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Personal Growth and Therapy as a Component of Graduate Training in Counseling Psychology Programs

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PERSONAL GROWTH AND THERAPY AS A COMPONENT OF GRADUATE TRAINING

IN COUNSELING PSYCHOLOGY PROGRAMS

by

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A Dissertation Submitted to the Faculty of the Graduate School

of Loyola University of Chicago in Partial Fulfillment

of the Requirements for the Degree of

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Vita

The author, Eric Arnold Visokey, is the son of Arnold Visokey and
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His elementary education was obtained in several parochial
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In June of 1974 he received the Bachelor of Science degree, with
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The author has held positions with several city and state
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CHAPTER I

INTRODUCTION

Purpose

A principle goal of graduate training programs in counseling

psychology is the development of effective psychotherapists, but we

are not fully aware of all the factors involved in such development.

One issue of growing interest in psychological teaching and training

concerns psychotherapy or personal growth experiences as a part of

training. While there is widespread agreement about the core

knowledge and training necessary for students in psychology doctoral

programs, program requirements and components with regard to personal

growth experiences are far from standardized.

The general attitude among practicing psychotherapists supports

some form of personal growth or personal therapy experience. Division

29 (Division of Psychotherapy of the APA) recommends a number of

standards of psychotherapy education in doctoral psychology programs.

Among these recommendations is Principle 21, which states:

> Methods for enhancing the student's self-awareness, sensitivity
> and personal growth should be an integral part of psychotherapy
> education. The personality of the student has not traditionally
> been a concern of university psychology departments. However, the
> student's interpersonal skills, awareness of his own personality
> and of his effects upon others, sensitivity to both verbal and
> non-verbal communication, tolerance to emotional stress, and
> emotional maturity play a significant role in his learning and
> practice of psychotherapy. Individual supervision will help to
> accomplish these goals, but, in addition, the program might
> include such approaches as T-group experience, sensitivity
> training, marathon, encounter group, group supervision, human
> relations laboratory, or personal psychotherapy.

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If, indeed, Counseling Psychology, as a discipline, is committed
to the process of training graduates to be effective psychotherapists,
knowing the philosophical and experiential components of the graduate
training process is of the utmost importance. The researcher's goal,
then, is to discover to what extent Counseling Psychology programs
adhere to Principle 21, what factors are influential in such a
policy-making decision, and how the recommendations stated in the
Principle are implemented, if they are implemented at all.

Background

Interest in personal therapy as a component of training has been
widespread for some time. Personal analysis has long been advocated
and required in the training of psychoanalysts. Part of the rationale
is that only through an intensive psychoanalysis can therapists become
aware of their unresolved developmental conflicts, their defenses and
their unconscious motivation. Realization of these "blocked" areas
will better prepare the therapist to work effectively with clients
experiencing similar difficulties. Fromm-Reichmann argued the point
persuasively over 35 years ago:

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

Implicit in this assumption is the importance of working through
critical conflicts relating to transference and countertransference
processes; the psychoanalytic profession maintains that this can be
done effectively only when therapists have completed their own

analyses and consequently increased their levels of self-knowledge and understanding. Rachmann and Kauff (1972) report that the great majority of analytic training institutes require personal therapy and analysis either prior to training or concurrent with training.

Many psychologists who employ psychoanalytic techniques also stress the importance of the elucidation of transference and countertransference processes (Weiner, 1983). While many other training programs may not specifically focus on these processes as integral to therapeutic process, there is consensus across theoretical lines that the relationship between therapist and patient is crucial to positive treatment outcome. Strupp (1980a) has written extensively regarding the delineation of curative factors in therapy; when he speaks specifically of the "therapist-client" relationship he stresses that a good working relationship involves not only the patient's pathological process but also the therapist's personal reaction to these processes. Therapists need to be aware of their own areas of difficulty and work through them. If not, their effectiveness with certain clients will of necessity be limited, since they will be unable to respond nondefensively to certain material produced in session by the client. Strupp (1980b,c) cites a comparison study of lay and professional therapists; he reports that both groups responded "reciprocally" to negativistic and resistant treatment candidates e.g., both groups were likely to treat the difficult client as the client treated them. Theoretically, though, the client is establishing contact in the only way possible for him at the time. He enacts within the therapy session the crucial difficulties that he

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experiences in his daily life. It is the therapist's responsibility,

then, not always to respond in an "expected" fashion, that is, in a

harsh and rejecting manner. Without the customary response, the

patient is better able to objectively view and evaluate the

interaction (Binder, Strupp & Schact, 1983). The therapist, however,

must previously have come to terms with his own reactions in

affectively charge situations, especially when the client presents

with emotions that relate to the therapist's own weaknesses, problems

or deficiencies. Bandura, Lipsher and Miller (1960) observed

therapists' responses to patient's hostile verbalizations and

concluded that hostility directed at the therapist did not elicit as

many positive or approach responses as did hostility directed at

others. Russel and Snyder (1963) also report that therapists' anxiety

level is typically raised in response to client negativity.

Therapists do react "personally" to their clients' behavior.

Waterhouse and Strupp (1984) state succinctly,

> Experienced therapists, regardless of theoretical orientation,
> recognize that not only do various patient characteristics serve
> to influence an individual's amenability to specific technical
> interventions, but the therapist's own personal reactions and
> attitudes toward their patients color and shape the application of
> therapeutic tools.

Indeed, it is precisely the personal nature of the relationship

that Carl Rogers (1957) drew upon in formulating his revolutionary

"client-centered" philosophy. The client is usually in therapy due to

intrapsychic and interpersonal difficulties. Often the patient

developed symptoms in an effort to cope with his difficulties.

Symptoms eventually prove counter-productive to the client, however,

causing more stress and discomfort instead of alleviating it. Through interaction with a therapist who provides the "necessary and sufficient" conditions for change e.g., empathic understanding and respect communicated with high positive regard while being genuine, the client begins to interact more productively with a concomitant decrease in symptomology. Rogers believes that one of the best ways to become a therapist with the capacity to be caring, nonjudgemental and congruent is to undergo "experiential" training that incorporates personal growth or personal therapy experiences of the student. The rationale is twofold: the therapist-in-training acquires increased self-knowledge and becomes more adept at working with personal conflicts that might hinder productive facilitation with clients presenting with similar difficulties. Through increased self-knowledge comes increased self-acceptance, which is likely to exhibit itself in the therapy situation as increased acceptance of the client and his difficulties (Truax & Carkhuff, 1967). The second benefit is that the student experiences first-hand some of the difficulties associated with self-exploration or behavior change in addition to some of the positive results of the application of the "necessary and sufficient" conditions in a personal growth or personal therapy experience.

While many therapists do not adhere to Rogerian theory exclusively, many agree that the Rogerian conditions set forth over 40 years ago at least provide a positive foundation for other types of therapeutic interventions (Strupp, 1977; Truax & Mitchell, 1971). Many prominent authors in the field conclude that personal growth or

personal therapy experiences are some of the best ways to develop

therapeutic expertise. Garfield and Kurtz (1976) summarize:

> One of the prominent beliefs held by a large number of
> psychotherapists is the importance of personal psychotherapy as
> desirable preparation for the practice of psychotherapy. Among
> the propositions advanced on behalf of this view are that the
> future psychotherapist will gain a more complete understanding of
> his own personality dynamics and reduce his personal blind spots,
> and that he will, by having experienced the role of client or
> patient, be able to be more sensitive to the therapeutic needs of
> the client.

Irvin Yalom, one of the leading theorists in the area of group

therapy, believes that experiential groups provide an important source

of growth for the therapeutic trainee. Yalom (1975) states that "I

believe student group therapists profit from 1.) observing experienced

group therapists at work, 2.) close clinical supervision of their

maiden groups, 3.) a personal group experience, and 4.) from personal

psychotherapeutic (or self-exploratory) work." Truax and Carkhuff

(1967) believe that a "quasi-group therapy" format wherein "the

trainee can explore his own existence and his individual therapeutic

self can emerge" is highly advantageous. Behaviorally, students in

these personal growth groups worked with their own personal or

emotional difficulties experienced in their role as therapists. Thus,

in the group process the student examines his training in light of his

therapy experience in the context of his own development. Battegay

(1983) states an added dimension of a group experience is that "it

allows the trainee to learn about himself through interaction in a

social setting, thus working through some of his own transference

processes in ways not available through a dyadic process."

Specifically, he refers to the "familylike" nature of the group

experience and the relevant responses elicited, and states that a
group experience should be a required component of training, since
interactional processes are not as apparent in a one-on-one encounter.
A group experience also teaches the trainee the value of "staying in
the present", since emotions are often heightened in the group, due to
the nature of common problems or the sheer number of views presented.
Working through such enactments within the group then elucidates
processes in other ongoing relationships. Thus the experientially-
oriented group trainers arrive at conclusions similar to the
individual theorists. Both individual and group experiences of a
personal growth or a personal therapy nature can act as adjuncts to
each other. Yalom (1975) stresses that, regardless of format, he
views such experiences as necessary components of effective training.

He states:

The training group rarely suffices to provide all the personal
therapy the student requires. Though we cannot set firm
guidelines for so individualized a process, few would dispute that
some extensive self-exploratory venture is necessary for the
maturation of the group therapist. An inability to perceive
countertransference responses, to recognize personal distortions
and blind spots, to use his own feelings and fantasies in his
work, limits the effectiveness of any therapist.

Statement of the Problem

We have thus far been discussing the theoretical foundations of a
personal growth or a personal therapy component of training. The
field of psychology, in general, stresses research, a large portion of
which concerns therapeutic process and outcome. Unfortunately there
is a dearth of literature on the subject of whether such experiences
actually increase the therapist's effectiveness. The handful of

studies that have addressed this question yield ambiguous and contradictory results.

Hans Strupp (1955) first addressed the question of the effect of the therapist's involvement in therapy over 30 years ago. At that time he reported that the "analyzed" therapist tended to be more active. Garfield and Bergin (1971), however, report that therapists with no personal therapy experience effect more change in clients than do therapists who have had therapy. Silverman (1972) evaluated two groups of students involved in therapy supervision groups. While both the "experiential" and the "didactic" processes were helpful in terms of increasing the student therapist's effectiveness with clients, there were only chance occurrences of significant differences between students in both groups on rating scale of the nature of the therapeutic relationship. Eiben and Clock (1973) had trouble measuring the significant differences on the Personal Orientation Inventory between therapists who had been involved in an experiential group and those who had been in a didactic group. McNair, Lorr and Callahan (1963) had previously stated that there were differences between therapists who had had therapy and those who had not; they cited significant differences in the premature termination rate of clients for both groups, with the therapist who had therapy experiencing a significantly lower premature termination rate. Greenspan and Kulish (1985) also reported similar findings. The issue has remained undecided for some time; ratings of therapist effectiveness at Adelphi University (Derner, 1960) did not distinguish between the top ranked and the lowest ranked therapist with regard to

incidence of therapy; half of each group had had therapy. Katz, Lorr and Rubinstein (1958) likewise stated that outcome had little to do with having undergone personal therapy. Recently Wogan and Norcross (1983) replicated Wallach and Strupp's (1964) study of therapist personality variables. Both studies concluded that therapists who have experienced therapy are more flexible, maintain less distance and are less goal-limited than the therapists who have not undergone therapy.

Thus, questions remain unresolved as to whether personal therapy or personal growth experiences affect personality attributes of therapists, whether these experiences affect therapeutic technique, or whether these experiences affect positive client change in therapy.

