Transcripts have been coded so that participants' names do not appear anywhere. Coded transcripts have been submitted as appendices to the dissertation for examination purposes, but will not be part of the final publication lodged in the university library. The researcher has attempted to mask, to the best of her ability, the gender, age and identities of the

participants when submitting the transcripts to her supervisor and examiners. No identifying information will be included in any publication of research results.

3.8.4 Researcher Integrity and Reflexivity

The researcher attempted to maintain researcher integrity throughout the study as per the guidelines described by Mouton (2001): adhering to high technical standards; indicating the limits and constraints of the study at the conclusion of the research in section 5.2 (*Limitations*); disclosing the theories, methods and research design as fully as possible; and reporting findings fully and not misrepresenting the results in any manner.

Patton (1990) stressed the importance of being aware of one's own researcher biases. The researcher was aware that her own subjectivity would impact the process of data collection and analysis, especially as she herself was a third year master's student who had completed two years of personal therapy as part of her training. The researcher attempted to assess and analyse her own perceptions, views and possible biases throughout the study. At the onset of the study, the researcher did not have a specific bias for or against personal therapy as part of training. The researcher felt that her own personal therapy had been beneficial in some ways, but also challenging and at times difficult and was interested to know what other students' experiences had been like. The study did not propose a particular argument at the outset and the researcher looked forward to developing interpretations and hypotheses from the analysis of the data.

The question was how to collect and analyse the data in such a way that her own subjectivity did not unduly influence the results of the study. The researcher felt that the best approach would be to question and reflect on her own responses during and after the interviews and throughout the process of data analysis.

Before the interviews the researcher felt ambivalent about personal therapy, concurrent with and as a requirement for training, and was interested to see what would emerge from interviews on this subject. As the interviews commenced she found herself silently agreeing or disagreeing with what was said by the participants, but did not find it difficult to hide her own internal responses as she had a strong desire to remain unbiased and to not contaminate the data in any way. The researcher was acutely aware of how it would enrich and validate the study to have a variety of experiences and opinions as part of the data.

During the interviews the researcher took care not to influence the responses to the interview questions through the way questions were asked, or by the feedback given to the participants. It will be evident from the transcribed interviews that the researcher limited herself to minimal feedback aimed at either creating rapport or encouraging the participants to recount their experiences in as much detail as possible.

The researcher felt that the ultimate aim of the study was not to take a stance or draw conclusions on the desirability or not of personal therapy, but rather to thoroughly and honestly explore and discuss students' experiences thereof and to make interpretations and recommendations on the basis of the results. In order for these conclusions to flow from the data it was important that the researcher be open to varied and possibly conflicting experiences of the participants.

CHAPTER 4 RESULTS AND DISCUSSION

This chapter presents and discusses the research findings. Seven main themes and fourteen sub-themes were inductively developed from the data. The chapter demonstrates the results of the thematic content analysis: descriptions and discussions of the participants' experiences are presented according to the identified themes. The researcher attempted to provide descriptions in the participants' own words as far as possible in order to convey the essence and authenticity of their experience. Each theme is discussed and linked to the existing research literature on the subject. The identified themes are:

Theme 1: Personal therapy as part of training

a) The mandatory requirement of personal therapy
b) The importance of personal therapy as part of training
c) The challenges of personal therapy concurrent with training
d) Separating personal therapy from the training

Theme 2: The impact of personal therapy on a personal level

a) Insight and personal growth
b) Impact on close relationships
c) Support and Containment

Theme 3: The impact of the therapy on a professional level

a) The therapeutic process
b) The frame
c) Theory
d) Empathy
e) Modelling
f) Countertransference
g) Professional growth

Theme 4: The therapeutic approach

Theme 5: Initial versus later experiences of personal therapy

Theme 6: Personal therapy as supervision

Theme 7: Financial implications

Before discussing the themes it would be prudent to give a summary of the duration and nature of each participant's personal therapy. All participants had therapy on a one-session-per-week basis. The duration of therapy is counted as the total number of months the participants had engaged in personal therapy from the start of the masters training in January 2007 until the time of the interview in May 2008. Some of the participants had had therapy before 2007, but this will only be referred to if relevant as it was not considered part of "required personal therapy" and is thus incidental to the research focus.

Participant 1 had never been in therapy before. They commenced personal therapy in February 2007 and terminated with that therapist in January 2008. The participant immediately took up therapy with another therapist and was still in therapy at the time of the interview in May 2008. The participant had completed a total of 16 months of required personal therapy by May 2008.

Participant 2 had been in therapy previously, but commenced personal therapy in March 2007 with one of the therapists recommended by the university. The participant was still in therapy with the same therapist at the time of the interview in May 2008, a total of 15 months, and planned to continue personal therapy indefinitely.

Participant 3, who had previous experience of short term therapy, commenced required personal therapy in April 2007 and was still in therapy with the same therapist at the time of the interview in May 2008 – a total of 14 months.

Participant 4, who had never been in therapy before, commenced therapy in May 2007 with an educational psychologist and terminated with that therapist in March 2008. The first therapist then referred the participant to a psychodynamic therapist as there was a specific issue both the first therapist and the participant felt would be better suited to psychodynamic-oriented psychotherapy. The participant commenced therapy with the psychodynamic therapist in April 2008 and was still in therapy at the time of the interview in

May 2008 – a total of 13 months. The participant planned to continue with this therapy indefinitely.

Participant 5 had been in therapy before applying for clinical training. He/she commenced with personal therapy in February 2007 and was still in therapy at the time of the interview in May 2008, totalling 16 months of personal therapy. The participant planned to continue with the therapy at least until the end of 2008.

Participant 6 commenced therapy in April 2007 – it was their first time in therapy. The participant was still in therapy at the time of the interview in May 2008, a total of 14 months at that stage, and planned to continue indefinitely.

Participant 7 had been in therapy since 2005 and continued with the same therapist during the first year of clinical training in 2007. The participant terminated with the initial therapist in December 2007. The participant then commenced therapy with a more psychodynamically oriented therapist and was still continuing with this therapy at the time of the interview in May 2008 – a total of 16 months of required therapy as part of the masters training.

Participant 8 commenced therapy around the middle of 2006 and then continued with the same therapist through the first year of clinical training in 2007. The participant terminated therapy in December 2007 due to a combination of inflexible working hours at the internship institution and transport difficulties. The participant had therefore completed a total of 12 months required personal therapy from January 2007 to December 2007.

Participant 9 commenced therapy in February 2007 and was still in therapy with the same therapist at the time of the interview in May 2008, a total of 15 months.

4.1 THEME 1: PERSONAL THERAPY AS PART OF TRAINING

4.1.1 The Mandatory Requirement of Personal Therapy

The psychology department at Wits requires clinical psychology students to be in weekly personal therapy for the two-year duration of their masters training. The required personal therapy is nonreporting, meaning the therapist does not report back to the university on any aspect of the therapy, including the progress of the therapy, the suitability of the trainee, concerns the therapist may have about the trainee, etc. The therapist is only asked to confirm to the university that the trainee is in therapy. The therapy is considered a private matter between the therapist and trainee and it would be an ethical violation on the part of the therapist should he/she transgress the confidentiality of the therapeutic relationship.

This theme is concerned with the mandatory nature of the therapy: the participants' thoughts and feelings about the requirement and how it influenced the participants' experience of their therapy. Every participant made reference to the fact that the therapy was mandatory, but their opinions on, and feelings about, this requirement differed widely.

It seems that, before the start of their clinical training, at least five of the nine participants (Participants 1, 2, 4, 5 and 6) did not have a comprehensive understanding of what personal therapy was or why it was required. They also indicated that they initially did not feel a need to embark on their own personal therapy and would not have done so independently if it had not been a requirement of the training. Participant 6 explained that at the time she started her clinical training she did not understand the need for personal therapy and would most probably not have commenced therapy independently if it was not a requirement of the course. She explained that she did not fully appreciate the value of therapy as she had never been in therapy before:

“I’ve never ever been in therapy before. And of course I knew [that] during the [course] I was going to have to be in therapy. I have to say it was daunting for me because it was something that I’d never done, and I kind of, I was thinking ‘this is a hard enough year for me’….And it kind of makes me wonder, if it wasn’t a stipulation of the course, would I have gone? Would I have stuck it through, you know?”

As part of the orientation phase of their training, the trainees were presented with a written rationale for the requirement of personal therapy. The rationale and the specifics of the requirement were also discussed with the class at the time. It is interesting that, despite the explanation and discussion, four of the participants (participants 1, 2, 5 and 6) still felt that they lacked an understanding of personal therapy and that they felt they would have benefited from a better explanation of why personal therapy was required. Participant 5 could not even remember any explanation given by the department and initially thought that the reason therapy was required was to support them through the difficulties and challenges of their studies:

“I think initially when they say look this…personal psychotherapy is a requirement as part of the course, it’s quite daunting in a way,…because they don’t say why they recommend psychotherapy, that’s not clear, you know. Um, and so initially I thought perhaps it’s to help us manage the course. And then after going to psychotherapy I realized it actually has nothing to do with the course, it’s more about, you know, our personal stuff and I found it incredibly valuable….I mean I’m still in therapy, so I’ve chosen to continue…”

Participant 1 expressed a need for more in depth discussion with the trainees about the requirement:

“If there was more of a conversation about it…what it means for trainees to be in therapy, why it is that [the department] is so strongly recommending it, I think that would have been quite a useful thing.” This participant adds, “We were under pressure…it was a compulsory part of the course. And I do think that was a valuable thing. I just don’t think we were given enough time initially

in terms of talking about what it means to be in therapy….Initial discussion about it could be given a bit more time and explanation, so that we could understand."

Participant 2 felt that the rationale for personal therapy "could have been explained more" by the university: "I can't remember there being a tremendous understanding of why we needed to go. It was very much 'You will do!' It felt like that, sort of, at the time. And so I think the whole thing of going off to our own therapists might have been quite mysterious. A bit like the process itself."

This general confusion and poor recall of the course coordinator's introduction to this requirement of and reasons for personal therapy could indicate some initial conflict and anxiety about therapy as a course requirement. Freud identified several kinds of resistance to therapy, including resistance to uncovering repressed material, resistance to the insights provided by the therapist, etc. Much has been researched and written about resistance to therapy, however no studies could be found on the resistance of trainee therapists to the training analysis/personal therapy. This is an area that warrants further study. One of the participants, Participant 2, did in fact propose that some of the class' objections to the requirement of personal therapy could be explained by their resistance to therapy per se. The participant pondered the idea that their resistance to undergo therapy might have been projected onto the "university" (implying the psychology department): "I mean therapy is a painful process, you know. Maybe it suited us also to resent the fact that the university was forcing us to go." And: "Your resistance to go…maybe the university offered a very nice place to, you know, project your resistance…"

Participant 2 remembered the class discussing the ethics of mandated therapy at the beginning of the masters' year, but explained that his/her own need for therapy once the course started solved the personal dilemma. "I was aware that you can't be forced…you can't be told you have to go into therapy…and I think a few of us were aware of that, so we had a little bit of a

discussion around the nature of how it was presented to us…But, the feeling that I needed my own therapist…happened within about three weeks of starting training."