While Counseling Psychology programs focus on the development and training of psychotherapists as one of their goals, there are no published studies of Counseling Psychology's position with regard to advocacy or non-advocacy of experiential aspects of graduate training. Not only do we not know if these experiences produce better therapists, but we also do not know if Counseling Psychology graduate training programs are philosophically oriented toward espousing this type of training and programmatically implementing it. There are few studies that have examined these programmatic components of Counseling Psychology programs with regard to therapy or personal growth experiences. Jorgensen and Weigel (1973) submitted a questionnaire to APA approved programs in clinical, counseling and professional psychology programs. Therapy experiences were required in 2% (two clinical) of the responding programs, with group therapy the required

experience in both cases. Ten percent of the respondents stated that a therapy experience was available and occasionally encouraged. Wampler and Strupp (1976) distributed a letter to directors of clinical psychology training programs asking for their views on how to best provide students with the opportunity for personal growth experiences and requesting specifics reporting the method students used to obtain therapy. Four percent of the respondents stated some type of therapy experience was required; 67% encouraged students to seek therapy, either explicitly or through the provision of a special opportunity that implies encouragement. Rachelson and Clance (1980) submitted questionnaires to members of Division 29 (Division of Psychotherapy) of APA regarding standards of training experienced. Seventeen percent of respondents stated methods for enhancing personal growth were "always" present during their course of training, while 18% responded that these opportunities were "often" present. Forty-six percent stated that these experiences facilitated therapeutic competence. Ten percent were required to be involved in personal therapy, and this experience was rated second (next to their private practice) in teaching the means of becoming an effective therapist.

These studies raise more questions regarding current training practices. They focus primarily on Clinical Psychology programs, which have previously focused on remediation of dysfunction. Counseling Psychology programs, however, stress the importance of therapy as a growthful or preventive experience rather than simply as a remedial, problem-focused experience. Kagan (1980) states

"Counseling psychology is devoted to helping the great mass of people who are not chronically disturbed.... People who do not wait until their marriages and careers are a shambles to seek professional help. They want prevention and enrichment." Tipton (1983) sent questionnaires to both clinical psychologists and counseling psychologists throughout the country. He asked each to rank in order of importance from 1 to 50 the differing functions of both the clinical and counseling psychologists. Clinical psychologists rated "therapy with normals for personal growth" as number 40 of 50 in terms of relevance for defining their professional role. Clinical psychologists then rated "therapy with normals for personal growth" as number 9 in terms of relevance for defining the Counseling Psychologist's role. Counseling Psychologists, however, rated such therapy a number 3 in terms of defining their roles and number 39 in terms of defining the Clinical Psychologist's role. It is reasonable to assume, therefore, that Counseling Psychologists would espouse such experiences for members of their own profession as well as for the population as a whole.

One wonders whether this assumption is valid. This study will survey the Program Directors of Counseling Psychology training programs across the nation with regard to the beliefs and practices of their departments so that we can more accurately state what philosophical tenets are being followed. Are students encouraged to become involved in personal growth or personal therapy experiences as part of training? The factors that influence such philosophical orientations and resultant programmatic development should be

delineated as well.

It is when such information has been gathered as to the fundamental beliefs and practices of people in one field regarding the necessary and effective components of graduate training that we can more readily make future decisions with regard to the most productive means of structuring (or not structuring) this one component of the training experience. Future research would then include these results in examinations of therapeutic process and outcome, thus contributing another building block to the structure of "What works in effective therapy?"

<div align="center">Definition of Terms</div>

Personal Growth Experience - A structured experience that adds to the individual's self knowledge or facilitates the development and maintenance of positive interpersonal relationships.

Personal Therapy Experience - Driscoll (1984) describes psychotherapy as an "attempt to alleviate restrictions in one's abilities to participate in meaningful and satisfying ways of life." This description portrays therapy as a process of remediation.

Rogers (1969) describes therapy as a process of self-actualization. The individual and not the problem is the focus. The aim is not to solve one particular problem, but to assist the individual to grow.... It relies much more heavily on the individual drive toward growth, health and adjustment. Therapy is not a matter of doing something to the individual or of inducing him to do something about himself. It is instead a matter of freeing him for normal growth and development.

While this study will focus primarily on therapy in the Rogerian sense for trainees, the issue of therapy as a means of problem remediation is also addressed in the questionnaire.

Limitations

1. This study surveys only Counseling Psychology Departments in the United States that are either APA approved or that belong to the Council of Counseling Psychology Training Programs.

2. This study surveys Counseling Psychology programs with regard to the personal growth or personal therapy components of their training.. This study also surveys the Program Director's attitudes and behaviors relating to their personal experience with such components. The possibility exists that the Program Director's attitudes or behaviors may not agree with their department's philosophical position or requirements.

3. While personal growth and personal therapy experiences have been addressed separately on the questionnaire, in reality the experiences are sometimes indistinguishable. Standard criteria such as the format of the experience or the length of involvement are not definitive. What is interpreted by one respondent as a personal growth experience may be interpreted by another as a personal therapy experience. Trainee supervision, depending on the relationship of the participants and the supervision style, may likewise be viewed legitimately as a personal growth or a personal therapy experience or neither.

4. Division 29 of the APA publishes "Recommended Standards for Psychotherapy Education". These standards were referred to in the

cover letter. Division 29 recommendations might not accurately reflect Division of Counseling Psychology's (Division 17) orientation.

Organization of the Study

Chapter I has provided an introduction to the study, including purpose, background, statement of the problem, definition of terms, and limitations. Chapter II will review related literature on experiential requirements in graduate schools, the incidence of personal therapy for therapists, and the effects of such therapy on therapist technique and therapy outcome. Chapter III will provide an outline of the design of the study and the research measures used. Chapter IV will report the statistical analysis of the data and a discussion of the results. Chapter V will present a summary of the study, conclusions drawn from the surveys and recommendations for training and future research.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Several areas pertaining to personal growth experiences as
training will be reviewed in this chapter. They include theoretical
views of professionals regarding the value of personal therapy for the
therapist, the incidence of such personal therapy, the effects of such
treatment on therapist technique and therapy outcome, and general
observations regarding these beliefs and practices.

Theoretical Views

Psychoanalytic

Freud (1937) first postulated that the practitioner could benefit
personally and professionally by undergoing the same process of
self-exploration that was used in treating patients. He wrote, "but
where and how is the poor wretch to acquire the ideal qualifications
which he will need in his profession? The answer is in an analysis of
himself." Freud advocated long-term intensive psychoanalysis for
analysts, as did Fromm-Reichman (1950). Rachmann and Kauff (1972)
report that the process of personal psychoanalysis remains a
requirement of the majority of analytic training institutes. As
previously mentioned in Chapter I, the psychoanalytic profession
believes that effective analysis can only be performed by analysts who
have been analyzed.

There are several reasons why practicing psychoanalysts believe that personal analysis is a necessary requirement for their profession. Freud (1937) first stated the concept that undergoing analysis puts the trainee in touch with unconscious processes that effect his professional practice. Langs (1984), more recently, states that through the analytic experience the analysand can "best and most fully realize his own creative potential through the sound resolution of his neurotic conflicts." This view of increased personal development by working through "blind spots" associated with personal defenses is a major component of current psychoanalytic thought. Not only is the process one that ameliorates possible defensive maladjustments, personal analysis also provides an opportunity to enhance one's self, to further develop therapeutic skills (Kohut, 1977). Thus the trainee is not only working through unresolved conflicts but, simultaneously, growing personally and developing capabilities that are based on self-knowledge. Weissman (1986) elaborates, stating,

> The training analysis was seen as a place for further character growth and resolution of unresolved conflicts. If we accept this view, we can see the training analysis as freeing up the analysand so that he may more effectively use various elements of his self in his own therapeutic work. The analysis will facilitate greater freedom of the ego, or, to use the language of self-psychology, will foster the development of a more cohesive self.

Through the development of a more cohesive self, the analyst becomes more acutely aware of his own defensive, non-productive reactions to patients' material. Speaking of the relation of personal analysis to countertransference material, Weissman states,

> It is essential that the therapist monitor himself so that his

needs or prejudices do not intrude on the patient. A personal analysis will put a psychiatrist in touch with his own needs and will assist him in developing a self-analyzing function with which to address disruptive affects when they are triggered in him by his patients.

While the stress on the need for personal analysis in order to work through countertransference issues has been previously documented (Reichman, 1950; Laplanche and Pontalis, 1973; Weiner, 1983; & Strupp, 1980a), the focus on the analytic process as a tool for growth and lasting personal change is a recent corollary. Sclessinger and Robbins (1983) comment that personal analysis not only opens up blocked areas, but shows the analyst how to work with similar issues or processes as they become re-mobilized. They state that while analysis is not likely to totally resolve conflicts, the process aids the development of a self-analyzing capacity that continues to prove productive.

Support for personal analysis is no longer unanimous in psychoanalytic circles. Leader (1971) states explicitly that analysis is not a necessary precursor to professional competence, and cites the report of the Commission on Psychodynamics of the American Psychiatric Association and the Association of Medical Colleges in concluding that such a requirement is not as universally accepted as had been assumed. Burton (1973) also questions the efficacy of therapy for therapists, stating that the healer is quite likely to begin viewing himself as "sick", thus undermining the assurance and confidence needed to gain and maintain patients' trust and respect. He also states that in his personal experience he has noticed that therapists undergoing therapy often experience a decrease in referrals from colleagues, perhaps

indicating that professionals in the field still stigmatize the patient in therapy, contrary to positive verbalizations to the contrary. Bone (1960) and Rubinfine (1971) state that required participation in analysis may have deleterious effects on the trainee, since the patient will not have the proper motivation for experiencing the pain or discomfort that is usually involved. Most recently, Weissman (1986), reporting on a 1983 survey of psychiatric residents, stated that approximately 50% felt that individual psychotherapy was essential to be a psychotherapist and only 20% planned their own analysis.

Rogerian

Carl Rogers established client-centered psychotherapy over 30 years ago. He posits the view that all clients have the potential to develop into more fully functioning human beings, and that through the application of certain "core conditions", the therapist can facilitate such growth (Rogers, 1957). These "necessary and sufficient" conditions are accurate empathy, warmth, congruence and high positive regard. Rogers believes a number of training methods are effective in aiding therapists' ability to communicate these conditions. Rogers (1969) elaborates on the ability to learn and states that significant learning is acquired by doing, and that self-initiated learning which involves the whole person of the learner, as well as the intellect, is most effective. Experiential learning is thus espoused highly in order to significantly heighten understanding of the therapy process. Truax and Carkhuff (1967) concur, stating that the therapist can best develop empathy for the client and his vulnerability by being clients

themselves in a therapy situation. The student, by experiencing first-hand some of the difficulties associated with the experience, becomes more attuned to the patients' reactions during the process.

Also, by experiencing first-hand the process of therapy, the trainee will hopefully experience some of the other positive aspects of therapy, such as enhanced interpersonal capability and increased self-esteem. With increased self-knowledge and more productive interpersonal relationships the trainee more truly believes in the value of therapy as a tool for growth and is thus better able to instill hope in the client. Carkhuff and Berenson (1967) and Truax and Carkhuff (1967) concur that experiential learning in the form of personal therapy or personal growth experiences for the trainee is an integral part of the Rogerian training process, and that this process effectively develops counselors who consistently communicate the core conditions to clients. Gurman (1973) and Truax and Mitchell (1971) rated counselors in terms of accurate empathy, non-possessive warmth and genuineness of attitude and found that the most effective counselors were those judged to have the highest ratings on those interpersonal variables. Rogerian theorists maintain that the development of such therapeutic skills is at least partly due to having experienced the therapeutic conditions themselves during training.

Existential-Humanistic

Existential-humanistic theorists such as Maslow, May, Frankl and Jourard are probably best known for their extension and elaboration of philosophical concepts of being and the way such concepts relate to

psychology and the practice of psychotherapy. Maslow (1968) speaks of a hierarchy of needs, with the person becoming more self-actualizing and more developed, as he passes through each stage of growth. Self-actualization is seen as "acceptance and expression of the inner core of the self, i.e., actualization of the latent capacities and potentialities, the fully functioning availability of human and personal reserve." This concept of "being" and "fully functioning" pervades existential-humanistic theory. Gable (1970) states that Maslow valued experiential knowledge above all else, and that the very essence of existential psychology is incorporated in experience. He thus advocated encounter with the other in therapy as a "here and now" process of immediacy, and one that could be learned only by experiencing the process first hand. May (1953), in his discussion of will and the desire to be fully present in the psychotherapy situation details the need for personal exploration in order to fully develop as a person; personal development being a necessary component of professional development. Frankl (1967), in discussing the beliefs that form the foundation for logotherapy, states that the therapist needs to have his own version of a search for meaning and that this often includes personal growth or therapy experiences similar to the client's. The therapist is then better able to pass on the knowledge gained through the same struggle that the client is experiencing. Jourard (1978) discusses humanistic psychology's challenge to the therapist to become fully functioning, and cites some of the "great men" of psychology as embodying the spirit of courage and exploration that serves as an example to all healers. Jourard believes that

Freud, Herbert Mowrer, R.D. Laing, Carl Whitaker, Fritz Perls and

Victor Frankl were great psychotherapists because they had overcome

tremendous personal odds through self-exploration experiences and

enabled them to unlock their own blocks, become better adjusted, and

thus work more effectively with their patients' blocks.

Thus, one of the most basic and fundamental principles of

existentialist-humanistic therapy is that only through experiencing

can we truly learn. This experiencing is heavily relied upon as a

tool of training. As Lieter (1980) states, such experience provides

understanding of the patient's position from within, and thus

facilitates a gut-level understanding of what helps and hinders in

therapy. Further, Lieter sees existential and client-centered therapy

as sharing certain principles; as the trainees become more fully

functioning individuals in therapy, they become more open to

themselves and their environment and, consequently, become more

accepting of others. Thus existentialism incorporates empathy along

with congruence (openness to self) and positive regard (openness to

others). He summarizes a shared opinion of client-centered and

humanistic psychotherapists:

> The more I can be in touch with my own experience, at all levels,
> without fear or defense, the more I can be receptive to the inner
> world of my client. ...the problems in it (effective therapy) are
> not technical in nature but are to a great extent connected with
> personal maturity, with the degree to which I have worked through
> my own life problems.

Gestalt Therapy

Gestalt therapy, founded by Perls, incorporates aspects of

existential-humanistic psychology such as the need for personal growth

and development and the necessity of maximizing potentialities through
the exploration of immediate experience. Perls (1951, 1969) shows us
that by working within the realm of immediate experience, enactment of
felt conflicts, the gestalt of the person could be understood.
Dualities, contradictions, and polarities become integrated into a
whole, and a gestalt is formed as the person experiences emotions
previously defended against. As the person accepts the parts of
himself that were previously hidden, they become whole. In other
words, they have experienced, understood, and grown. Experiencing
one's personal conflicts in the context of training is a fundamental
component of Gestalt therapy training. Van DeReit, Korb, and Gonell
(1980) discuss that the Gestalt therapist is one who has experienced
the process as a patient and has achieved a high level of awareness
and ability to maintain awareness of personal processes. Through an
integration of skills, knowledge of theory, and personal
characteristics, the therapist is secure and integrated enough to
respond authentically and spontaneously. Simkin (1976) agrees and
states that Gestalt therapy, by its very nature, necessitates
experiential involvement in order to learn the mechanics and the
dynamics of working in the "here and now". The author describes
numerous Gestalt training programs, all of which require the trainee
to personally experience the therapy process. Stephenson (1975),
Burkens (1980) and Rosenblatt (1975) concur, it is only through the
immediate experiencing that the trainee can gain accessibility to the
flow of inner experience that is necessary for productive therapeutic
work. Enright (1970) believes that while the experiential process for

the trainee is especially suited to Gestalt principles, it is helpful

for psychotherapists of any school, since the experience of the

constant flow of subjective awareness is endemic to all forms of

therapy.

Group Therapy

Irvin Yalom, one of the leading theorists in the area of group

therapy, has written extensively on the nature of the training that he

considers necessary for the student therapist. Yalom (1975) espoused

both individual and group psychotherapy experience for trainees.

These experiences heighten trainee awareness of their own defenses and

countertransference areas, and their experience of the group process

as a member helps them to more fully understand the process, thus

enabling more effective participation as a leader. Battegay (1983)

concurs, but adds that an even more important rationale for the group

therapy training situation is that the group involves both social and

familylike interactions; the interactions are in the here-and-now,

however, thus more clearly delineating interactional patterns

occurring in daily life. Battegay and Rauchfleisch (1980) clarify the

importance of the interaction between past influences and present

patterns:

> It is not possible to recognize the interactions which take place
> between his personal systems - or his field of forces - and those
> of other persons in such a clear way as in a group. Particularly
> problems linked with family, siblings, rivalry, loyalty, and
> narcissism. The emotions which come up in a group provoke the
> manifestation of the problems linked with a similar or even
> another affective content in another participant. This amplifying
> effect of the group on the emotions leads to a much more direct
> confrontation of the participants with conflicts linked with
> earlier experiences.

It is precisely due to the seeming universality of processes that some theorists recommend participation in a training group regardless of whether the training is specifically tailored to the acquisition of group leadership abilities. Goldberg (1973) advocates individual psychotherapy experiences and, additionally, a wide variety of group experiences for the practitioner in training, including sensitivity training and encounter groups. The author asserts that without such preparation the group leader is likely to affect the group deleteriously in at least one situation e.g., when attacked by group members. . Cane (1977) states that "the student can feel what it is like and can observe the group process while living it. Many processes that occur in students' groups repeat themselves... the conflicts are universal because they represent natural stages of group development." Glatzer (1975) reported the basic prerequisites of becoming a group leader included: "1) Acquisition of cognitive knowledge and information about the group process, 2) Experiential involvement as a participant in the process, 3) Development of skills and techniques, and 4) Experience in the leadership role." Berger (1969) reports that training programs that required experiential groups as a part of training cite results that include increased interpersonal skills, the ability to give feedback, and a more accepting nature.

Many group theorists thus believe that experiential learning in a group provides the trainee with valuable experience including acquisition of knowledge of group stages, processes and dynamics, awareness of countertransference material, and heightened ability to

communicate core conditions necessary to effective psychotherapy.

Marriage and Family Therapy

It is only natural that some theorists in the field of family
therapy would advocate experiential training for students; previously
cited authors have consistently stressed the importance of recognizing
and working through areas of unresolved conflicts, many of which are
related to current or former family functioning. Bowen (1978)
discussed his current class of psychiatric residents and stated that
both formal therapy and informal dialogue with family trainees around
areas of their own unresolved family difficulties were extremely
helpful. The difference he noted between good and bad residents were
"those that had done their best work with their parental families were
also doing their best clinical work." Bowen goes on to explain that
the process of understanding the nature of their own conflicts and
finding ways to work through them enabled them to facilitate changes
more easily with families in the psychiatric clinic. They learned by
doing. Jurorsky (1964), who ran training groups with trainees and
spouses, theorized that any disruption in the therapist's own family
will affect the therapists' own resistances and defenses with their
patients, thus diminishing their therapeutic effectiveness. Cleghorn
and Levin (1973) agree, stating that when doing consultation and
supervision they noticed a clear relationship between work done in the
therapists' families of origin and their clinical proficiency. Novak
and Busko (1974) stated that "reverberations from unresolved
relationship problems within their own families" created barriers to
effective therapeutic work with other families as uncomfortable

feelings are raised by situations that remind the therapist of his own

family. A number of researchers express similar theoretical

orientations, including Guldner (1978), Carter and Orfondis (1976),

and Woody and Weber (1983). Kaslow (1977) succinctly summarizes the

increasingly popular view requiring some form of personal growth or

personal therapy experience for the family therapist trainee:

> In this way, they experience what it is like to be in the client
> role, how painful it can be to open up submerged conflict areas
> and how difficult it can be to accept interpretations and
> confrontations. Just as many graduate and professional programs
> require that students in the process of becoming therapists become
> analysands or psychotherapy patients, I believe that it is
> imperative that marriage counselors and group therapists have at
> least a few treatment sessions with their close relatives
> participating.

Thus, the author believes that the trainee, through the process of

being a patient, develops increased knowledge of self which

facilitates empathic communication with future patients.

Behaviorist

While a majority of behaviorists do not advocate experiential

processes as a necessary component of training, it is important to

note that some behaviorists currently disagree. Sahakian (1984) looks

at the stimulus-response connection as one of association, stating

that the response follows the experience of the stimulus because the

two were associated in the past. While this concept is similar to

Pavlov's reinforcement, it is errant reasoning to conclude the

corollary "Learn by doing." The author prefers "What is learned is

what will be done." The stimulus becomes a cue to elicit behavior

that is expected from past experience. Thus, by being involved in the

therapeutic situation, the trainees will best learn how to supply

therapeutic conditions for their future patients.

Ramsay (1980) clarifies:

> Behavior therapists should and do go into treatment as a part of
> their training programs. In order to carry out behavior therapy
> with a client, there are a number of skills that have to be
> mastered. Relaxation training may sound simple, but it takes many
> hours of practice before the therapist is relaxed enough himself
> to relax a client. The fledgling behavior therapists use each
> other as clients.

The author states that this is not merely practice therapy, but that
the students, by being in the role of the patient, experience the
process as more personal and get immediate feedback, through their own
reactions., as to how an effective technique works.

Regardless of theoretical orientation or preferred mode of
treatment, numerous divergent theorists have seemingly agreed on the
reasons why they endorse personal growth or personal therapy
experience as a part of training. Garfield and Kurtz (1976) summarize
the rationale for a psychotherapy practitioner of any orientation
undergoing personal therapy:

> One of the prominent beliefs held by a large number of
> psychotherapists is the importance of personal psychotherapy as
> desirable preparation for the practice of psychotherapy. Among
> the propositions advanced in behalf of this view are that the
> future psychotherapist will gain a more complete understanding of
> his own personality dynamics and reduce his personal blind spots,
> and that he will, by having experienced the role of client or
> patient, be able to be more sensitive to the needs of the client.

Incidence of Personal Therapy

One of the earliest surveys regarding the incidence of therapy
among psychotherapists was conducted by Lubin (1962) who polled
clinical psychologists. Fifty-seven percent of respondents indicated

that they had had some personal therapy, with 46% having had therapy for one year or more. Goldschmid, Stein, Weisman and Sorrels (1969) reported similar findings after polling members of the Division of Clinical Psychology of the APA; 64% of the respondents had had therapy, and 50% had had two or more years of therapy.

Garfield and Kurtz (1976) distributed a questionnaire to 855 members of the Division of Clinical Psychology of the American Psychological Association. The authors report that approximately 63% of respondents had had some form of therapy. Psychologists in private practice and in outpatient clinics had significantly higher rates of personal therapy of 70% and 77% respectively. Those respondents in university psychology departments and those checking "other" institutional affiliations were involved much less frequently, with rates of 57% and 52% respectively. Similarly, the two groups attributed different levels of importance to the process; 48% of those in private practice and outpatient clinics rated personal therapy as "very important", while 25% of those in university settings rated such experience similarly. Further, 45% of all respondents recommended that "all" clinical psychologists undergo therapy, while another 36% rated personal therapy as "very important" to a psychologist's professional development. Thus, a total of 81% of respondents strongly favored such involvement. In addition, the experience of undergoing therapy positively influenced the respondents' outlook: 65% of those who had recommended personal therapy for all had undergone therapy themselves, as opposed to 10.5% of those who had not undergone therapy recommending it for all. Data from this study imply

that the more psychologists work in therapy with patients, the more

they see its value for themselves, the more they become involved and

the more highly they recommend it as a component of training.