The participants were aware of the fact that therapy could not be enforced, and that even though it was a course requirement, participation in personal therapy was still voluntary. This seeming ambivalence was pondered by some of the participants and also led to spontaneous discussions among the students in class.

Participant 8 mentioned class discussions debating the requirement of personal therapy in the light of section 11 of the Rules of Conduct Pertaining Specifically to the Profession of Psychology (2006) that states that a client of psychotherapy should be "aware of the voluntary nature of participation and has freely and without undue influence given his or her consent." The participant recollected the class discussions as follows:

"I think it was towards the end of the year when…there were debates about this you know. My colleagues were debating…they were sort of raising the point about, you know, um…I think something in our ethics psychology…where it talks about, um, students can't be forced to see a psychologist. So we're talking about that, just discussing it and I remember I didn't have any strong feeling [about] it. I had sort of a neutral stance you know, because I felt it was useful for me. I didn't feel like I didn't have a choice, you know".

It was not clear exactly what positions the class debated. The participants mostly remembered the debates centering on the ethical implications of mandatory therapy, how therapy could not be enforced, countered by the reasons they thought it necessary to have personal therapy. They did not appear to debate the ethical foundations of the ethical code. In other words, they did not appear to discuss the possibility that it could be unethical for someone to treat patients without having had treatment themselves. In this regard Participant 2 observed that one of the reasons they found the therapy

“vital” was “definitely because of the consciousness of how our own issues can impede our therapeutic relationships with our clients and our patients.” The participant felt that in that sense it was part of their “professional ethic” to have therapy.

When participants were asked specifically whether the fact that the therapy was mandatory impacted in any way on their personal therapy most (participants 2, 3, 4, 5, 7, and 8) felt that it did not have an impact. Participant 3 answered: “Well, I think…the fact that you kind of had to find the therapist and begin therapy…did give me that push to be there…but…other than [that] I don’t think that it really impacted to any great degree, the fact that I felt I had to be there.” Also, the participants who had been in therapy before (participants 2, 3, 5, 7, 8 and 9) did not seem to be much affected by the fact the therapy was “required”. Participant 7 stated: “I’ve been in therapy before so I kind of continued with the therapist I was seeing before…so I didn’t feel like…forced into therapy.”

Participant 1 felt that the mandatory requirement of therapy did have an impact on their experience of therapy. When asked whether they thought it made a difference going to therapy that was mandatory the participant replied: “I think it makes a big difference, I think it changes the investment in it”, thereby implying that s/he was less invested in personal therapy as a consequence of its mandatory status.

Participant 9 felt that the mandatory requirement only impacted on their initial experience of personal therapy: “Ethically, you shouldn’t be *made* to do therapy, so I think it’s a different kind of therapy. In terms of ethical stuff it was initially difficult to get my head around the fact that it was part of our course.” This ambivalence was resolved as the participant’s therapy progressed. Asked how the they felt about the therapy being mandatory the participant replied that they thought it “necessary” and felt that “if you are going to be going into this field, you have to be quite clear on your biases…I think that [it poses a question] if you do have an issue with going to therapy and you train in your master’s year of clinical psychology…I think it’s telling if someone

doesn't want to go to personal therapy, [especially] if they've never had it before and they are going into psychology…I think that if you're training as a professional and you're not prepared to practise what you preach, it's telling."

All of the participants either expressed being grateful for the mandatory requirement, or considered the requirement necessary. Participant 1 describes being "grateful to have had that pressure…someone pushing me into this and saying that 'this is important'…"

4.1.2 The Importance of Personal Therapy as Part of Training

This subtheme is concerned with whether the participants considered personal therapy to be a necessary part of training or not. Past research has commonly shown two significant findings, namely that the majority of therapists and trainee therapists rated personal therapy as an important part of training (Darongkamas, 1994; Macran & Shapiro, 1998; McEwan & Duncan, 1993; Norcross, *et. al.*, 1988; Pollard, 2005; Pope & Tabachnick, 1994); and that participants who had undertaken personal therapy themselves were more likely to favour mandating therapy as a training requirement (Pope & Tabachnick, 1994) and to recommend it to other trainees (Darongkamas, *et. al.*, 1994). The Pope and Tabachnick (1994) study found that the majority of respondents (70%) believed that personal therapy should be a mandatory requirement of training. The responses of the participants in this study mirrors the results from these previous studies.

The researcher explicitly asked all the participants their opinion on the importance of personal therapy as part of training. Putting the question to them, I did not use the word "mandatory" because of the ethical and emotional issues that appeared to be tied up in that, but instead asked whether they thought personal therapy *should be part of training* and, if so, whether they thought it to be "desirable" or "necessary"? Their answers were varied, but all of the participants felt that personal therapy was an important and valuable aspect of their own clinical training. All, except Partipant 8, thought personal

therapy to be a “necessary” part of clinical training. They gave various reasons, including gaining insight into their personal dynamics, enhanced empathy for clients, and personal therapy as a source of containment and support. The reasons mentioned will be discussed as part of Themes Two and Three when we look at the impact personal therapy had on the participants. Herewith some of the participants’ thoughts on the importance of personal therapy as part of training:

Participant 1 commented: “I do think it’s an important part of the training…and I am grateful for it….I do find it difficult when I hear of people who’ve been trained and they haven’t been in therapy. I don’t know how they then are therapists.”

Participant 2 offered the following remarks: “On the whole, I found therapy vital.”; “for me, I couldn’t imagine my masters training program without it…That’s how strongly I would advocate it…”; and “…I can just really say…I would not like to do my masters program without going to psychotherapy. I think that’s how strongly I feel about it.” The participant also described the therapy as “vital for my own self care.”

Participant 3 was concerned by the fact that more universities in South Africa do not require personal therapy during clinical training and proclaimed this “a shame”. When asked about the desirability of personal therapy during clinical training the participant answered: “I think it’s essential. And I don’t know if I had that opinion to begin with, you know…I understood why it was beneficial, but…as I progressed with the MA and with therapy, so more and more so…I think that it’s absolutely essential.” “In the beginning, and I saw [this] for myself…it didn’t seem that necessary. But now…I really have a much stauncher position on prescribing it…as it progresses you see the benefits more and more.”

The participant expressed their opinion on the value of the therapy as follows: “I found it incredibly valuable, incredibly valuable. It’s been a really valuable experience, um, not just like personally, but as a psychotherapist in training.”

When asked for their thoughts on the need for personal therapy Participant 7 replied: “I think it should be mandatory. Yah, I really don’t see how you can do that course without it, and it’s not only the changes you go through, and understanding who you are, and what’s happening, and how you’re trying to negotiate all the new stuff that’s going on, but it’s also, you need to know what it feels like to be a patient. You need to know how damn hard it is sometimes to be a patient and I feel like, I really do feel like, I’ve benefited in that way. And it does give an increased amount of empathy. How can you sit with someone if you don’t know what it feels like to be in their place?” Earlier in the interview the participant also said: “If this is the work I want to do I need to know how it feels like to be a patient in that situation, and it is quite a different experience.” “In retrospect, I see the value of it. I’m not sure how you can get through M1 [the first masters course year] without your own personal therapy. Because it’s an academic year but it also challenges a lot about what you think, and who you are. And, um, and to deal with that alone is maybe not such a good idea. I think you are changing and you’re experiencing stuff you haven’t experienced before and then I think it’s so important to just have a space where you can just settle that and try and figure out at least, you know, what’s going on.”

Although Participant 8 did not feel that therapy should be mandatory, they found it very valuable: “I feel personally…I think it was very useful for me, very, very useful.”

When asked whether they thought therapy in the context of training to be desirable versus necessary, Participant 9 replied that they thought it “necessary”: “Once I got over the fact that my therapist wasn’t gonna be assessing me in terms of for marks, it was quite a valuable space….I think that personal therapy in general is necessary to be a psychologist.”

Talking about the importance of personal therapy as part of training, two of the participants (participants 4 and 6) mentioned that they had not understood the importance of personal therapy before they had experienced it themselves.

Both said that their opinion changed from not thinking it necessary at the beginning of their course, to valuing it after having had personal experience of it. It is notable that participants 4 and 6 had not been in therapy before and that this was their first experience of therapy.

It is understandable that a person who has not experienced therapy before would not appreciate its value, but it is surprising to find students of psychotherapy admitting that they did not understand the value of therapy at the time of undertaking their clinical training – an advanced stage in the study of psychology. This demonstrates, at least in this case, how the theoretical study of psychotherapy does not instil the value and importance of therapy to the same extent as a personal experience of therapy.

Participant 4 stated, “Personally, actually, I don’t think if I hadn’t gone through therapy, I…would have known what the value of it is. Um, I think it really made me see what the value of therapy actually is…and what it can do for a person and not just, because I mean yes, we had to do it because we were training, but the value that I got on a personal level.” The participant stressed that they thought personal therapy during training to be important: “the first year definitely. Without therapy I don’t think [shakes head]…It’s a very hard course…It’s very self-reflective…”

Asked their opinion on therapy as part of the course, Participant 6 answered: “I mean it is difficult, you know, to have to do it during that year, but I don’t think it’s something that you can pass on. Because, like I was saying earlier on, I don’t know if I would have, if it wasn’t necessary for the course, if I would have chosen to do it…I see the importance of having done it you know. It is…an important aspect of becoming a psychologist, I believe. So I think it may sound harsh, but I think it’s like, Wits [the University of the Witwatersrand] is correct to make it compulsory. I really do.” Also: “Seeing patients it’s important to, kind of like, know what your issues are, I think, and to be aware of them…as a therapist…be aware that sometimes your countertransference may be biased by your own issues. And I think it’s important to have…well, not necessarily worked through all of your issues, but

to be aware of them, to be aware of what might come into play. So I understand why it has to be, you know, compulsory that we do it…during the course.

4.1.3 The Challenges of Personal Therapy Concurrent with Training

Another theme that emerged from the interviews was the challenges involved in embarking on therapy at the same time as commencing a postgraduate degree. All of the participants mentioned some challenges of having personal therapy concurrent with training. This was not surprising as previous studies have found similar responses from participants. Kaslow and Friedman (1984) found one of the negative aspects of personal therapy listed by respondents to be the stress of graduate school in combination with personal therapy. Macran and Shapiro (1998) found that, "despite its positive qualities, personal therapy imposes a major burden, particularly for therapists undergoing training" (p.16). In the Darongkamas (1994) study, 88% of respondents reported that they found personal therapy "stressful" to some extent.