Unfortunately, demographic data as to respondents´ period of

involvement in therapy and the reason for therapy were not obtained.

Henry (1977), in an attempt to shed some light on such

demographic influences surveyed 4,000 practicing psychotherapists in

New York, Los Angeles, and Chicago. This sample represented

approximately 60% of all known psychotherapists in these cities who

are classified as psychoanalysts, psychiatrists, psychologists, and

social workers. All those involved were actively engaged in doing

psychotherapy according to evidence gleaned from professional

directories and membership in specifically psychotherapy-oriented

organizations. Results show that 97.5% of analysts responding had had

personal therapy. Psychologists had undergone therapy at the rate of

74.7%, while psychiatrists had been personally involved 65% of the

time and social workers 64% of the time. Fifty-two percent of the

analysts and 41% of the psychologists reported that they had been in

therapy two to four times. Again, however, specific inquiry regarding

the choice of time period for involvement and motivation for

involvement were not included.

Support for personal therapy as training is not unanimously

endorsed however. Buckley, Karasu and Charles (1979) distributed

questionnaires to 97 therapists at the Bronx Municipal Hospital Center

who had voluntarily undergone either analysis (76%) or psychotherapy

(24%). While 94% reported "improved self esteem" as a result of

involvement, 21%, or one in five, reported that "treatment was harmful in some respects." Wampler and Strupp (1976) surveying Program Directors of APA clinical psychology programs, found that directors were almost unanimously opposed to departmental requirements of personal therapy on the grounds of infringement of privacy and difficulty with confidentiality.

Practicing psychotherapists appear to strongly endorse personal therapy as a component of training. Jorgensen and Weigel (1980) distributed questionnaires to 518 members of Division 29 (Division of Psychotherapy) of the APA regarding their concept of an "ideal" training program for psychotherapists, 68% of all respondents would require some form of personal therapy during graduate training, and 80% would include provisions for free or inexpensive therapy for students. These individual responses reflect the official positions of several psychotherapy organizations. Division 29 of the APA strongly recommends both personal growth experiences and personal therapy for the developing practitioner. Matarrazzo (1977) cites the Accreditation Committee of the American Group Psychotherapy Association (A.G.P.A.) when discussing an overview of currently held opinions regarding experiential facets of professional training. The A.G.P.A. recommends 60 hours of group participation as a prelude to leading a group in order to transfer to an emotional level what previously was known only intellectually. The therapist then "learns what self-disclosure really entails, how difficult it is to reveal one's secret world, one's fantasies, one's feelings of vulnerability, hostility and tenderness." The A.G.P.A. thus contends that the

personal experience of the difficulties encountered by the patient during the therapeutic process enhances his understanding and promotes increased empathy.

None of the aforementioned data have referred to the influence of the psychotherapists' training program in their personal outlook and resultant therapy involvement. Rachelson and Clance (1980) distributed the Psychotherapy Training Questionnaire (PTQ) to 518 members of Division 29 of the APA. This questionnaire incorporated questions related to Division 29 Psychotherapy Curriculum and Consultation Committee (1971) recommendations. Adjacent to each of 16 recommendations and five additional questions relating to training was a scale representing three dimensions of training: (1) activity was present in training (never, seldom, sometimes, often, and always), (2) activity was facilitative of your therapeutic competence (cannot determine, no, sometimes, and yes), (3) would include activity in an ideal training program (yes and no).

The questionnaire also addressed an important and relevant issue for Counseling Psychology, that of therapy for growth and learning as opposed to therapy for remediation of dysfunction. The question, "Students had experiences in situations where the aim of treatment was preventative or maximizing potential" garnered a response of "sometimes" 28% of the time, "often" 22% of the time, and "seldom" 23% of the time. Forty percent of respondents felt that such an experience facilitated competence, however, and 93% would include such an experience in an ideal training program. The question "You were required to be involved in your own personal therapy" received "never"

76% of the time and "always" 10% of the time. Somewhat surprisingly,
62% felt that such an experience should be included in an ideal
training program. In response to "Provisions were made for
inexpensive or free psychotherapy", 40% replied "never" and 27%
replied "always". Eighty percent of respondents would include such
availability in their ideal training program. The final question, and
possibly one of the most important, "Did you learn more about being an
effective therapist in graduate school, internship, personal therapy,
my practice, advanced training in workshops and no response?" elicited
responses indicating psychotherapists valued their own therapy as
second only to their practice in terms of valued learning.

Availability of Experiential Components in Graduate Programs

Thus far, much of the data reflects the opinions and behaviors of
practicing psychotherapists. This section explores the positions of
the graduate departments that develop curricula and actually provide
training opportunities for graduate students. There have been few
studies relative to required or recommended experiential components of
psychotherapy training in general and even fewer regarding the status
of this component of training in Counseling Psychology programs. It
is of interest to know whether our training programs adhere
philosophically to Division 29 recommendations. It is also important
to know what factors influence decisions relevant to programmatic
implementation of these recommendations.

Jorgensen and Weigel (1973) mailed a questionnaire to program
directors of APA approved programs in clinical, counseling, and
professional psychology programs. The questionnaire covered a wide

variety of training issues, of which personal therapy was one. Formal

therapy experiences were required in only 2% (two clinical) of the

programs, and group therapy was required in both cases. Ten percent

(seven clinical, three counseling) of the programs responding stated

that a therapy experience was available if desired by the student, and

that a group therapy experience was often encouraged. Unfortunately,

the rationale behind the development of specific programmatic

requirements was not addressed. Wampler and Strupp (1976) provided

more detail in their questionnaire of clinical directors, focusing

especially on provisions made for those who desired therapy in terms

of cost, availability and faculty support. APA approved programs in

clinical psychology were surveyed by mailing questionnaires to

directors of clinical training. Only 4% of the respondents required

any form of personal therapy, and this requirement involved only

short-term participation in some type of T-group experience. The

distinction between a personal growth and a personal therapy

experience was not addressed in this or any other study. Predictably,

the program directors expressed grave concern regarding

confidentiality difficulties related to such a requirement. Several

directors also reported concern that even active encouragement to

participate in such activity might be interpreted as political

coercion. Also of concern was the issue of how therapy involvement

and outcome was to be evaluated, should it be required. In response

to "Departmental attitude toward personal therapy for clinical

students", 67% of respondents replied the "department encourages

students to seek therapy, either explicitly or through the provision

of special opportunity", while 17% responded that "director will make

referrals if asked, personal therapy is OK but low priority." In

terms of providing resources for trainees for free or low-cost

therapy, 35% of responding programs stated that there was available a

"University counseling center staffed independently of psychology

department", and 23% provided a "referral list of therapists in

private practice who will see students for free or at reduced rates."

Nine percent of the programs even developed an "exchange program" in

which faculty members serve as therapists for students at neighboring

universities." Rachelson and Clance (1980), reporting Division 29

members' retrospections, reported that 17% of respondents felt that

methods for enhancing personal growth experiences were "always"

available to them during their course of training, while 18% replied

that such opportunities were "often" present.

Thus, program directors and practicing psychotherapists appear

generally to agree that personal therapy is a valuable training

experience for the student. Implementation of these views in a

training format does not follow any standardized guidelines at this

time.

Efficacy of Personal Therapy in the Training of Therapists

Perhaps one of the reasons there are such divergent opinions and

practices regarding personal therapy in training involves the

difficulty of establishing a direct correlation between undergoing

therapy and developing therapeutic competence or expertise.

Evaluation of therapy outcome is extremely difficult, even without

attempting to delineate exactly what occurs and why. Multiple

uncontrollable variables will always be present in the process of
therapy. Therapeutic effectiveness involves numerous intangibles;
explicating exactly what part training contributes to the development
of skills and what part therapy contributes usually occurs only on a
piecemeal basis. The interaction of personal development and skill
acquisition is extremely complex; evaluation of such interaction is
not yet an objective process.

Although it may be extremely difficult to separate the component
parts of effective psychotherapy, there is much evidence to indicate
positive changes do occur. Greenberg and Staller (1981), in a brief
review of the literature cite Eisler and Greenberg (1977), Meltzhoff
and Konreil (1970), and Smith and Glass (1977) in concluding that
change in the form of positive patient adjustment occurs during
therapy. While there continues to be disagreement as to the reasons
for patients' improvement, Buckley, Karasu, and Charles (1979) posit
the view that the psychotherapists they surveyed who had undergone
personal therapy reported improved self esteem and improved
interpersonal relations, due at least partially to "reciprocal liking"
between themselves and their therapists. Lieter (1980) hypothesizes
that this is an experiencing of the "necessary and sufficient"
conditions of warmth, empathy, respect and congruence. Having
experienced these conditions, the therapists can then better provide
similar conditions when working with their own patients. Shapiro,
Struning, Shapiro and Burton (1976) concur that the provision of such
conditions in therapy is a factor related to patient improvement. A
number of other prominent authors and researchers agree that the

patients´ perception of such positive regard is conducive to therapeutic progress, including Rogers (1957), Truax and Carkhuff (1967), Carkhuff and Berenson (1967), Yalom (1975), and Strupp (1977). Truax and Mitchell summarize:

> Therapists and counselors who are accurately empathic, non-possessively warm in attitude and genuine are indeed effective. Also, these findings seem to hold with a wide variety of therapists and counselors, regardless of their training and theoretic orientation, and with a wide variety of clients or patients including college underachievers, juvenile delinquents, hospitalized schizophrenics, mild to severe outpatient neurotics, and a mixed variety of hospitalized patients. Further, the evidence suggests that these findings hold in a variety of therapeutic contests and in both individual and group psychotherapy or counseling.

Gurman (1973) agrees, stating that the most effective therapists he evaluated were the ones highest on these three interpersonal variables. Indeed, lack of communication of these conditions may be detrimental to the client´s progress. The widely quoted "Wisconsin Project" conducted by a research team including Rogers and Bergin and reported by Truax (1963) concluded that schizophrenics who deteriorated during treatment were patients of therapists lacking in empathy, unconditional positive regard, and genuineness. Therapists who offered these conditions at a high level had a high percentage of successful outcomes. Patients of these therapists also experienced a significant decrease in anxiety level. The Arkansas study, as reported by Mitchell, Truax, Bogarth and Krauft (1973) concurred, stating that low ratings of genuineness, is described by "defensiveness" or "phoniness", influenced both negative client outcome and lessened the helpful effects of empathy and warmth. Lambert, Bergin, and Collins (1977) summarize the positive effects

inherent in the core conditions:

> there is still considerable support that they are not school specific but that therapeutic encounters which are highly loaded with these positive relationship factors produce much higher positive outcome rates than those which are low in these conditions.

Is there research evidence, though, to support the theoretical contention that therapists who have undergone therapy communicate higher levels of facilitative conditions? Strupp (1958) found that experienced psychologists and psychiatrists who had undergone analysis were more empathic. Peebles (1980) evaluated graduate students with and without personal therapy who were seeing patients as a part of training. She found that the higher amount of time correlated positively with increased levels of empathy and genuineness. She recommended that educators "make the options and merits of personal therapy known to graduate students." Kernberg (1973), in a study conducted at the Menninger Foundation, concluded that experienced therapists who had completed personal analysis obtained greater improvement than inexperienced therapists who had not had personal analysis. Since experience was not controlled for, however, the authors could not determine whether it was the experience or the analysis or both that contributed to patient improvement. Also, the personal growth treatment evaluated was personal analysis, a method of training undertaken mainly by psychiatrists. Strupp (1973) also attempted to differentiate between analyzed and unanalyzed therapists. Written reports of patients´ statements in three different conditions were presented to therapists for their response. Statements involved suicide threats, schizoid productions, and transference phenomena.

Strupp hypothesized that according to the relevant literature, the more analyzed therapists would respond more effectively. He stated that analyzed therapists would be more likely to respond to suicide threats with more explorations and fewer reassurances than the unanalyzed group. He also hypothesized that transference reactions would elicit a larger number of interpretations from the analyzed group. Thirdly, Strupp felt that analyzed therapists would respond to psychotic productions with a smaller number of silent responses and a larger number of explorations than those who had not been analyzed. Strupp's hypotheses were for the most part validated. There was a significant difference overall between the responses for the analyzed vs. the unanalyzed therapists. With regard to suicide threats, both groups gave a high number of reassuring responses, although unanalyzed therapists gave fewer numbers of reflective responses. In response to transference reactions, both groups showed an increase in interpretive responses, although the difference is significant only in the analyzed group. Increments in structuring and decrements in exploratory responses were noticeable for both groups, but again significant difference was noted only for the analyzed group. With schizoid productions, analyzed therapists' responses are characterized by a marked decrease in silent responses, while the unanalyzed group tends to increase such responses. Analyzed therapists give a proportionate number of exploratory responses, while unanalyzed therapists decrease such responses. Strupp concludes that the analyzed therapists are more active, more skilled, and willing to interact more spontaneously in therapy. He also concludes that analyzed therapists' behaviors

were more in line with suggestions in the literature concerning effective intervention with specific conditions. In the article, numerous difficulties are noted in drawing conclusions from the study, however; therapists were responding to written statements, not to patients, and the statements were brief and out of context. No background information on the case was presented to the therapists. The number of statements responded to was extremely small also. In a follow-up study (1973c) Strupp had raters classify responses from analyzed and unanalyzed therapists, and empathy ratings were significantly higher for the analyzed group. Noting such methodological weakness, Wogan and Norcross (1983) polled 136 psychologists from division 29 of APA. The Therapeutic Attitudes, Skills and Techniques (Taste) scale of the Usual therapeutic Practices (UTP) inventory was analyzed from five different variables. Therapists who had had personal psychotherapy scored higher on level of activity and flexibility and lower on therapist distance. These findings of Strupp, Wogan and Norcross have been corroborated by McNair and Lorr (1964), Peebles (1980), and Wallach and Strupp (1964). Also, Guild (1969) states that he found analyzed therapists to evidence more of the qualities of warmth, empathy and genuineness.

McNair, Lorr and Callahan (1963) surmised that if personal therapy produced better therapists, then these therapists would have lower premature termination rates. They reported that therapists who were female, with more experience, who liked their patients, lost fewer patients prematurely. Perceived therapist competence and incidence of therapists´ personal therapy were reportedly not

influential in the patients' decision to terminate, however.
Greenspan and Kulish (1985), in a very recent study, disagreed
strongly with those findings. They evaluated 718 patients whose
therapists had explicitly recommended a period of treatment of at
least six months duration. Cases in group, short-term, family or
marital therapy were excluded. These 718 patients were treated by 27
therapists whose orientation was described as insight-oriented. Data
on numerous independent variables was collected, of which personal
therapy was one. Premature termination was defined as the patient
leaving therapy against the recommendation of the therapist. Ph.D.
psychologists displayed a premature mean termination rate of 34%,
which was significantly lower than those of the M.S.W. therapists, who
experienced a termination rate of 60%. M.D. therapists also
experienced a significantly higher rate of termination, with 71% of
their long term patients leaving therapy prematurely. M.A. therapists
experienced a termination rate of 45%, which was not significantly
higher than the Ph.D. psychologists.

While the amount of personal therapy experienced by therapists
did appear to affect termination rates, the experience of personal
therapy did not appear to contribute significantly to the results.
The mean termination rate for therapists who had experienced therapy
was 52%, while the mean termination rate for therapists without
personal therapy was 72%, a clearly significant difference. Each
subgroup was also analyzed according to professional affiliation.
M.D. therapists with therapy experienced a termination rate of 67%,
significantly lower than that of the M.D. therapists without therapy,

who averaged an 85% dropout rate. M.S.W. therapists with therapy

averaged a group rate of 68%, also significantly higher than the

M.S.W. therapists who had had therapy, with a termination rate of 56%.

All Ph.D. and M.A. therapists reported having had therapy, so

differentiating therapy effects for those groups was not possible.

The authors noted that the population being evaluated were mostly

lower middle class auto workers, and that this population might not

have been the best candidates for insight-oriented long-term

psychotherapy.

Thus, several studies allege that personal therapy for the

therapist has a positive effect on psychotherapists in terms of their

ability to conduct psychotherapy effectively. However, research

design difficulties are apparent in the studies cited.

Katz, Lorr and Rubinstein (1958) investigated patient and

therapist variables and attempted to relate these attributes to

therapeutic improvement. Two samples of 58 patients were rated by

therapists on progress in therapy. Ratings were then compared to

therapist characteristics. They concluded that improvement was

unrelated to having undergone personal analysis, although improvement

was positively correlated with level of therapist experience. Again,

only involvement in analysis was considered a criteria for therapy.

Holt and Luborsky (1958) reported similar findings, also based on the

therapist's experience in analysis. Derner (1960) reported that in a

study undertaken at Adelphia University Clinic the therapists were

ranked in order of perceived therapeutic effectiveness by senior staff

members. The top two therapists and the lowest two therapists over

four years were found to be evenly divided; half of each group had had therapy. Derner concluded "Senior staff judgment was to competence in therapy was unrelated to whether the therapist did or did not have therapy." The authors, note, however, that this judgment was based on a subjective evaluation of an extremely small sample. Garfield and Bergin (1971), in a widely quoted study, evaluated therapists who had no therapy, 175 hours or less of therapy, and 175 hours or more of therapy. These 18 therapists worked with 38 patients who took the MMPI both pre-treatment and post-treatment. Changes in the Depression and the K scale were compared with changes on a five point therapist rating of severity of disturbance (also pre-treatment and post-treatment). The clients of those therapists who had no therapy consistently showed more change than the clients of therapists who had had up to 175 hours of therapy.

In discussing the results, the authors note that all therapists were graduate students and thus relatively inexperienced. It is also hypothesized that the students who had experienced more than 175 hours of therapy were more dysfunctional than their counterparts with less therapy involvement e.g., inexperienced therapists in graduate school who have experienced over three years of intensive therapy might evidence some personal difficulties that could affect their effectiveness as therapists.

Summary

Research findings on the effect of personal therapy on therapeutic outcome are sparse. Reports of positive effects are balanced by other studies claiming no effect or negative effect. All

studies cited are limited in scope and suffer from design flaws. Perhaps the nature of the subject being investigated and the sheer number and complexity of the factors involved in effective psychotherapy will always contribute to the limitations of conclusions based on the isolation of one particular variable such as personal therapy.

Psychotherapists are, however, making decisions regarding their involvement in therapy. The research cited shows that between 60% and 70% of practicing psychotherapists have undergone therapy. An even higher percentage reports a belief in growth and learning experiences as a part of training. Counseling Psychology graduate programs have never been polled extensively on the opinions and experiences of the professionals that are influential in formulating curriculum policy. It is important that we, as a profession, understand the motivation for our beliefs and actions relative to therapy and the nature of the educational messages that are being transmitted to future psychotherapists. The research undertaken by this writer will hopefully contribute to the answering of some of these questions.

This chapter has provided a review of the literature, including theoretical views regarding the value of personal therapy for the therapist, the incidence of such therapy among professionals, the availability of such a component in graduate schools, and the effects of such treatment on the future therapist's effectiveness. Chapter III will provide an outline of the design of the study and the research measures employed. Chapter IV will report the statistical analysis of the data and the discussion of the results. Chapter V

will present a summary of the study's conclusions and make

recommendations for training and future research.

CHAPTER III

METHOD

Introduction

This study investigated a number of factors relative to the
beliefs and policies of Program Directors of Counseling Psychology
Departments, regarding whether personal growth or personal therapy
experiences were, or should be, a part of training. Extensive
information was also garnered regarding the experiential requirements
and expectations of Counseling Psychology programs nationwide.
Chapter III describes the methodology employed in the study and
includes a description of subjects, procedures, instrumentation, and
analysis.

Subjects

Fifty-seven Program Directors of Counseling Psychology programs
throughout the United States were mailed questionnaires. All programs
were either APA approved or current members of the Council of
Counseling Psychology Training Programs.

Procedure

In addition to the questionnaire, a cover letter was included
explaining the nature of the study and its rationale. A stamped,
self-addressed return envelope was also included. All programs were
assigned random identifying numbers in order to ensure confidentiality
and ease of follow-up.

Approximately three weeks after the initial mailing, a follow-up letter and another copy of the questionnaire was mailed to Program Directors who had not yet responded. A second follow-up letter was mailed to non-respondents approximately three weeks later. Phone calls were placed to remaining non-respondents approximately three weeks after the second follow-up notice. A total of 46 Program Directors, or 81%, responded.

Instrumentation

The questionnaire employed in this study was designed by this researcher (see Appendix A). Parts of the questionnaire incorporated concepts researched in two previously reported studies by Jorgenson and Weigel (1973) and Wampler and Strupp (1976). Some questions replicated or resembled parts of questionnaires employed in these studies. Questions were multiple choice and in some instances more than one choice could be checked if applicable. Opportunities for short-answer responses were provided if respondents felt the need to elaborate, explain, or question. Questions were designed to be mutually exclusive whenever possible.

The questionnaire was divided into three sections. Section A examined departmental requirements or recommendations relative to personal growth experiences as delineated in Principal 21 of Division 29 of the APA, Recommended Standards for Psychotherapy Education in Psychology Doctoral Programs. Section B referred to departmental requirements or recommendations relative to personal therapy experiences for graduate students. Section C polled Program Directors on their attitudes and experiences relative to their own personal

therapy experience.

Analysis

Responses were tallied and percentages of responses computed for each question. Percentages of responses were then rank ordered and comparisons made between different items. Particular response percentages were also compared with data accumulated from previous studies addressing some identical questions.

Research Questions

Division 29 of the APA has published "Recommended Standards for Psychotherapy Education in Psychology Doctoral Programs." Principle 21 of the standards advocates personal growth and/or therapy experiences as part of students' training.

The overall research question will be addressed through a survey of Program Directors of Counseling Psychology Programs. This survey will investigate to what extent Counseling Psychology programs concur with and implement this standard. The issues studied are:

(1) Is a "personal growth" experience as delineated by Principle 21 required of students? Is it recommended?

(2) Is a "personal therapy" experience required of students? Is it recommended for students?

(3) How are these expectations communicated to students?

(4) Are there provisions made for students' participation in such experiences in terms of providing facilities, information and financing?

(5) What factors were influential in the development and implementation of policy regarding this facet of training?

(6) What is the personal attitude and experience of the Program Director with regard to this aspect of training?

Summary

Chapter III has outlined the methodology followed for this study. Chapter IV will present the results. Chapter V will contain a discussion of those results, a summary of the study and recommendations for further research.

CHAPTER IV

RESULTS

Introduction

Chapter IV presents questionnaire data collected from 57
Counseling Psychology Program Directors across the nation. All
questions involved multiple choice responses, which were then rank
ordered in terms of percentage of respondents. Several questions
related directly to prior questions. In these cases respondents were
asked to qualify or explain previous responses, again with multiple
choice responses. Similarity of responses to the two questions was
then calculated according to the percentages of total respondents.
Certain sections of the questionnaire present successive questions
involving mutually exclusive categories. In these cases the numbers
of responses for each question are less than the total number of
Directors responding overall.

Questionnaire Responses

Introduction

Questions 1-9 concern "personal growth experiences" as a
component of graduate training. The questions assess whether such
experiences are required or recommended.