Most of the participants (Participants 1, 2, 3, 5, 6, 7 and 9) reported some difficulty coming to terms with the simultaneous demands of the training and the emotional toll of therapy. Words they used to describe their experience included: "overwhelmed", "challenging", "stressful" and "demanding". At the same time, and often in the same breath, the same participants (Participants 1, 2, 3, 5, 6, 7 and 9) mentioned the value of having therapy while in training – finding the therapy a supportive space.

Participant 1 experienced the simultaneous commencement of training and personal therapy as "overwhelming": "We had to start the therapy…and it was anxiety provoking because…I think it's the time of the year as well. Everything about that time, the beginning of your M1 year is quite stressful." The Participant described "feeling overwhelmed with a lot of stuff happening at [once]…because I do think that therapy is challenging under the best circumstances." "A lot of the learning happens in your own therapy…in some

of the challenges of therapy." Also: "I think M1 is a very, very tough year. I think it throws most people into some kind of spin, and I think therapy is also just basically a very supportive place where you could go with that." "I think a lot of us were carried through the year because we had someone to go and speak to every week. So it feels like a bit of a mixed experience."

Participant 1 also found that another challenging aspect was the meta process of "learning about therapy" while having therapy: "On [the] one hand it's just therapy, it's therapy as anyone would experience it, but then there is the added dimension of learning about therapy, trying to understand it, being a trainee, what that means, and taking that to therapy, which I think does complicate it to some extent…I think it's such a strange experience for anyone who is a therapist to be in therapy. It's always going to be a little bit different when you actually have a way of thinking about therapy."

Participant 2 experienced therapy as "hard work", but felt it filled a need for "self care" during a trying course: "I really felt that I needed my own space, I needed somewhere away…due to the stress, I think, of the course." "Therapy was somewhere where I took my 'unravelledness' from the university to."

Participant 3 referred to the vulnerability that comes with having therapy and how it was not easy to carry that into class and weather the demands of training while feeling exposed: "You kind of feel like not having therapy so I don't…so my defences aren't pulled down…You kind of feel like you need your defences, especially if you're in the beginning of the year." "The issues that come up and the theory that you're reading…it's anxiety provoking. I think the M1 year on its own without the therapy is quite anxiety provoking."

Participant 5 explained: "It was quite demanding...because the effect of my therapy lasted a long time beyond those 50 minutes that we would work on whatever it was in therapy and I would still carry that with me until the next time I went to therapy. So the work was happening all the time which is quite a strain with all the other work we had: being therapists ourselves, academic stuff… Um, yah it was a strain but in a way which I would still…[I] wouldn't

trade it for not having the therapy, definitely not." "It was really hard work trying to balance my own stuff and what I was unpacking…every week in therapy and what I had to do every single day in class. So that was, it was quite a strain I think."

When Participant 6 was asked how they experienced embarking simultaneously on both therapy and training, the participant answered: "At times it was, like I said, a supportive environment, but mostly just emotionally exhausting. I mean the course in itself is emotionally exhausting. You learn so much about yourself, as well as about all sorts of things, you know, so I did find it very difficult in terms of, I suppose, emotionally. Yes it was hard, it was hard work. The course was hard work, so was the therapy. And I didn't, it wasn't something I looked forward to going to every week." "I think its just such a…packed course, there wasn't any time to do anything."

For Participant 7 the therapeutic space provided a refuge from the demands of the training: "I think just to be in M1 is a very difficult experience. I don't think you realise it until you're in there…it's really important to have that kind of space you can go to every week." Participant 8 talked about the heavy cost" of training "but when you go [to therapy] you offload stuff…that's why…for the whole year, I attended therapy almost every single week. You know, I attended therapy, I didn't miss any session."

Participant 9 referred to their difficulty with "opening up" in therapy, while at the same time withstanding the continuous assessment of the first year of training: "It was quite an assessment-based year, you know, where you were being continually assessed, and I think in some ways, in some ways going to therapy, and opening up every week was kind of sometimes, um…counter-productive to surviving all that assessment…"

The experiences reported above are not unique. It corresponds to other first-hand accounts of the difficulties of personal therapy. In "Some Thoughts on my Own Training Analysis", Vives (2005, p.710) reflects on his own analysis:

> The experience of free association, the appearance of resistance all the time, moments of despair alternating with liveliness and gratitude, deep regressions that occurred during the process, and the new modalities of thought and comprehension that I was able to extract from them are unforgettable parts of a long analytic process—painful and exasperating at times, and very enriching at others.

4.1.4 Separating Personal Therapy from the Training

Anna Freud wrote in 1938 (Desmond, 2004) that she considered the main problem with the training analysis to be that the analyst reported back to the training institution on the suitability of the trainee. From about the 1940's this has been one of the major and most persistent criticisms of the training analysis: "To the extent that an analysis is 'therapeutic', it stands a chance of being successful, to the extent that it is a 'training' analysis it is fraught with problems" (Desmond, 2004, p.38). That the trainee was also being trained, assessed and supervised by the therapist complicated the therapeutic relationship, especially the transference and countertransference. The critical voices called for a non-reporting analysis and a complete separation of training and analysis.

Geller *et. al.* (2005) note that today we are generally "aware of boundary issues in analysis…The philosophy is to preserve the privacy of every candidate's personal analysis" (p.30). The personal therapy required from the trainees in this study was a non-reporting personal therapy, meaning that the therapists were not required or allowed to give feedback to the university on the trainee or the therapy. The therapists recommended to the trainees were not involved in their training in any way. The therapist's role was also not supposed to be that of a supervisor, at least not in any official capacity. Trainees were handed a substantial list of recommended therapists, but were also free to choose any other appropriately qualified therapist (participants 4 and 7 chose therapists that were not on the list). Still, some of the participants struggled to mentally separate the personal therapy from the training, especially initially. It seems that this may have been partly because the

therapy was a mandatory requirement of the training and was experienced as linked to the training in that sense.

Participants 2, 3, 4, 8 and 9 reported difficulty separating their personal therapy from the training. Some found that they projected the difficulties they had at university and with their lecturers onto the therapist. Participants 2, 4 and 9 struggled with irrational feelings of being monitored and evaluated by the therapist.

Participant 2 found that the "link" to the university influenced their therapy at first: "I think initially…the relationship that I built with my therapist…the first couple of sessions were a little bit marred by the fact that…it felt like there was this link back to the university with my therapist.…If you weren't in therapy, your therapist would need to inform the university at some point that you were no longer in therapy."

Participant 4 experienced personal therapy as connected to the training in the way that both activities were "monitored" by the psychology department: "we had to, when we found our therapist, we had to give [the department] the therapist's details, and then the therapist would give um…it wasn't feedback, but just [the department] would call, once every three months I think it was… just to make sure that we were still in therapy. I'm not too sure if [the department] even did call every three months, but [they] did contact [our therapists] to make sure that we were in therapy…" The participant talked about being monitored and being evaluated as part of the course and then related that back to the personal therapy: "Yah, I think that was the other thing, that's why I'd never do it [the course] again. To be monitored every single step of the way was just…because in the beginning I was very guarded, I didn't want to speak in therapy. I was quite fine with the silences, but eventually I think the course just got to me, and I really didn't care anymore about being monitored."

Participant 9 discussed their struggle to separate the therapy from their training: "it took me a while in the therapy itself to try and separate my

personal therapy from the course, it did feel like another element of assessment…it took a while in our relationship to distinguish [the therapist] from just another element of the course." The training "takes over your life" and "it felt like it sort of came into that space as well."

Participant 3 described their experience of therapy in this regard: "For me, in many ways…it was part of the training….First of all my therapist happened to be off [i.e., from] a list that was given to us. So, I think in some way that impacts on…the way you experience the therapy, because…it feels like it's still tied into it. And it's very much part of the training. So I think there was a bit of that that I…was negotiating all the time." Later in the interview the participant said: "I felt pressured by my own internal kind of pressure to work kind of really hard as well in the therapy because I felt that embarking on this profession I owed it to myself to use the space as much as I possibly could. Because I realized, even then, it's my therapy…it's something that's separate [from the training] as well."

Another obstacle for Participant 3 was coming across their therapist, outside of therapy, in professional circles: "And just the fact that you've embarked on this professional training and your therapist is part of the society [is] also like an obstacle to negotiate….You would also…be in some of the circles and [attend] talks, and that kind of thing where you'd see them as well…it took some negotiating…it was a little difficult in the beginning, that kind of thing." Geller, *et. al.* (2005) acknowledges this dilemma and states that the aim of a training analysis "is clearly different from that of a person who comes for the relief of symptoms. In the non-training analysis, there is an endpoint at which the analyst and analysand separate, whereas in the training analysis there is a continued connection in their shared professional world" (p.30).

Participant 8, who was the only participant to see a therapist on campus, explained their experience of the connection between their training and therapy as follows: "Because I'm still on campus, my therapy is on campus, I attend lectures on campus, so everything was around here…the two for me were not separate, you know. It was sort of one and the same thing."

The separation of “training” and “therapy” in the training analysis has been a longstanding problem. As mentioned earlier, the training institution (Wits) that produced the participants in this study has taken careful measures to separate the clinical training from the personal therapy. It therefore appears that the trainee’s suspicion and discomfort with the real and perceived connection between the university and their personal therapy can be attributed to the trainees’ transference issues. In “Reflections on Training Analysis” (1970), Fordham explained that the transference in a training analysis presents certain unique characteristics. Candidates don’t dare to attack their therapists directly in therapy for fear that the therapist may retaliate by “blocking their membership of the Society” and obstructing their future careers, even though they knew rationally that there wasn’t a real possibility of that happening. According to Fordham the trainee’s “position supports splitting of the transference” (p.65) with parts of it projected onto the training institution and the supervisors. That makes it safer for the trainee to be suspicious of and attack the institution rather than the therapist. Although conjecture on the researcher’s part, this may have been the dynamic at work in participants’ responses presented in Theme 1.

4.2 THEME 2: THE IMPACT OF PERSONAL THERAPY ON A PERSONAL LEVEL

Two of the questions listed in the interview guide were: “How did the personal therapy impact on the participant’s own professional and personal development, if at all?”, and “How did the personal therapy impact on his/her significant relationships, if at all?” The interviewer put these questions to the participants at the end of the interview in those cases where the subject matter had not spontaneously presented itself. All of the participants reported that the therapy had an impact on their personal lives. Common themes that emerged from these discussions were: therapy as catalyst for personal growth and insight; therapy as place of containment and support; and the impact of therapy on close relationships.