Section A: Personal Growth Experiences

Question 1: "My department requires a personal growth experience
of all students." Forty-six Program Directors responded to this

question; 39% (n=18) responded "Yes" and 61% (n=28) responded "No".

Question 2: "My department requires a personal growth experience only for those students whose personal difficulties are interfering with productive participation in the program." Twenty-seven Program Directors responded; 22% (n=6) responded "Yes" and 78% (n=21) responded "No".

Question 3: "If personal growth experiences are required they are...." Twenty-two Program Directors responded to one or more of the following choices. Choice I. and J. represent the combination of methods specified most often by dual-choice respondents.

A.	T-Group	17%	n=3
B.	Communication Skills Training	55%	n=12
C.	Assertiveness Training	5%	n=1
D.	Relaxation Training	9%	n=2
E.	Desensitization Training	5%	n=1
F.	Group Supervision	77%	n=17
G.	Curriculum Course with Experiential Component	68%	n=15
H.	Other	23%	n=5
I.	Communication Skills and Curriculum Course	45%	n=10
J.	Communication Skills and Group Supervision	40%	n=9

% > 100 due to multiple responses.

Question 4: "If a personal growth experience is not required of any students it is because...." Twenty-four Program Directors responded to one or more of the following reasons. Choice G.

represents the combination of reasons cited most often by dual-choice respondents.

A. Unnecessary for therapeutic competence   21%   n=5

B. Infringement of privacy   67%   n=16

C. Issues of confidentiality   29%   n=7

D. Issues of affordability   13%   n=3

E. Unavailability of appropriate resources   8%   n=2

F. Other   33%   n=8

G. Infringement of privacy and of
    confidentiality   29%   n=7

% > 100 due to multiple responses.

Question 5: "My department recommends a personal growth experience for all students. Thirty Program Directors responded; 50% (n=15) responded "Yes" and 50% (n=15) responded "No".

Question 6: "My department recommends a personal growth experience only for those students whose personal difficulties are interfering with productive participation in the program." Sixteen Program Directors responded; 41% (n=7) responded "Yes" and 59% (n=10) responded "No".

Question 7: "If personal growth experiences are recommended they are...." Sixteen Program Directors responded to one or more of the following choices. Choices I. and J. represent the combination of reasons cited most often by dual-choice respondents.

A. T-Group   43%   n=7

B. Communication Skills Training   56%   n=9

C. Assertiveness Training   43%   n=7

D.	Relaxation Training	37%	n=6
E.	Desensitization Training	25%	n=4
F.	Group Supervision	50%	n=8
G.	Curriculum Course with Experiential Component	43%	n=7
H.	Other	37%	n=6
I.	Communication Skills and Curriculum Course	37%	n=6
J.	Communication Skills and Group Supervision	25%	n=4

% > 100 due to multiple responses.

Question 8: "If a personal growth experience is required or recommended, have APA Division 29 recommendations been influential in your policy formation?" Thirty-seven Program Directors responded. Eleven percent (n=4) responded "Yes", and 89% (n=33) responded "No". Of the 33 who responded negatively, 20 mentioned other influences. Twelve (32%) indicated faculty judgment was the most salient factor influencing policy. Three (8%) cited consideration of students' needs and two (5%) cited accreditation concerns as having influenced their department's philosophy and requirements.

Question 9: "Students' possible involvement in a personal growth experience is addressed." Thirty-nine Program Directors responded to one or more of the following choices. Choices F. and G. represent the combination of methods cited most often by dual-choice respondents.

A.	In class	67%	n=26
B.	General information sources	36%	n=14

C. Department meetings open to students   33%   n=13

D. Referral sources available to students   64%   n=25

E. Through "Advisor"   31%   n=12

F. In class and open department meetings   26%   n=10

G. In class and other referral sources   28%   n=11

% > 100 due to multiple responses.

Section B: Individual and Group Therapy Experiences

Questions 10-21 concern individual and group therapy experiences as a component of graduate training. The questions assess whether such experiences are required or recommended.

Question 10: "My department requires an individual or group therapy experience of all students." Forty-six Program Directors responded; 2% (n=1) responded "Yes" and 98% (n=45) responded "No".

Question 11: "My department requires an individual or group therapy experience only for those students whose personal difficulties are interfering with productive participation in the program." Thirty-eight Program Directors responded; 39% (n=11) responded "Yes" and 71% (n=27) responded "No".

Question 12: "If therapy experience is required it is:" Nine Program Directors responded. Sixty-seven percent (n=6) indicated that only individual therapy was required, while 11% (n=1) indicated that only group therapy was required. Twenty-two percent (n=2) indicated that both individual and group therapy were required.

Question 13: "If a personal therapy experience is not required it is because:" Twenty-five Program Directors responded to one or

more of the following reasons. Choice G. represents the combination

of reasons cited most often by dual-choice respondents. Reasons for

not requiring personal growth experiences (Question 4) are presented

for comparison purposes.

		Therapy N=25		Personal Growth Experiences N=24	
A.	Unnecessary for therapeutic competence	24%	(n=6)	21%	(n=4)
B.	Infringement of privacy	60%	(n=15)	67%	(n=16)
C.	Issues of confidentiality	32%	(n=8)	29%	(n=7)
D.	Issues of affordability	32%	(n=8)	13%	(n=3)
E.	Unavailability of appropriate resources	12%	(n=3)	8%	(n=2)
F.	Other	40%	(n=10)	33%	(n=8)
G.	Infringement of privacy and confidentiality	28%	(n=7)	29%	(n=7)

% > 100 due to multiple responses.

Question 14: "My department recommends an individual or group

therapy experience for all students." Forty-three Program Directors

responded; 47% (n=20) responded "Yes" and 53% (n=23) responded "No."

Question 15: "My department recommends a personal therapy

experience only for those students whose personal difficulties are

interfering with productive participation in the program." Twenty-six

Program Directors responded; 39% (n=10) responded "Yes" and 61% (n=16)

responded "No."

Figure 1 represents the extent to which departments require or

recommend personal growth or personal therapy experiences.

Figure 1

Programmatic Requirements and Recommendations

Number of
Respondents
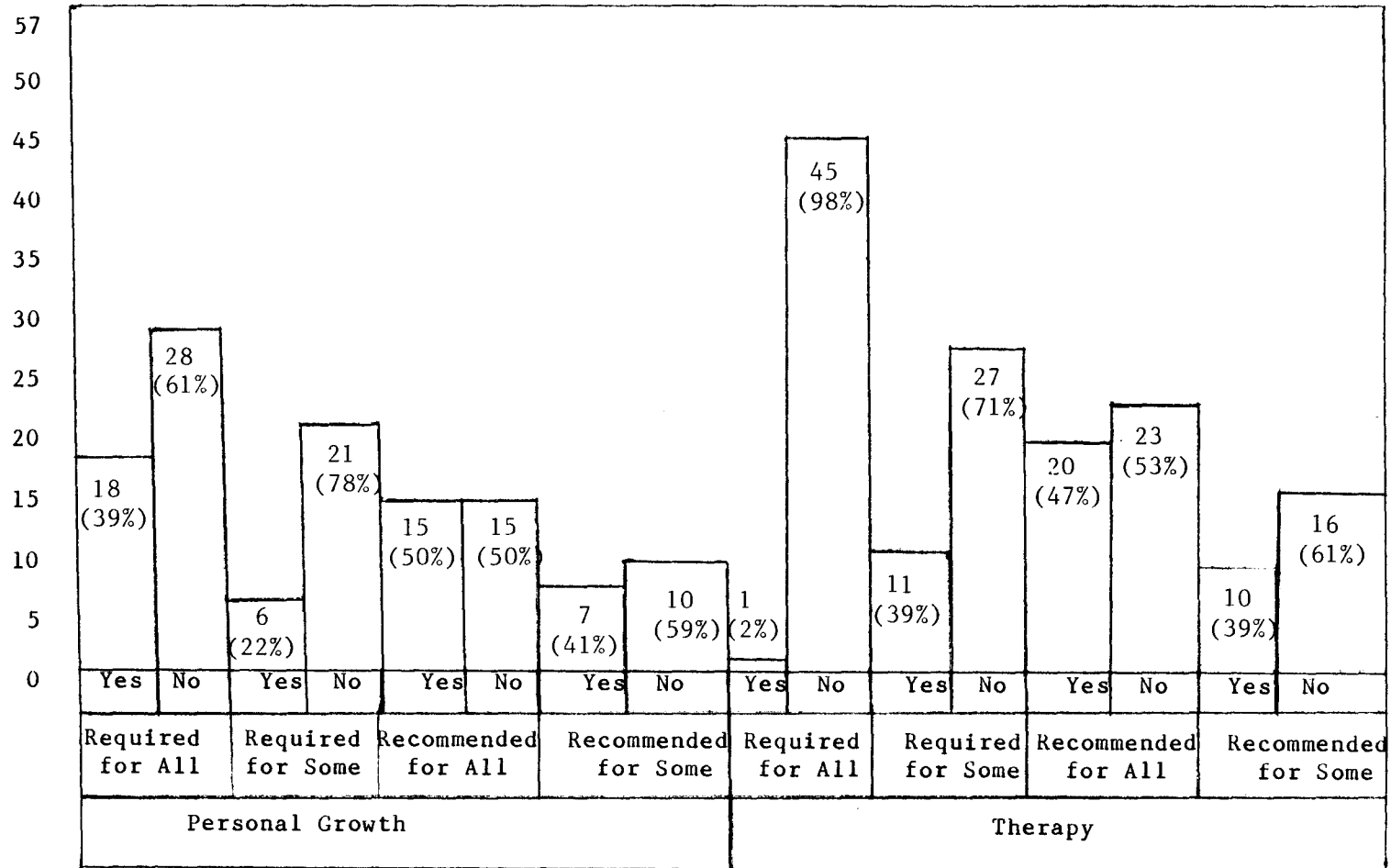
Question 16: "If therapy experience is recommended it is:"
Twenty-one percent (n=5) indicated that only individual therapy was
recommended, while 13% (n=3) indicated that only group therapy was
recommended. Sixty-five percent (n=15) indicated that both individual
and group therapy were recommended.

Question 17: "If an individual or group therapy experience is
required or recommended, have APA Division 29 recommendations been
influential in your policy formation? Thirty-two Program Directors
responded; 13% (n=4) responded "Yes" and 87% (n=28) responded "No."
Of the 28 who responded negatively, 14 mentioned other influences.
Nineteen percent (n=6) indicated faculty judgment was the most salient
factor influencing policy, which 9% (n=3) cited consideration of
students' needs as having influenced them. These responses are
summarized in Table 1, which also includes responses to Question #8
for comparison.

Table 1

Influential Factors When Personal Growth or Personal Therapy

Experiences are "Required or Recommended"

	APA Recommen- dations	"Faculty Judgment"	"Needs of Students"	APA Accredi- tation	Other
Question 8: Personal Growth Experience (N=37)	11% (n=4)	31% (n=12)	8% (n=3)	5% (n=2)	8% (n=3)
Question 17: Personal Therapy (N=32)	12% (n=4)	19% (n=6)	9% (n=3)	0% (n=0)	16% (n=5)

Question 18: "Students possible involvement in an individual or group therapy experience is addressed..." Thirty-three Program Directors responded to one or more of the methods presented. These responses are summarized in Table 2 which also includes responses to Question 9 for comparison. Categories E_1 and E_2 represent specific "write-in" responses. Categories F., G., H., I., and J. represent multiple responses.