4.2.1 Insight and Personal Growth

Some of the reasons Freud gave for analysts to have an analysis themselves (see 2.2.3), were “learning to know what is hidden in one’s own mind” and gaining “impressions and convictions…in relation to oneself which will be sought in vain from studying books and attending lectures” (Freud, 1912, p.116). More recently, Mackey & Mackey (1993) concluded that developing insight was the most valuable effect of personal therapy: “Most frequently, the value lies in developing insights into one’s self which may enhance skill and functioning as a psychotherapist” (p.98).

The participants in this study credited personal therapy with self-discovery; personal change; increased self-knowledge; gaining understanding and insight into their own dynamics; and general personal growth. This resonates with previous research that found that personal therapy: led to personal growth, increased reflexivity and positive self-regard (Murphy, 2006); increased self-understanding and self-esteem (Pope & Tabachnick, 1994), increased self-awareness (Mackey & Mackey, 1994; Murphy, 2006; Pope & Tabachnick, 1994); substantially improved self-esteem and “clarification of the therapist’s own issues” (Darongkamas, *et. al.*, 1994, p.19); ameliorated personal conflict (Mackey & Mackey, 1993); and led to self-discovery, self-knowledge and increased accurate perceptions of their own pathology (Kaslow & Friedman, 1984).

Three of the participants (1, 4 and 5) also mentioned that their therapy brought insight on the specific matter of their identity as a psychologist and why they chose psychology as a career.

Asked about the personal impact of therapy, Participant 1 answered: “It was powerful. I think therapy is powerful and, personally, I think there was growth for me in it.” The participant described how exploring themes like: “why did I want to be a therapist?” led to insight and growth. The participant felt that

therapy led to a deeper understanding of their own interpersonal and intrapsychic dynamics: “Understanding all your dynamics in your relationships with people and how they relate back to early dynamics and how it brought you to where you are now.”

According to Participant 4, an objective of the initial (Rogerian) personal therapy was “really to grow me both as a person as well as a therapist”. Participant 4 described how “through the process [of therapy] I learnt to relax a bit and not be as controlling…So I think through that process [I got] to know myself a bit better, because I always thought I knew myself…I think I’ve become more secure in myself and…I trust myself a bit more. And through that I’ve been able to not be so guarded.” The participant also discussed the discussed the dissonance they experienced around feeling “worthy” of being selected for the course in clinical psychology and how therapy assisted in gaining insight into and accepting themselves: “So therapy was about trying to bring all these pieces together and be okay with, you know, being a masters student…knowing that I’m good enough to, you know, do this job.” This resonates with one of the four key phases Murphy (2006) found associated with personal therapy, namely the authentication phase. Murphy described it as a phase in personal therapy where confirmation is obtained “of the self as a valid and acceptable tool for practice” (p.31).

Discussing the impact of the therapy on a personal level, Participant 5 echoed other participants’ experience of increased self-knowledge and insight: “…just personally you know, [the therapy] allowed me to explore things that I didn’t really think about. Why I wanted to become a psychologist before. [To] know the deeper understandings of why I wanted to be a psychologist, it’s allowed me to come to that sort of point where I understand myself a lot better.”

Participants 6 and 8 both emphasised the insight they obtained in personal therapy by addressing past experiences. Participant 6 explained that therapy helped them to explore and work through conflicts from their past, leading to personal growth: “Sometimes you have things go on as you grow up, or in your life and, you know, you deal with them. They pass, but you never really

work through them all, or really have space to explore them all that much. And I think having had the space to do that has…has helped me…to know my issues, to know myself more and to grow, you know, as a person."

Participant 8 reported a similar experience of being confronted with past traumas and how insight into their personal dynamics brought personal growth: "I think…that's what made it very useful for me. Personal growth definitely and gaining insight into your problems. Also into some of the things that you never thought were problems….Some of the material that came out in therapy [was] very, very useful. Personally, because of the things that I was going through and things that I hadn't dealt with… Like previously in my life as a child, you know…and all those childhood traumas…stuff that I didn't talk to anyone about."

Participants 3, 7 and 9 felt that the M1 year brought about personal "change" for them and participants 3 and 9 attributed it to the concurrent experience of personal therapy and training. Participant 3 explained that they had been in therapy before, but "I think the training has magnified the therapy and I have been able to get so much more." "I find [the therapy] valuable in…the way it has made me look at things and look at myself and experience the world."

Participant 9 credited their process of personal "development" to the combination of the clinical training and personal therapy: "I think it's quite hard to separate out what had the greatest impact for me. Whether it was my personal therapy, whether it was the masters' [training], whether it was the both combined. I definitely see, sort of, changes in myself." And: "I found the last year and a bit [of therapy] very beneficial for me just because it was a time in my life where, because of the pressure of the course and what we were studying, stuff was coming to the surface that I could work with [in therapy]."

Participant 7 related how the therapy influenced their personal growth: "I have experienced some personal changes this year and I'm not sure if it's because of the old therapy [before clinical training] or because of the new therapy

[required personal therapy] or because of a combination….I really feel like [required personal] therapy did help me to discover a lot about myself as a person."

4.2.2 Impact on Close Relationships

All of the participants, except for Participant 8, reported that personal therapy impacted on their relationships with family or friends in some way. Pope and Tabachnick (1994) listed two of the main benefits of personal therapy to be a better understanding of, or relationship with, family of origin and a general improvement in relationships. This seems to have been the case for Participant 4 who reported that their personal therapy significantly impacted on their relationship with their parents. The participant experienced that their parents "grew…with me…and there was a big change in them and in myself. And this year as well, their growth has been phenomenal….You know, we are sort of separating that enmeshed relationship and the boundaries are becoming more clear."

Mackaskill and Mackaskill (1992) found one of the negative effects of personal therapy to be increased relationship stress. Asked whether the personal therapy had an impact on their close relationships, Participant 1 answered: "I think inevitably, because if you shift I think it shifts dynamics around relationships as well…and [this] will need to be worked through, so I think that sometimes, if stuff was taken to therapy and you understood something in a different way, that could put a relationship into crisis, which *was* [researcher's emphasis] difficult. Or it could resolve something…so it could go either way." One can see a shift from initially talking in a general way and in the third person and then switching to the first person mid-sentence ['*was* difficult'] an implicit admission that their own relationship was put into crisis by the impact of the personal therapy and that it "was difficult".

Participant 2 stated that just the fact that they were attending personal therapy had an impact on their relationship. They explained that the demands of the

training created a sense of alienation in their partner: “You are sitting sixteen hours a day…behind a computer and laptops and lectures and with your nose in a book” and that the therapy “added to my partner’s alienation.” “I think my partner felt that I was now talking to someone [else] and not him.” “I think he felt quite cut out sometimes by it [but] what relieved him, I think, was the compulsory nature.”

The other participants’ experiences of the impact of personal therapy on their relationships were surprisingly similar. Participants 3, 5, 6, 7 and 9 reported that partners, family or friends have had to adapt to the changes that occurred within the participants as a result of the therapy.

Participant 3 recounted how personal therapy impacted on their relationships with friends: “I’ve seen in my personal life that I have moved away from certain people or…become a little more distant in certain relationships…and moved towards other people that previously I would perhaps not have formed such close friendships with.” The participant attributed these changes in relationships to internal changes ascribed to the combination of personal therapy and clinical training. “Some (friends) have been able to negotiate the change in me, and others I think have found it difficult. Not that there’s been major shifts, but just a slight different way of seeing things, of seeing the world, a different perspective on things, perhaps also a different way of interacting with them.”

Participant 5 reported that their family had a difficult time adapting to the changes in the participant: “I think probably the biggest impact [of personal therapy] is on the people around me, my family…when I return home they’re quite startled because they are not with me every single day, going through the process with me…you know that’s when I really see how it impacts on people. Because they’re like, ‘We really don’t know you anymore’, you know. Sometimes it’s really a huge shock to them that I’ve learnt certain things or I’ve grown and because I’m living it each day I don’t often realize that. So it’s impacted them a lot. Oh, I think I’ve changed…I don’t know if that’s the right word, but…grown into myself more. Um, yah it’s definitely had an impact on

people, and not necessarily a positive impact, sometimes, on those people around me."

When participant 6 was asked about the impact of the therapy on their close relationships, they replied: "Through the process of therapy I am slowly becoming different and it's something that yes, we talk about it, but still, it's difficult to live with somebody and all of a sudden see them changing, you know? Yah, so it did impact quite a bit on our relationship. Like sometimes [my partner] wouldn't understand…the differences that [my partner] saw in me and although you try to explain it, but sometimes it's difficult…because [my partner] knows me as me. And of course, as life goes on we all change, but I think if, if you are in therapy maybe you… change at a faster pace than you would ordinarily. And because it is such a…almost solitary thing you're doing by yourself, you change alone. And if you're in a partnership, in a relationship, that's strange for somebody, you know?" "So it [personal therapy] did impact on us quite a bit…[my partner] knows what the course is all about and all that, but it's difficult to live with it at times….You know, I think it would be such a good thing if our partners could go through the process. Not necessarily be in therapy with us but also go through the process of being in their own personal therapy…it would help them to understand the process more."

Participant 7 distinguished between the impact of their previous therapy (2005 – December 2007) and the "more psychodynamic" therapy they commenced four months before the interview, finding that the more recent therapy had lead to "shifts" in their relationships: "I can without a doubt say that the psychodynamic therapy this year has much more of an impact on the people close to me than the therapy last year." When asked to elaborate, the participant replied: "In…I'm finding it a lot more challenging and I'm having to look at things that perhaps I was able to…I don't know…I wasn't ready to look at last year, but therapy didn't challenge [me] as much [last year] or it didn't um…yah, I don't know. But I've experienced some shifts in relationships this year and I mean it's only been four months."

When asked whether the therapy had any impact on their close relations, Participant 9 answered: “Yah, I suppose there was. I think it is quite hard for me to separate out what had the greatest impact for me. Whether it was my personal therapy, whether it was the masters year, whether it was both, combined. I definitely see changes in myself…The people around me have had to kind of adapt to those.”

4.2.3 Support and Containment

Seven of the nine participants (Participants 1, 2, 4, 5, 6, 7 and 9) referred to their personal therapy as being either supportive or containing, or both. “Support” was one of the main benefits of personal therapy indicated by respondents in the Pope and Tabachnick (1994) study. Most of the participants were at pains to mention that their therapy was not “supportive therapy”, which would be contrary to the psychodynamic emphasis on addressing unconscious conflict, but that they experienced it as supportive nonetheless.

Not only did the participants find the therapy supportive and/or containing, but Participant 1 and 5 also mentioned that they found the routine of having therapy at a specific time each week to be containing. Participant 5 found personal therapy “supportive” in that “it helped knowing that there was a specific time for me every single week no matter what was going on outside. I think [therapy was] supportive in that way. I mean [the therapist] by no means did ‘supportive therapy’ with me at all.” Participant 1 describes being “carried through the year because we had someone to go and speak to every week….Because I think M1 is a very, very tough year. I think it throws most people into some kind of spin. Um…and I think that the therapy is also just basically a very supportive place, a place where you could go with that.”