Question 19: "Actual resources available to graduate students in your department include:" Forty-four Program Directors responded by citing one or more of the following resources:

A. University counseling center staffed independently of psychology department	93%	n=41
B. Referral list of therapists in private practice who will see students free or at reduced rates	41%	n=18
C. Group or workshop experience provided by the department	57%	n=25
D. Community mental health centers	75%	n=33
E. Exchange programs in which faculty members serve as therapists for students at neighboring universities	7%	n=3
F. Supervision and faculty-student relationship cited as therapeutic	43%	n=19
G. Nearby psychoanalytic institute	9%	n=4
H. Nearby non-analytic institute e.g., Center for Rational Living, Gestalt Institute, etc.	18%	n=8
I. Faculty members serve as therapists for trainees	5%	n=2
J. Psychiatry department provides therapists	5%	n=2

Table 2

Comparison of Means of Conveying Departmental Policy to Students

Methods of Addressing Students' Involvement	Question 18: Personal Therapy Experience (N=33)		Question 9: Personal Growth Experience (N=39)	
A. In class	60%	(n=20)	67%	(n=26)
B. Through "general" information sources such as a bulletin board	39%	(n=13)	36%	(n=14)
C. At department meetings open to students	33%	(n=11)	33%	(n=13)
D. Through referral sources available to students	52%	(n=17)	64%	(n=25)
E. Other	52%	(n=17)	51%	(n=20)
E Advisor (write-in choice)	36%	(n=12)	31%	(n=12)
E Program description material	3%	(n=1)	10%	(n=4)
F. A and B	39%	(n=13)	31%	(n=12)
G. A and C	18%	(n=7)	26%	(n=10)
H. A and D	33%	(n=11)	28%	(n=11)
I. B and D	24%	(n=8)	26%	(n=10)
J. A and B and C	21%	(n=7)	18%	(n=7)

K. Special therapists hired part-time by   2%   n=1
   department to see students

L. Loan fund available to finance therapy   0%   n=0

M. Other   5%   n=2

Responses to Question 19 were compared to questionnaire results

reported by Wampler and Strupp (1976) concerning therapy opportunities

for students and are reported below in Table 3.

Table 3

Past and Present Availability of Resources

	% Training Programs Where Resources Available	
	Wampler and Strupp (1976)	This Questionnaire (1986)
University counseling centers staffed independently of Psychology department	35%	93%
Referral list of therapists in private practice who will see students for free or at reduced rates	23%	41%
Groups or workshops provided by the department	22%	57%
Community mental health centers	17%	75%
Supervision and student-faculty relationships cited as "therapeutic"	7%	43%

Question 20: "Some models of supervision incorporate experiences

of a personal growth or therapeutic nature. Do you think the

individual supervision experiences of the students in your department

qualify as:" Forty-five Program Directors responded in one of the

following mutually exclusive categories. Table 4 (below) incorporates

data from Question 21 regarding Director's opinions of students' group

supervision experience for comparison.

Table 4

Supervision as Personal Growth or Personal Therapy

	Personal Growth Experience (only)	Personal Therapy Experience (only)	Personal Growth and Therapy Experience (both)	Not a Personal Growth or Therapy Experience (neither)
Individual Supervision (N = 45)	62% (n=28)	0% (n=0)	22% (n=10)	16% (n=7)
Group Supervision (N = 42)	59% (n=25)	0% (n=0)	20% (n=11)	14% (n=6)

Question 21: "Do you think the group supervision experiences of

the students in your department qualify as:" (see Table 4).

Section C: Program Director's Perspective

Questions 22-30 concern Program Directors' personal experiences

in therapy and personal beliefs regarding the role of therapy in

graduate training.

Question 22: "I have been involved in personal therapy."

Forty-five Program Directors responded; 69% (n=31) stated they had

been involved, and 31% (n=14) stated they had not been personally

involved.

Question 23: "If you have been involved in therapy it was:"
Thirty-one Program Directors specified the type of therapy in which
they had first been involved. Fourteen Program Directors specified
the type of therapy in which they had been involved the second time.

	Individual	Marital	Family	Group	Other
1st Experience (N=31)	58% (n=18)	16% (n=5)	0% (n=0)	29% (n=9)	3% (n=1)
2nd Experience (N=14)	64% (n=9)	21% (n=3)	14% (n=2)	21% (n=3)	0% (n=0)

% > 100 due to multiple responses.

Sixty-nine percent (n=31) of responding Program Directors had
been involved in therapy at least once and 31% (n=14) had been
involved in therapy at least twice.

Question 24: A.) "The reason for your first involvement was."
Thirty Program Directors responded to this part of the question,
specifying one or more of the following choices, as did 14 Program
Directors who had undergone therapy at least twice and responded to
part B.).

	A Required	B Personal Growth	C Personal Difficulties	D Supervision	E Other	Dual Response B & C
1st Experience (N=31)	13% (n=4)	60% (n=18)	50% (n=15)	10% (n=3)	7% (n=2)	26% (n=8)
2nd Experience (N=14)	0% (n=0)	64% (n=9)	71% (n=10)	0% (n=0)	0% (n=0)	36% (n=5)

% > 100 due to multiple responses.

Question 25: "Indicate the time periods of your involvement in personal therapy." Thirty-one Program Directors specified one or more of the following time periods:

Pre-graduate school	n=5	16%
During graduate school	n=20	65%
1-3 years immediate following graduate school	n=5	16%
3-10 years following graduate school	n=14	45%
More than 10 years following graduate school	n=5	16%

% > 100 due to multiple responses.

Question 26: "The reason I have not been involved in therapy is..." Fourteen Program Directors responded, citing one or more of the following reasons for non-involvement. Choice F. represents the combination of choices cited most often by respondents.

A. Not necessary to my professional development	n=11	79%
B. Never took steps	n=0	0%
C. Too expensive	n=1	7%
D. Not encouraged during training	n=9	64%
E. Therapy only for seriously dysfunctional	n=0	0%
F. Did not view as necessary and was not encouraged during training	n=7	50%

% > 100 due to multiple responses.

The following table presents the programmatic requirements or recommendations of departments whose Program Directors have undergone

Table 5

Programmatic Expectations With and Without Program Director's Personal Therapy Experience

| | Recommended | | Required | | Recommended or Required | |
	Growth Experience For All	Therapy Experience For All	Growth Experience For All	Therapy Experience For All	Growth Experience For All	Therapy Experience For All
Have Had Therapy (N=31)	35% (n=11)	52% (n=16)	38% (n=12)	0% (n=0)	73% (n=23)	52% (n=16)
Have Not Had Therapy (N=14)	7% (n=1)	21% (n=3)	29% (n=4)	7% (n=1)	36% (n=5)	28% (n=4)

personal therapy. These requirements or recommendations are compared with those of departments whose Program Directors have not undergone therapy.

Question 27: "My attitude toward therapy is..." Thirty Program Directors responded; 58% (n=18) responded that they thought therapy was necessary for maximizing potential as a therapist. Thirty-nine percent (n=12) responded that they thought therapy was necessary for developing competency. Twenty-nine (n=9) respondents wrote in a third alternative, stating that while therapy might not be necessary to develop competency or maximize potential, it was "helpful", "desirable" or "valuable" in training.

A comparison was made between incidence of personal therapy and attitude toward personal therapy and is presented in Table 6.

Table 6

Differential Views: Personal Therapy Experience and Perceived Value

	Have Had Therapy and Responded to Question 27	Have Not Had Therapy and Responded to Question 27
Therapy necessary to maximize potential as a therapist (N=18)	67% (n=12)	33% (n=6)
Therapy necessary for competency as a therapist (N=12)	83% (n=10)	17% (n=2)

Question 28: "I am currently a practicing therapist." Forty Program Directors responded; 53% (n=21) responded "Yes" and 47% (n=19)

responded "No." The following table compares Directors´ attitudes

toward therapy with the rates at which they practice therapy.

Table 7

Differential Views: Therapists and Non-Therapists

	Practicing Therapist	Not a Practicing Therapist
Therapy necessary to Maximize Potential as a Therapist (N=18)	67% (n=12)	33% (n=6)
Therapy necessary for Competency as a Therapist (N=12)	58% (n=7)	42% (n=5)

Table 8 compares the incidence of personal therapy for practicing

and non-practicing Program Directors.

Table 8

Differential Practices: Therapists and Non-Therapists

	Have Had Therapy	Have Not Had Therapy
Practicing Therapist (N=21)	86% (n=18)	14% (n=3)
Not Practicing (N=19)	42% (n=8)	58% (n=11)

Question 29:   "I would describe my therapeutic orientation as:"

Forty-three Program Directors responded.

Rogerian	n=4	9%
Psychodynamic	n=2	5%
Cognitive-Behavioral	n=18	45%
Behavior Modification	n=2	5%
Gestalt	n=1	2%
Eclectic	n=22	51%
Other-Specify	n=8	19%

% > 100 due to multiple responses.

Question 30: "The question of `therapy as training` is:"

Forty-two Program Directors indicated that they endorsed one or more

of the following choices:

Overworked and unimportant	14%	n=6
Appropriate only with a psychoanalytic orientation	10%	n=4
Fairly important but not high on a list of priorities for students	24%	n=10
Important and adequately addressed in my program	45%	n=19
Important and not adequately addressed in my program	33%	n=14
Other	14%	n=6

% > 100 due to multiple responses.

Research Questions

The research questions addressed in this study are as follows:

(1) Is a "personal growth" experience as delineated by Principle

21 required or recommended of students?

This question was subdivided into four sections, making

distinctions between "required for all" (Question #1), "recommended for all" (Question #5), "required only for those whose personal difficulties are interfering with productive participation in the program" (Question #2), and "recommended only for those students whose personal difficulties are interfering with productive participation in the program" (Question #6).

It was found that 61% (n=27) of responding departments do not require any personal growth experiences of their students. If personal difficulties are interfering with the student´s functioning, 22% (n=6) of responding departments stated that they would require participation in some type of personal growth experience. When these experiences were required, group supervision was recommended 77% of the time, a curriculum course with an experiential component was required 69% of the time and communication skills training was required 55% of the time. When more than one experience was required, communication skills training in conjunction with a curriculum course with an experiential component was required 45% of the time. Communication skills training in conjunction with group supervision was required 40% of the time. Sixty-seven percent (n=16) of Program Directors who stated that these types of experiences were not required stated they considered it an infringement of privacy. Twenty-nine percent reported issues of confidentiality influenced their decision not to require such experiences. Three of eight Program Directors who wrote in responses cited "ethical concerns".

Fifty percent (n=15) of Program Directors who responded to Question #5 stated that a personal growth experience was recommended

for all students. Forty-one percent (n=7) of respondents to Question #6 stated that a personal growth experience was recommended only for those students whose personal difficulties are interfering with productive participation in the program.

Involvement in personal growth experiences is often assumed to be an integral part of graduate training. Results of this study, however, show such experiences are required for all only about one-third of the time and recommended for all only one-half of the time.

(2) Is a "personal therapy" experience required of students? Is it recommended?

This question was likewise subdivided into the four categories. Two percent (n=1) of the departments required a personal therapy experience. This percentage mirrors the rate that Jorgensen and Weigel (1973) found in their study of graduate psychology programs. In contrast, 29% (n=11) of responding Program Directors stated that their departments required distressed students to undergo personal therapy. Individual therapy was most often recommended for these students. Twenty-nine percent (n=7) of programs that did not require personal therapy for any students cited issues of "infringement of privacy" and issues of confidentiality, together; these same issues were cited as reasons for not requiring personal growth experiences 29% (n=7) of the time. The main difference between groups was that issues of ethics and affordability were more often cited in reference to therapy requirements. Forty-three percent of the departments recommended therapy experiences for all students. Therapy experiences

were required or recommended for all students 45% of the time, while

personal growth experiences were required or recommended for all 72%

of the time. Personal therapy was required or recommended for

distressed students 46% of the time, while personal growth experiences

were required or recommended 38% of the time for the same group,

implying that Program Directors favored the more intensive experience

when there were perceived difficulties.

A combination of individual and group therapy was most often

recommended for all students, in contrast to a marked preference for

individual therapy for the distressed student.