Participant 2 described personal therapy as “a healing process” that became “my self care, my psychological care, my container…and a relationship of trust was built – that I actually felt [the therapist] was there for me and not as a leg

of the university." The participant stressed that even though the therapist didn't work "in a very supportive way", they nevertheless experienced the therapy as supportive: "He (the therapist) never provided…supportive therapy….I was going to have to grow psychologically and intrapsychically and that would be my stability in the end….The support didn't come so much from outside, but eventually from within." The participant found that "through the way [the therapist] worked it was containing, it was containing but very exploratory….The containment came through growth, and that self-containment eventually came to grow."

Participant 4 remarked that they experienced therapy as helpful and containing: "With a therapist, you know you can go there with your problems and they'll sit and they will listen to you and they are there for you one hundred percent… Initially…I thought 'why do we have to go through this?' But I think through the year it was helpful. I think it was a very containing experience for me."

Participant 6 also found personal therapy supportive: "I started [personal therapy] with reservations and found it difficult but quite helpful as well…I found it quite a supportive environment."

Participants 7 and 9 both referred to the personal therapy as containing. Participant 7 described how the relationship with the therapist carried them through a difficult time: "I think the first therapist…with her there was quite a strong maternal transference. And her warmth and her empathy, that impacted and that…was quite influential, I think. And just the way she really managed to take me through a very difficult time…I felt like she was kind of with me in that difficult time."

Participant 9 twice mentioned that they found the therapy containing:
"I've found it beneficial. I've found it a very containing space." Also: "I think I work well with my therapist. I really, I value her; I do now look forward to going…because…I found her to be containing…we related."

Meredith-Owen (2007) points out that containment is implicit in the training environment and the training analysis. A training analysis "offers the prospect of a structured environment within which a purposeful evolution may take place" (p.390). The outcome of the training is the trainee's "confirmation as part of the analytic family" and Meredith-Owen argues that this seductive prospect is capable of insulating the trainee from the threat of "infinite uncontainedness", which inevitably blocks the transference and inhibits development. He cautions against the training analysis becoming a refuge "where order, meaning and containment can be accessed, whilst the subjective state of dismay remains unengaged" (p.390).

The extent to which this may be true for the participants in this study can only be speculated on. It was clear that the participants mentioned above experienced the therapy as a refuge, a safe haven. And the fact that most felt inclined to specifically state that their therapy was "not supportive therapy" (but experienced as supportive nonetheless) may hint at some conflict about them feeling that it may have been too supportive and not challenging enough. This could be a subject for a further study.

4.3 THEME 3: THE IMPACT OF PERSONAL THERAPY ON A PROFESSIONAL LEVEL

In 1946 Jung wrote: "anybody who intends to practice psychotherapy should first submit to a 'training analysis', yet even the best preparation will not suffice him" (1946, p.177). According to Jung, a personal analysis was an absolutely necessary prerequisite for clinical practice. It prepared and taught the therapist to become a therapist themselves.

4.3.1 The Therapeutic Process

Participants in the Grimmer & Tribe (2001) study believed that they had obtained a better understanding of the therapeutic process by being in the role of the client themselves. And Mackey & Mackey (1993, 1994) found that

personal therapy complemented professional training by providing a "vehicle" for cognitive and emotional understanding of the therapeutic process and the dynamics of psychotherapy. This study's results support the above-mentioned findings as most of the participants (participants 1, 2, 3, 5, 7 and 8) referred to how their experiences of therapy enhanced their understanding of the process and dynamics of therapy. Participants specifically referred to their experiences of transference (Participant 2, 7 and 8), interpretation (Participant 8), termination (Participant 3) and the "techniques" of therapy (Participant 7).

Through their personal therapy Participant 2 acquired a deeper understanding of some of the dynamics of therapy, such as transference, and a better "understanding of my own patients, what their experience was like and also…what a therapist can symbolise…to the patient…There was a time I absolutely idealised [my therapist]. I went through an absolute idealisation; what dripped from his mouth was gold….I've seen it in my own patients." The participant thought it valuable "to understand that...by going through that yourself."

The unique nature of transference in personal therapy has been noted by a number of authors. Thomä (1993) explains that in personal therapy it should be kept in mind that the trainee aims to follow the same profession as the analyst and that this "influences the relationship and has consequences in the transference" (p.3). Geller *et. al.* (2005) similarly notes that the trainee "wishes to have the analysis serve the ego aim of becoming an analyst, which means forming some kind of identity with the analyst, often raising unresolved issues for both the analyst and analysand" (p.30). Therefore, Thomä and Kachele (1999) considered it "indispensible" for the therapist to experience through personal therapy "the effects of unconscious processes on transference and defences in an intersubjective exchange" (p.34).

Participant 7 described becoming more aware of the therapeutic process during their personal therapy than they were in therapy prior to the clinical training: "It's difficult being a trainee therapist going to a therapist. Because you're kind of, while you are a patient, you are also quite aware of stuff like

transference and countertransference and the techniques [of therapy] and whatever else." Referring to their experience of transference and interpretations in their personal therapy, Participant 8 remarked: "…those kind of things, I learnt them in my own therapy."

Participants also discussed the reciprocal effect of experiencing the process of therapy and simultaneously learning about the process of therapy in class and how these two experiences inform and enrich each other. Participant 1 discussed their thoughts on the connection between personally experiencing therapy and learning about the process of therapy: "I think a lot of the learning does happen in your own therapy. I think in the process of therapy….you just learn so much from…that process I think." After therapy "you go back and you think, and…I think that's how you end up learning a lot about therapy, 'cause you can see it happening there. I do think it valuable." Participant 3 gave the example of termination of therapy and how they realised the importance of termination through their own experience of termination: "I've realised how important termination is and so in my therapy [with clients] I was able to work using that…so much more."

Participant 3 then highlighted the opposite, namely how academic knowledge about the therapeutic process can inform the experience of personal therapy: "I think that as you develop as a therapist…as you learn more, you are understanding more of the dynamics of therapy…" The participant pondered whether clients, who do not have "the benefit of training", can "use therapy to the same degree…because we understand the dynamics and the transference…"

4.3.2 The Frame

No literature was found on trainees' experience of the therapeutic frame *per se* in personal therapy. Here it is listed as a separate sub-theme because three of the participants specifically mentioned how being in personal therapy concretised and demonstrated the frame to them.

The personal therapy assisted Participant 1 in “thinking about basic things like the frame” and it gave the participant , through his/her own experience as a client, a deeper “understanding of the frame…understanding the limits around payment issues, issues around breaks, issues around all those basic things that you learn about in your training year.”

Participant 2 explained that personal therapy served as a practical example of how to negotiate the frame: “Sometimes [the therapist] absolutely adhered to the frame and I experienced what, how containing that was…but [the therapist] had [his/her] own personality as well and in some ways it almost gave me permission to try little things that didn’t adhere to the frame.”

Participant 5 gave examples of how therapy informed their conception of the therapeutic frame, i.e. “Breaks with my patients became more real to me when I experienced them in my own therapy and sort of what they meant,” and concluded: “I’ve learnt those kinds of things from [my therapist].”

4.3.3 Theory

Most of the participants (Participants 1, 2, 3, 5, 8 and 9) mentioned that personal therapy brought the theory alive; it made the theory salient and, on its part, the theory illuminated the therapy. This reflects Mackey & Mackey’s (1993, 1994) finding that personal therapy complements training by helping to integrate theoretical concepts in a meaningful way.

Participant 1’s experience was that the therapy “could solidify some of the theory in practice.” Participant 2 described how “a lot of the theory, I think for me, came alive in my own therapy. But then, obviously, when I was a therapist with patients a lot of it made sense. Instead of just being, that sort of, the black and white on hard paper, um a lot of it, yah it was brought alive…in my own therapy.” The participant would also bring the newly acquired theoretical knowledge to personal therapy and apply the theory to their own life: “I loved

the psychodynamic approach. I would gush in there some weeks, full of the theory we've learnt…'cause I mean, you're checking [your] own self, you know, do I think this is what I'm experiencing, have I done this, or is this…?"

It seemed that therapy illuminated the theory for Participant 3: "But I do think…that [personal therapy is] so beneficial being in this training…as you learn things they become…they're so salient."

Participant 5 experienced that the therapy "allowed me not only to think about things, but to actually relate to the material that we were learning during our masters as well. Where I could experience something in the therapy, and know to say 'oh, here it is', you know, 'this is Klein', and 'this is what it's like'. I was so far removed from that before I went to therapy." "I think there is a lot of theoretical underpinnings that we understand…well for me they would start happening in my therapy where I could understand it better and think about it a lot better because I was training."

Participants 8 and 9 also reported that therapy impacted on their academic learning in a positive way: "Therapy becomes an extension of your own [academic] course, you know. It becomes also valuable in terms of understanding certain things that you study in your own degree, academically you know" (Participant 8). "Also just understanding, having a greater, developing a greater understanding about theories and paradigms, and…how things develop in people" (Participant 9).

4.3.4 Empathy

Many studies have found an important benefit of personal therapy to be the development or increase of empathy within the trainee (Norcross, *et. al*.,1988; McEwan & Duncan, 1993; Mackey & Mackey, 1993, 1994; Grimmer and Tribe, 2001; and Murphy, 2006). In this study participants 1, 2, 3, 4, 5, 7 and 8 have similarly reported that personal therapy impacted on their empathy with clients, making them more empathic. Participants talked about their own

vulnerability as a client and how the experience garnered greater sensitivity and appreciation for the position of the client.

Participant 1 reported that the experience of personal therapy increased her empathy towards clients “because it’s very different to be the therapist and to be the client….I think you become more sensitive to what the experience is like when you are a client.” She also stated “I think it is good to be reminded what it feels like to be in the other chair and to experience that. I think that’s very important, I think it’s crucial.”

Participant 2 emphasised that personal therapy was a “training experience” in the sense of experiencing what it was like being a patient: “It was also an experience of being a patient…there were times that I would leave the rooms and I would feel quite vulnerable…and it reminded me never to forget that in my patients. That when they leave, there will be many a time when they feel like I felt, like raw mince meat, and it’s a very, very vulnerable sort of making process.”

Participant 3 reported that personal therapy increased their “empathy with a patient sitting in front of you.”

Participant 4 described how valuable it was to experience therapy from the position of the client: “I think just being able to have gone through the therapy, to experience that…I think that’s what helps a lot because at least you know, when you are the therapist and you are giving therapy, at least you get a sense of what the therapy actually means to the other person. And to be in that seat…because when you are only in the therapist’s seat you never really know what the other person experiences. Whereas when you are put in the other seat and you actually have to develop and grow and take in the process and be in that process, I think that’s what’s…definitely, definitely helped me.”

Participant 5 found that the experience of personal therapy increased their empathy with clients: “It is hard to explain but I think the personal experience of being a patient gave me a lot more empathy for my own patients and, kind

of, things became more real to me…and I could feel a lot more for my own patients through my own therapy."

Participant 7 reported a better understanding of the ambivalence clients feel about being in therapy: "I know what it feels like to be thinking 'Oh I don't really wanna be here right now!' and I think that's such a valuable thing to know for our patients' [sake] because I think often they don't really want to be in therapy, they want to, but they don't want to and it's really just…understanding that ambivalence in myself that helps me to understand the ambivalence in my own patients and to be able to bring it up in sessions." The participant considered it very important to have had the experience of being a client oneself: "You need to know what it feels like to be a patient. You need to know how damn hard it is sometimes to be a patient and I feel like, I really do feel like I've benefited in that way. And it does give an increased amount of empathy. How can you…sit with someone if you don't know what it feels like to be in their place?"

4.3.5 Modelling

"Jung wrote powerfully about the importance of the model of the analyst" (Roazen, 2002b, p.73) since the inception of the training analysis. Modelling seems to have always been a part of the function of the training analysis. As Geller (2005) puts it: "Academic knowledge helps orient the developing analyst, but personal analysis provides the model for his or her own professional work. With time and experience the new analyst develops a unique style, which continues to evolve over the course of his or her professional career." (p.31). Most of the participants (Participants 2, 3, 4, 5, 6, 8 and 9) mentioned the value of their personal therapist as model. They found themselves identifying with, idealizing and imitating their therapists. Participants reported internalizing various aspects of their therapists' modus operandi, including mannerisms, sayings and techniques.

Participant 2 remembered a discussion in class: “A couple of us once discussed [how] we almost borrowed lines from our therapists, you know. It sort of gave us permission to…phrase things a certain way, because the people that they recommended to us were really well recommended. So we were sort of having a first-hand experience of watching a therapist in action and I learnt a lot from my therapist. I really did. And I think that the therapist is also very aware that that is part of their role with us.” The participant explained that some of the therapist’s behaviour in therapy made such a positive impression that the participant wished to use it in their own therapy with clients: the therapist “was comfortable in his chair, comfortable in his skin, there were things that I really…wanted to internalize for me, to [emulate] as a therapist.”

Participant 3 talked about the benefit of observing how a therapist worked: “I think a lot of what you learn…you see it in practice to a large extent in the therapy….There is this therapist who’s had x-amount of years of experience and so… sometimes I did find myself…saying things that I thought that my therapist would say.”

Participant 5 discussed closely observing their therapist, learning from the therapist and subsequently copying the therapist. They gave some examples of how they would imitate “some of the things my therapist did or said”. The participant credited the therapist as a valued model of how to be a therapist: “I was fortunate enough…to have quite an empathic…psychodynamic therapist who [was] not afraid to explore things. And in some ways that influenced the way I did therapy with my own patients… So there were, there were things that I would take from my therapist into the room with my clients sometimes…and I don’t mean…my issues…because I think my therapy was a good place to contain that, but mannerisms almost. I was a trainee and I had no idea how to be with my patients initially.”

Participant 6 also found that they could not help but study, and learn from, the therapist: “It was very difficult for me to not study [the therapist] as well. How, what kind of a therapist he is and what techniques he uses and all of that.

And…I think my therapist is a good therapist, and I think…you kind of see somebody at work. I mean it's a bit weird, because he is there not as a teaching tool…but he is a therapist and you are training to become one."

Participant 8 stated that during personal therapy they would closely observe the therapist to see how they would handle certain therapeutic situations ("Okay, fine, this is how [the therapist] does this") and the participant "learned" from that example and used it "in my own therapy".

Participant 9 experienced that in therapy they were "learning from [the] therapist all the time": "I do think that she's been very useful because she's just been a different example…of what I'm training to do. And I'm having my own personal experience of what I'm training to facilitate…in that way it's been very beneficial." It is clear that the participants above identified and learned from their therapists. Anna Freud called this an "identificatory learning process". In a 1976 symposium organised by the IPA on "The Identity of the Psychoanalyst" Anna Freud commented on the problems of the training analysis at the time, but balanced it by "a positive supplement to the effect that too little mention had been made in the symposium of the identificatory learning process, transmitted via the training analysis, which, she maintained, inspires love for psychoanalysis" (Thomä, 1993, p.6). She asserted that an enthusiasm for psychoanalysis could be passed on through identification rather than by indoctrination and it seemed like that was the case for the above participants (2, 3, 4, 5, 6, 8 and 9) as well.

4.3.6 Countertransference

Kaslow & Friedman (1984) reported that one of the positive effects of personal therapy on clinical work was the trainee's increased ability to attend to countertransference. Asked about the impact of personal therapy on their work with clients, four of the participants (participants 2, 3, 6 and 9) in this study felt it had an impact on how they recognised and handled countertransference with their clients.

Participant 2 stated that they found therapy “vital for two reasons”: “one, for my own self-care…two, definitely because of the consciousness of how our own issues can impede our therapeutic relationships with our clients. So to have that dealt with was part of my professional ethic as well.” The participant described how “Sometimes, when I was working through a very particular issue of my own therapy…I would be thinking along the lines of *my* therapy [when with a client]. And I think it could confound it sometimes, because there were issues coming out raw and fast in me and, perhaps I was starting to identify them in my patient, and in fact it was mine. They were mine and not those of the patient.”

Participant 3 described how their personal therapy has impacted on their therapy with clients: “I see it with [my] patients. The…issues that would have made me feel uncomfortable and did make me feel uncomfortable…when I first started seeing patients…but I don’t [feel uncomfortable any more], because I’ve dealt with it. I feel…a lot more robust, and stronger.”

Participant 6 emphasized that “Seeing patients it’s important to…know what your issues are” and explained that “…sometimes I would have a patient and I would…have quite a strong countertransference response to them, and I think if I wasn’t in therapy I could have just thought maybe it’s to do with the patient, whatever. At times I did, I [then] realised ‘hold on, I think this may be more my stuff than the patient’s stuff,’ you know.”

Participant 9 also experienced the value of personal therapy in recognising their countertransference: “It helped a lot in terms of countertransference and being able to separate out countertransference, which I don’t think is always possible with a supervisor…I think [personal therapy is] a better environment to be doing that…so that was useful.”

4.3.7 Professional Growth

In the previous sections of 4.3 all of the participants have mentioned multiple aspects of their professional development that have been positively impacted by their personal therapy, but Participants 3, 4 and 5 also mentioned professional growth as such. Their descriptions of growth can also be translated as experiences of integration – the integration of themselves on a personal and professional level (Participant 3) or the integration of theoretical training and therapeutic experience (Participant 5). Mackey & Mackey (1993) refers to the importance of integration to professional identity and growth: "Integrations were often a matter of bringing together personal development with professional identity. As a catalyst for personal development, therapy became a central resource in the journey toward professional competence" (p.108).

Participant 3 found that the personal therapy contributed to "developing myself as a person…as a therapist, as an instrument….For me, in many ways, it was part of the training: just becoming this instrument, becoming this person." Participant 4 felt that the "aim" of the personal therapy was "really to grow me both as a person as well as a therapist."

Participant 5 was of the opinion that the training and the personal therapy both impacted on, and informed, each other. The academic training assisted the participant in having a "richer" therapeutic experience, while the therapy developed them as a therapist: "The course helped me with my therapy and…my experience with my therapist helped me to become a therapist really."

4.4 THEME 4: THE THERAPEUTIC APPROACH

In their study of 800 registered psychologists Pope and Tabachnick (1994) found substantially higher incidences of therapy among psychodynamic and eclectic therapists compared to cognitive behavioural therapists. Norcross *et.*

al. (1988) and Darongkamas *et. al.* (1994) found that the type of personal therapy chosen by the majority of therapists was psychoanalytic or psychodynamic. This was found to be true even for cognitive and behavioural trained therapists with less than one in ten behavioural therapists choosing behavioural therapy for themselves.

Most of the participants (participants 1, 2, 4, 6 and 7) recounted something of their experience of the therapist's therapeutic approach. The clinical training was mostly psychodynamic and all of the participants saw a psychodynamic-oriented therapist at some time during their personal therapy. During the course of the two years, three of the participants (participants 1, 4 and 7) changed to therapists who were more psychodynamic in approach.

Participant 1 decided to change therapists at the end of the first year of training because the therapist did not work in a psychodynamic way. The participant experienced the therapist as too supportive and felt that she needed a more challenging therapist: "At the beginning I needed someone to work quite supportively…towards the end of the year I felt differently about therapy." "I wanted her to go places that she wasn't going before….I felt like it was difficult for us to move and to shift….I think it's different working with someone at the beginning of M1 year and at the end of M1 year".

Participant 2 "loved working with a psychodynamic therapist…because I hadn't before." They found it useful that both the training and the therapist were psychodynamic: "I loved the psychodynamic approach…we could speak the same language. That was fantastic….I was being trained psychodynamically and [the therapist] was working psychodynamically."

Participant 4 initially started with a Rogerian therapist: "I think it was a very containing experience for me, because I didn't go to a psychodynamic therapist [initially]… I went to an educational psychologist who was trained in a very Rogerian way…and so her way of working was actually very nice." The first therapist then referred the participant to a psychodynamic therapist as there was a specific issue both the therapist and the participant felt would be

better suited to psychodynamic oriented psychotherapy: “I’ve terminated with the therapist from last year…the beginning of April (2008). And then I started seeing the…psychodynamic therapist.” The participant reported a positive experience of that therapy as well: “It took me I think about seven months to first cry in therapy with my first therapist. After half an hour [with the psychodynamic therapist] I was crying…so [the psychodynamic therapist] was absolutely brilliant. And the strangest thing was, I wasn’t feeling anxious.”

Participant 6 was of the opinion that therapy was more “difficult” due to the therapist’s psychodynamic approach: “I started with reservations and found it difficult, but quite helpful as well…difficult…because my therapist is a psychodynamic therapist, so it wasn’t just about the support and being nice and all of that. So, difficult in…in the issues that it brought up, you know. Like um…I suppose…stuff from my past you know, to do with my parents and all of that.”

Participant 7 initially worked with an eclectic therapist and gave an extensive explanation of the process that made her change to a more psychodynamic oriented therapist:

> “As we were progressing in the course, I was starting to see that there were elements of the therapy that weren’t psychodynamic and I felt quite drawn to the psychodynamic way of therapy. I was actually able to address this with [the first therapist] when I did decide to terminate the process. So part of me felt like we’ve done the work we were meant to do, but there was another part of me that…feels like there’s other stuff that I want to work on in the therapy that I feel a psychodynamic process specifically will [address]…and also with a much more…neutral therapist…and so I think that the second therapist has given me more of that.” “The reason I changed therapists this year was because I felt that the process wasn’t as psychodynamic as I wanted it to be and after doing so much psychodynamic [training] last year I wanted more of that from a therapist. So while there were elements of psychodynamic therapy in the process I could also see after what we had done last year that this isn’t exactly the type of therapy that I want to practice one day and so I did choose to change therapists because of that.”

Participant 7 then described the experience of attending the psychodynamic therapy:

> "I found myself feeling a lot more ambivalent about going to this therapy than I was before. Because I know that sometimes quite painful stuff is gonna come out whereas before it felt like…more of a supportive process. Not to say that the psychodynamic therapy isn't supportive at times. And it's really…getting me in touch with some truths that I feel like the therapy from last year allowed me to avoid for a little while…like resistances are pointed out whereas before they wouldn't really be, and I think that's exactly when I felt I needed a different type of therapist. Because I was becoming quite resistant to it towards the end of the process and that's why I don't evaluate what I felt, because that's what I needed at the time but I did get to a point where I felt like I needed something different."

The participants' reasons for changing to more psychodynamic therapists included: wanting to experience the type of therapy that they were training in; that they felt they had reached an impasse with their current therapist and that psychodynamic therapy would be better suited to address their specific problem; and/or that they wanted to experience a more challenging, as opposed to supportive, therapy.

4.5 THEME 5: INITIAL VERSUS LATER EXPERIENCES OF PERSONAL THERAPY

Participants in the Mackey & Mackey study (1993) reported extensively on the differences between initial and later experiences of personal therapy. They described the beginning phase as a period of gradually gaining enough trust and comfort to explore inner conflicts. This phase, which could last weeks or months, was also found to be a period of crisis during which the therapist helped them to express their thoughts and feelings. The initial period was usually followed by a period that reflected changes in the transference and countertransference dynamics. It involved exploring, reflecting on, and thinking about their conflicts and the therapist was reported to become more interactive during this period.

The participants in this study also reported changes between their initial and later experience of personal therapy. Participants 2, 5 and 9 described initially experiencing therapy as “hard”, “uncomfortable”, and being connected (in their minds) to their training and assessment. They described feeling less persecuted and becoming more comfortable in therapy as the year progressed, until they eventually reached a point where they could separate the therapy from the training institution and recognise and claim it as their own. This corresponds loosely with the findings from the Mackey and Mackey study in the sense that both studies describe two phases of therapy, moving from a phase of emotional discomfort and defendedness to a phase of trust and comfort.

Participant 2 described how the experience of the therapy changed from an initial sense of it being part of their studies, to a later sense of it belonging to the participant, being their own personal process: “Especially this year, with my being away from the university [the therapy] has become something that I own. Because…I doubt that they [the university staff] would sort of phone and therapists would check in that you attend your sessions at this point. Um…so it was really something that I began to own more and more.”

Participant 5: “Initially [the therapy] was very hard, you know, it was quite uncomfortable and I think I felt like any new patient to therapy. Um, and because our training had just started, I hadn’t begun to realise that some of the dynamics were happening in my own therapy. But as I trained more and as I had more therapy, I kind of felt more comfortable, rather than ‘Oh this is what I have to do for the course and it’s something uncomfortable’. It’s become something I want to do now for me.”

With Participant 9 it seems that the participant’s later experiences of therapy also differed from their initial experiences: “I think I was able to use the space more for my personal use rather than in terms of feeling that it was an assessment…what I found really beneficial in terms of the therapy and what I’ve continued to do in the latter part of the year rather than earlier on was that

I was able to use...what was happening in my masters year, and make sense of that….I found that I could use the space more effectively than I had before"

Participant 1's experience of therapy also changed, but for a different reason than those mentioned by participants 2, 5 and 9. Participant 1 attributed their changed experiences of therapy to the training that took place during the year. The participant stated that "What happens is, I think your expectations change, because as you learn, for me personally, as I learnt more about therapy and about the psychodynamic understanding of therapy, I expected different things from my therapist." And "by the middle of the year, towards the end of the year I felt differently about therapy."

4.6 THEME 6: PERSONAL THERAPY AS SUPERVISION

It is only fairly recently that psychoanalytic training institutes have started to separate personal therapy from supervision. The training institution of the participants in this study (Wits) made it clear that personal therapy was to have only a therapeutic function and not a training or supervisory function. Trainees were provided with a supervisor at the university (usually one of the lecturers) whom they had to see regularly to discuss their patients, theory, training, etc. Supervisors would also diligently restrict themselves to handling issues related to training, referring students to their therapists if personal issues were raised in supervision that the supervisor thought would be more successfully and appropriately addressed by the therapist. From the participants' responses it seemed that they were quite aware of this distinction and were also eager to avoid blurring the lines between personal therapy and supervision.

Participant 1 felt that "one thing that's quite difficult about the therapy when you are in your training year…is for it not to become supervision, and how close those lines are…" because "you do take your clients to therapy" and "I think to bring it back to you as opposed to a more [supervisory] process is quite challenging as well."

Participant 2 clarified that, even though they would discuss their therapeutic work with patients with the therapist, the therapist would always bring the discussion back to the participant: “He was quite clearly just my therapist. Stuff I took back about what I was experiencing with my patients, what I was doing with patients in therapy, we related it directly back to me…and my personality, yah so I think he didn’t ever really stick to a supervisory role…I think he kept it quite divorced.”

Participant 7 was grateful that the personal therapy did not have a supervisory function: “I didn’t feel like we had a supervisory element. Maybe on like, the very odd occasion…”; “I was glad that it didn’t have a supervisory element…I felt like that was my space. And then, I had a supervisor. I didn’t really want the two to kind of, yah, get confused.”

Participant 4 was an exception in that they seemed to have difficulty separating the functions of the therapist and supervisor. The participant made a slip early on in the interview, referring to their personal therapy as “supervision”: “That was when I went to you know, sort of supervision to ah…therapy with it…to look at what was mine and what was the patient’s stuff.” The participant also said: “I went to an educational psychologist who was trained in a very Rogerian way…and so her way of working was actually very nice because I could go with my own stuff and I could bring, you know, what patients were doing.” When specifically asked: “It sounds like [your therapist] was also…your supervisor?” the participant answered: “Not so much. Because I mean, as much as I spoke about, you know, the patients and that, what [the therapist] would do was to get me off speaking about the patients. Um, she would then look at what the patients evoked in me and then we would talk about that as opposed to you know their problems and things like that, but what in them did I see in myself or things like that.” From this response it sounds like the participant’s resistance may have manifested in them focusing more on their patients in their initial therapy than on his/herself, perhaps preferring to view the therapy as supervision.

4.7 THEME 7: FINANCIAL IMPLICATIONS

Mackaskill & Mackaskill (1992) found that half of their sample of trainee therapists reported financial costs and time constraints to be a significant stressor. Five of the participants (participants 1, 4, 5, 8 and 9) in this study mentioned the financial cost of therapy and how that affected them. They experienced it as a strain, an added stressor and a disadvantage of personal therapy. Complaints about the financial strain of therapy may be just that, but it may also be, once again, resistance to the therapy. It could also be taken to refer to some other "costs" of therapy: the emotional cost; cost in time; cost to relationships, etc. To illuminate the meaning of each participant's response is, of course, not possible from the single interview available.

Participant 1 experienced the "financial aspect" and "negotiations around fees" as "difficult", "stressful", and an "extra pressure" and states: "it's quite something to work out how you are going to pay for it."

Participant 4 found the financial strain of being in therapy difficult: "And also the fact that it's so bloody expensive to be in therapy…for a student as well."

Participant 5 named "cost" as one of the disadvantages of personal therapy: "…just the financial strain of having to go to therapy every week."

Participant 8 referred to the cost of therapy as a reason why they thought that therapy should not be mandatory: "Then also finances. Money wise, you know, not all of us have got cash to afford psychologists."

Participant 9 found the financial demands of the therapy more difficult to deal with than the mandatory aspect of it: "The financial strain of going into therapy was more the thing that I was resentful of, in comparison to *having* to go. It's just that it's…a lot of people who are [studying] are paying a lot of money for university themselves, so they'd have to sort of be paying a lot of money a month."

4.8 SUMMARY

The first theme concerns findings on the participants' experiences of personal therapy as part of training. The participants' opinions on, and feelings about, the mandatory requirement of personal therapy were varied. Most of the participants reported initial anxiety and resistance to going to personal therapy, which changed over time into an appreciation of the value of personal therapy. Five of the participants (participant 1, 2, 4, 5 and 6) reported that they initially did not feel a need to embark on their own personal therapy and would not have done so independently if they had not been required to do so by the training institution. At the time of the interview, after being in therapy for at least a year, all of the participants felt that personal therapy was an important and valuable aspect of their own clinical training. Eight of the nine participants considered the mandatory requirement of personal therapy as part of training to be "necessary", as opposed to one who considered it "desirable", but not necessary. This supports the finding that participants who had undertaken personal therapy themselves were more likely to favour mandating therapy as a training requirement (Pope & Tabachnick, 1994). It consequently begs the question of whether trainees should be left to independently make the decision of undertaking personal therapy if it is not something that they would appreciate the value of, or choose, beforehand.

Some of the participants (participants 2, 3, 4, 8 and 9) struggled to separate the personal therapy from the training, especially initially. It seems that this may have been partly because the therapy was a mandatory requirement of the training institution and was experienced as linked to the training in that sense. Fordham (1970) argued that the trainee's "position supports splitting of the transference" (p.65) with parts of it projected onto the training institution and the supervisors. That makes it safer for the trainee to be suspicious of and attack the institution rather than the therapist. The researcher feels that this may explain some of the participants' criticism towards the training institution (as related in 4.1 (a). On the other hand, some participants found that they projected the difficulties they had at university and with their lecturers onto their therapists. Participants 2, 4 and 9 struggled with feelings of being

monitored and evaluated by the therapist that they related to their feelings about their training.

The second and third themes addressed the impact therapy had upon the participants and the reasons participants considered therapy to be of value. Theme two looked at the impact of therapy on a personal level and theme three on a professional level.

All of the participants reported that the therapy had an impact on their personal lives. Common themes that emerged from these discussions were: therapy as catalyst for personal growth and insight; therapy as a place of containment and support; and the impact of therapy on close relationships. Seven participants reported that personal therapy impacted on their relationships with family or friends in some way due to the changes that occurred within the participants as a result of the therapy. These changes were described as positive by all participants, but the impact on the relationships was not always positive. It mostly involved family and friends having to adapt to the emotional growth of the participants (participants 2, 3, 4, 5, 6, 7 and 9), but participants also reported that the therapy resulted in: a crisis in a romantic relationship (participant 1); the temporary alienation of a partner (participant 2); and the renegotiation of boundaries in the family (participant 4).

As for the impact on a professional level (theme three), most of the participants (participants 1, 2, 3, 5, 7 and 8) referred to how their experiences of therapy enhanced their understanding of the processes and dynamics of therapy. Participants specifically referred to their experiences of transference (Participant 2, 7 and 8), interpretation (Participant 8), termination (Participant 3) and the “techniques” of therapy (Participant 7). These findings correlate with previous studies that found that personal therapy complemented professional training by providing a vehicle for cognitive and emotional understanding of the therapeutic process and the dynamics of psychotherapy (Grimmer & Tribe, 2001; Mackey & Mackey, 1993, 1994).

Most of the participants (Participants 1, 2, 3, 5, 8 and 9) mentioned that personal therapy brought the theory alive; it made the theory salient and, for its part, the theory illuminated the therapy. This reflects Mackey & Mackey's (1993, 1994) finding that personal therapy complements training by helping to integrate theoretical concepts in a meaningful way.

Many studies have found an important benefit of personal therapy to be the development or increase of empathy within the trainee (Norcross, *et. al*.,1988; McEwan & Duncan, 1993; Mackey & Mackey, 1993, 1994; Grimmer and Tribe, 2001; and Murphy, 2006). In this study participants 1, 2, 3, 4, 5, 7 and 8 have similarly reported that personal therapy impacted on their empathy with clients, making them more empathic. Participants talked about their own vulnerability as a client and how the experience garnered greater sensitivity and appreciation for the position of the client.

Most of the participants (Participants 2, 3, 4, 5, 6, 8 and 9) also mentioned the value of their personal therapists as professional role models. They found themselves studying and imitating their therapists. Participants reported internalizing various aspects of their therapists' modus operandi, including mannerisms, sayings and techniques. The participants described identifying with and learning from their therapists. Anna Freud called this an "identificatory learning process" (Thomä, 1993, p.6). Modelling seems to have always been a part of the function of the training analysis. Jung wrote about the importance of the model of the analyst since the inception of the training analysis (Roazen, 2002b, p.73). Geller (2005) stated that "academic knowledge helps orient the developing analyst, but personal analysis provides the model for his or her own professional work." (p.31).

Another subtheme of the impact of personal therapy on professional development was a greater awareness of countertransference. Asked about the impact of personal therapy on their professional development, four of the participants (participants 2, 3, 6 and 9) in the study felt it had an impact on how they recognised and handled countertransference with their clients. This confirms an earlier finding that that one of the positive effects of personal

therapy on clinical work was the trainee's increased ability to attend to countertransference (Kaslow & Friedman, 1984).

The participants have mentioned multiple aspects of their professional development that have been positively impacted by their personal therapy, but Participants 3, 4 and 5 also mentioned professional growth as such. Their descriptions of growth can also be translated as experiences of integration – the integration of themselves on a personal and professional level (Participant 3) or the integration of theoretical training and therapeutic experience (Participant 5). Mackey & Mackey (1993) refer to the importance of integration for professional identity and growth: "Integrations [are] often a matter of bringing together personal development with professional identity. As a catalyst for personal development, therapy [becomes] a central resource in the journey toward professional competence" (p.108).

Theme four concerned the therapeutic approach. Most of the participants (participants 1, 2, 4, 6 and 7) recounted something of their experience of the therapist's therapeutic approach. The clinical training was mostly psychodynamic and all of the participants saw a psychodynamically-oriented therapist at some time during their personal therapy. It emerged that the participants were preferential to psychodynamic psychotherapy and over the two years of the training, three of the participants (participants 1, 4 and 7) changed to therapists who were more psychodynamic in approach. The participants' reasons for changing to more psychodynamic therapists included: wanting to experience the type of therapy that they were training in; feeling that they had reached an impasse with their current therapist and that psychodynamic therapy would be better suited to address their specific problem; and/or that they wanted to experience a more challenging, as opposed to supportive, therapy.

Theme five attends to the initial versus later experiences of personal therapy. Some of the participants reported a significant difference between their initial and later experience of personal therapy. Participants 2, 5 and 9 described initially experiencing therapy as "hard", "uncomfortable", and subjectively

feeling it to be connected to their training and assessment. They described feeling less persecuted and becoming more comfortable in therapy as the year progressed, until they eventually reached a point where they could separate the therapy from the training institution and recognise and claim it as their own. This corresponds with findings from a study by Mackey and Mackey (1993) that describes moving from an initial phase of emotional discomfort and defendedness to a phase of trust and comfort.

Theme six was derived from the participants' thoughts on personal therapy and its relation to supervision. The training institution of the participants in this study (Wits) made it clear that personal therapy was to have only a therapeutic function and not a training or supervisory function. From the participants' responses it seemed that they were very aware of this distinction and were eager to avoid blurring the lines between personal therapy and supervision: "I felt glad that it didn't have a supervisory element. I felt like that was my space. I didn't really want the two to kind of, get confused" (participant 7)

The final theme addressed the financial implications of personal therapy. Participants were responsible for financing their own therapy and five of the participants discussed how it affected them. They experienced it as a strain, an added stressor and a disadvantage of personal therapy, even though they paid reduced fees as a concession to their trainee status.

CHAPTER 5 CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

The purpose of this study was to explore, describe and interpret trainee clinical psychologists' subjective experience of personal psychotherapy in the context of professional training. It is hoped that this research will stimulate discussion and further research on the topic of personal therapy for psychology trainees, especially in institutions where clinical training of therapists is a priority.

A first limitation of the research is that the sample is small and contextually specific in that personal psychotherapy was a course requirement for the research participants. Consequently, findings cannot be generalized to all postgraduate trainees in clinical psychology or psychotherapy. However, the aim of qualitative research is not to establish generalizable findings but, rather, to deepen understanding of a specific aspect of experience. It is hoped that this research has made a modest contribution in this regard.

Secondly, the semi-structured interview is limited in that it depends on the participants' ability to express themselves in a rich and sophisticated way. Even though the participants described their experiences of personal therapy eloquently and in much detail, they shied away from illustrating it with personal examples. There may be three possible reasons for this: one, that participants felt the details of their therapy to be private, two, that the participants felt uncomfortable engaging in self-disclosure as they may have viewed the researcher as being associated with the training institution and, three, that the researcher failed to establish adequate rapport. It should be kept in mind that some of the participants revealed ambivalent feelings toward the training institution, and viewing the researcher as associated with f the institution may have inhibited the revelation of more personal information about themselves, in spite of the researcher's guarantee of anonymity and confidentiality. Although the researcher is confident about having established

good rapport, it may be that in my efforts to appear neutral I could have come across as possibly too detached and impersonal.

I deliberated whether to ask for more detailed examples from the participants' therapy. The reasons I did not do so, after initial requests for illustrations of what participants meant, were twofold: firstly, out of respect for the privacy of the participants and, secondly, due to the exploratory nature of the research. In line with exploratory research, I adopted an inductive approach that required me to explore genuinely open-ended questions and be open to what the participants introduced, rather than to steer the interview in a direction they did not willingly initiate.

It would be useful to see the results of similar studies at other training institutions and make relevant comparisons. Future research may consider exploring the experiences of trainees who were not required to have long-term personal therapy, but undertook it voluntarily. It would be of interest to compare the findings of such a study to the current study.

There has not been quantitative research in the form of surveys or questionnaires on this subject in South Africa. Such a study will have the advantage of a large sample and may include measuring attitudes toward, and experiences of, personal therapy among trainees and clinicians.

Another area that warrants future study may be trainees' resistance to mandated personal therapy and the implications concerning the therapy process and how beneficial they find it to be. Much has been researched and written about resistance to therapy, however no studies could be found on the resistance of trainee therapists to the training analysis/personal therapy.

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APPENDICES

APPENDIX A: PARTICIPANT INFORMATION LETTER

APPENDIX B: INTERVIEW CONSENT FORM

APPENDIX C: CONFIDENTIALITY FORM

APPENDIX D: INTERVIEW GUIDE

APPENDIX A **PARTICIPANT INFORMATION LETTER**

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May 2008

Dear Mr./Ms./Mrs./Dr. _____

My name is Corné Waldeck, and I am conducting research for the purposes of obtaining a masters degree in Clinical Psychology at the University of the Witwatersrand. My area of focus is that of personal psychotherapy, specifically, how trainee clinical psychologists experience personal therapy in the context of professional training. I would like to explore the impact of personal psychotherapy on the professional, educational and personal development of trainee psychologists. Another point of interest and exploration will be the influence of the mandatory requirement of personal psychotherapy on trainees' experience of the therapy. I would like to invite you to participate in this study.

Participation in this research will entail being interviewed by myself, at a time and place that is convenient for you. The interview will last for approximately one hour. With your permission this interview will be recorded in order to ensure accuracy. Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. All of your responses will be kept confidential, and no information that could identify you would be included in the research report. The interview material will only be processed by myself. Tape recorded interviews will be destroyed once the research report has been assessed and passed. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point. The research data will be written up in the form of a research report and possibly in the form of a journal article.

If you choose to participate in the study please contact me either telephonically at 082 417 1743 or via e-mail at corne.waldeck@gmail.com.

Your participation in this study would be greatly appreciated. This research will contribute to a larger body of knowledge on trainee psychologists' experience of personal therapy. This can help to inform the development of training programmes and policies.

Kind Regards

Corné Waldeck

APPENDIX B **INTERVIEW CONSENT FORM**

I _____ consent to being interviewed and recorded by Corné Waldeck for her study on **Trainee clinical psychologists' experience of personal psychotherapy in the context of professional training.**

I understand that:

- Participation in this interview is voluntary.
- That I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify me will be included in the research report, and my responses will remain confidential.

Signed _____

Name _____

Date _____

APPENDIX C **CONFIDENTIALITY FORM**

I _____

undertake to maintain the confidentiality of all participants, and their details, that I encounter during the task of the transcription of interviews conducted by Corné Waldeck for the purpose of her research.

Signed _____

Name _____

Date _____

APPENDIX D **GENERAL INTERVIEW GUIDE**

1. How did the participant subjectively experience his/her personal therapy?

2. What were the initial and later experiences of personal therapy during the training?

3. How did the personal therapy impact on the participant's own professional and personal development?

4. How did the personal therapy impact on his/her relationships, friends and/or family?

5. What, if any, was the impact of their personal therapy on the participant's therapy with clients?

6. What are his/her thoughts or feelings on the desirability vs. necessity of personal therapy as part of training?

7. What are his/her thoughts or feelings on the value of personal therapy during training (advantages/disadvantages).

8. How did the participant experience the type (psychodynamic, cognitive, etc.) of personal therapy received?

9. How did the participant experience the mandatory nature of the required personal therapy?