(3) How are these expectations communicated to students?

It was found that expectations regarding involvement in personal

growth experiences or personal therapy was communicated to students in

very similar fashions. Sixty percent of respondents stated that

therapy involvement was discussed in class; 67% of the Program

Directors responded that involvement in personal growth experiences

was a part of class discussions. Fifty-two percent replied that other

referral sources available to students accounted for therapy

information, while 51% stated that other referral sources provided

personal growth information to the students. Ninety-nine percent of

respondents stated that general information sources such as bulletin

boards informed students of personal therapy opportunities, while 36%

of Program Directors stated that personal growth opportunities were

communicated through similar general information sources. Thirty-six

percent of the departments relied on advisors to communicate

requirements or recommendations concerning personal therapy, and 31%

of the departments relied on advisors to communicate information

regarding personal growth experience. A combination of sources was

often available; 39% cited the same combination of sources for

informaton regarding personal growth experiences.

Program Directors were asked whether they viewed individual and

group supervision as either personal growth or personal therapy

experiences (Questions #20 and 21); a majority viewed both types of

supervision as personal growth experiences only. Approximately one of

four respondents also felt elements of therapy were involved in both.

(4) Are there provisions made for students' participation in

personal growth and therapy experiences in terms of providing

facilities, information and financing?

Results from this study show that, in comparison to the Wampler

and Strupp (1976) study, opportunities for personal therapy are far

more available today than they were ten years ago. Evidence is strong

that awareness and acceptance of therapy for students as a part of

training has grown (see responses to Question #19).

In 1976, 35% of Clinical Psychology departments surveyed reported

that a university counseling center staffed independently of the

psychology department was available to students. In 1986, 93% of

Counseling Psychology programs surveyed reported that there was access

to such a counseling center. Only 17% of the departments surveyed by

Wampler and Strupp reported the availability of community mental

health centers for their students. This research indicates such

community facilities are available to students 75% of the time.

University faculty has shown an increased awareness of the value of

such experiences; referral lists of private therapists who would see students for free or at reduced rates was available 23% of the time in 1976. In 1986 such lists are avaiable 41% of the time. Department groups or workshops have also increased in frequency from 22% to 57%. A changing focus in the nature of supervision practices is apparent, as supervision and faculty-student relationship cited as therapeutic occurred previously 7% of the time. Such interactions are now considered therapeutic in 43% of the cases.

(5) What factors were influential in the development and implementation of policy regarding this facet of training?

Division 29 of the APA publishes the "Recommended Standards for Psychotherapy Education in Psychology Doctoral Programs." Standard 21 recommends personal growth experience and personal therapy for the student trainee. Results indicate that the Division 29 recommendations are <u>not</u> a factor in determining program requirements. Only 11% (n=4) of respondents to Question #8 stated that the Division 29 recommendations were influential in policy formation with regard to personal growth requirements (Question #8). Of those responding that Division 29 recommendations were not influential, 60% (n=20) replied that "faculty judgment" was most often a determining factor, while 15% (n=3) stated the "needs of students" were influential and 10% (n=20) felt "APA accreditation" concerns were involved. With regard to personal therapy components of training, 12% (n=4) of respondents to Question #7 considered Division 29 recommendations. Of those responding that Division 29 recommendations were not influential, 43% (n=6) stated that "faculty judgment" was influential, while 22% (n=3)

cited the "needs of students". None of the Program Directors felt that APA accreditation was an issue.

It was determined that the Program Director's involvement in personal therapy corresponded to personal attitudes regarding personal growth and personal therapy experiences as a part of training. Sixty-nine percent of respondents to Question #22 stated they had been involved in personal therapy, and this percentage is similar to previous findings. Goldschmid, Stein, Weisman and Sorrels (1969) found that 64% of responding members of the Division of Clinical Psychology had had therapy. Garfield and Kurtz (1976) reported that 57% of the respondents from university psychology departments had experienced therapy. Henry (1977), in a study of 4,000 practicing psychotherapists found that 75% had been in therapy.

Results of this study indicate that Program Directors who have been involved in personal therapy are much more likely to require or recommend personal growth and personal therapy experiences for all their students. Of those that have had therapy, 74% were Program Directors of departments that required or recommended personal growth experiences. Thirty-six percent of Program Directors who had not undergone therapy recommended or required personal growth experiences. Similarly, 52% of the respondents who had undergone therapy required or recommended such therapy experience for all students, as compared to the same recommendation occurring 28% of the time in departments headed by those who had not had therapy. While such a finding does not imply causality, it is notable.

Of those Program Directors who experienced therapy, 65% did so

during graduate school, followed by 45% who were involved 3-10 years following graduate school. As 31% of those experiencing therapy were involved at least twice, there were multiple responses. Of the respondents who indicated that they were involved during graduate school, 60% are Program Directors of departments that recommend therapy experiences for all.

The most often cited reasons for Program Directors entering therapy were "personal growth" and "personal difficulties". "Personal growth" was reported at a slightly higher rate than "personal difficulties" for first-time participants, while the order was reversed for those entering therapy for a second time.

As Garfield and Kurtz (1976) stated, being a practicing therapist appears to increase the likelihood of personal involvement in therapy. They found that psychologists in private practice and in outpatient clinics had rates of personal therapy of 70% and 77%, respectively. Fifty-three percent of this study's respondents indicated that they were practicing therapists; 86% of those practicing therapy have had therapy, while 42% of those stating that they were not in practice have had therapy. Again, this correlation does not imply causality. There may be other variables such as personality constructs or environmental stressors that relate to the higher incidence of therapy among therapists. One might cautiously assume, however, that practicing therapists are much more likely to value personal therapy, and that this value will be reflected in programmatic development.

(6) What is the personal attitude and experience of the Program Director with regard to this aspect of training?

This study investigated some of the attitudes that influence the decision to become involved in therapy and the possible congruency of these attitudes with program expectations. When Program Directors were asked their views regarding this aspect of training, 58% of respondents stated that personal therapy was "necessary for maximizing one's potential as a therapist". Thirty-nine percent of those offering opinions stated that they felt that therapy was necessary for "developing competency as a therapist". Twenty-nine percent of those responding to the "other" choice wrote that while therapy might not be necessary to maximize potential or achieve competence as a therapist; it was "helpful" or "desirable". Total response was greater than 100% due to multiple responses. Of those respondents that had had therapy, 83% stated that they felt such experience was necessary for competency while 67% felt that it was necessary to maximize potential. The order of importance placed on personal therapy was reversed for those who had not undergone therapy; 17% of the respodents who stated they had not had therapy believed it was necessary for competency, while 33% who had not had therapy felt that it would be necessary to maximize potential. Apparently, four out of five respondents who have undergone therapy value the experience highly enough to consider it a prerequisite for therapeutic competency.

Those that had not undergone therapy stated that they did not become involved for similar reasons. Seventy-nine percent of this group stated that they did not view it as necessary for their professional development, while 64% stated they had not been encouraged to become involved during graduate school. Due to multiple

responses fully half of the respondents stated that it was a combination of these two factors that influenced their decision not to become involved. Of those that had not been involved in therapy, and did not view it as necessary to their professional development, 64% stated that they had not been encouraged to become involved during graduate school. Attitude formation and consequent behavior with regard to personal therapy appears to be highly influenced by graduate school experiences.

Finally, 45% of Program Directors responding to the overall question of "therapy as training" stated that they felt the issue was important and was adequately addressed in their programs. Thirty-three percent stated that although they felt the issue to be important, it was not adequately addressed in their program.

In conclusion, results of this study indicate that Program Directors evidence some continued interest in this aspect of training. It is evident that programs do not automatically require such experiences, but appear to be more apt to recommend or require them especially for distressed students. It may be hypothesized, especially from responses regarding the "value" of such experiences and the "problems" involved with recommending or requiring, that Program Directors may often view "therapy" (as well as "personal growth experiences") in somewhat of a "remedial" context. Therefore, they would hesitate to "require" such experiences of all students, since they are not all "sick". In spite of such hesitancy, however, personal growth experiences are required or recommended for all approximately three-fourths of the time, while personal therapy is

recommended for all approximately one-half of the time.

CHAPTER V

SUMMARY

The Problem

Personal growth experiences and/or personal therapy experiences
are recommended as a part of graduate training by Division 29 of
A.P.A. This study was implemented in order to determine whether
graduate programs in Counseling Psychology endorse or adhere to such a
standard. It was also considered important to delineate influential
factors in training program development. Counseling Psychology
programs had never been the total focus of such an effort.

The Purpose

Research regarding the efficacy of personal growth experiences
and personal therapy experiences in the formation of an effective
clinician has been sparse; results have been confusing and
contradictory. Much previous research, however, indicated that a
consistent majority of mental health professionals underwent such
experiences, and that they were highly valued as a component of
training. Practicing therapists, especially, tended to believe that
undergoing personal therapy contributed positively to both personal
development and professional development. The purpose of the study
then, was to determine if such beliefs influenced actual graduate
school training practices, and in what way. Before further, more
strictly controlled outcome research is undertaken, it is important to

report current views of Program Directors influential in program development and delineate factors that aided in such concept formation. Also, Counseling Psychology programs have never been extensively polled as an entity separate from Clinical Psychology. If, in the future, programmatic recommendations are to be made, it is important to clarify the nature of current training practices and rationales.

Sample

Fifty-seven Program Directors of Counseling Psychology programs across the country were polled. All programs were APA approved and/or members of the Council of Counseling Psychology Training Programs.

Instrument

A questionnaire designed by this researcher was employed in this study. It was divided into three sections: Section A examined departmental requirements or recommendations relative to personal growth experiences. Section B referred to departmental requirements or recommendations relative to personal therapy experiences. Section C polled Program Directors on their attitudes and experiences relative to their own personal therapy experience.

Procedure

Program Directors were mailed a cover letter with the questionnaire explaining the purpose and nature of the study. Follow-up letters were sent at three and four week intervals, respectively. Phone calls were placed to remaining non-respondents approximately 10 weeks after the original mailing.

Limitations

This study was based on a survey of Program Directors of Counseling Psychology programs. Survey research of this kind reports information garnered through the respondents' self-reports. These reports indicate the Directors' perceptions of programmatic guidelines and may not accurately reflect other faculty or graduate students' perceptions on the same issues. Also, since the survey polled only Counseling Psychology departments, the results are not generalizable to other areas of graduate Psychology training. It should also be noted that Division 29 recommendations were referred to in the cover letter.

Also, due to the inexact nature of the subject being studied, respondents occasionally expressed confusion regarding the behavioral differences involved in personal growth experiences and personal therapy. A two day encounter group, for example, while assumed to be a personal growth experience according to Principle 21, might effect more change in a participant than six months of individual therapy. The distinction between "recommended" and "required" could also be confusing, as a department's or an advisor's "recommendation" to an individual student could be construed as more than a request. Some respondents also remarked as to the length of a 30 question inquiry and the depth of thought required to respond adequately. Several respondents skipped questions, while others occasionally contradicted themselves by marking opposing choices.

Summary and Conclusions

Numerous theorists of diverse orientations recommend personal

therapy and personal growth experiences as a component of training for psychotherapists. Freud (1937) originally stated that one of the best methods of preparation for the psychoanalyst was to undergo psychoanalysis himself. Reichman (1950) later expanded on the concept that personal analysis was a necessary prerequisite due to the nature of countertransference processes that occur. The theory that "blocked" or undeveloped areas of the therapist's personality inevitably influence therapeutic progress is widely accepted (Rauchman and Kauff, 1972; Strupp, 1980a; Waterhouse and Strupp, 1984; Weissman, 1986), since patients re-enact dysfunctional processes within the context of the therapy session. Strupp (1980b, c) cites evidence that therapists unconsciously respond reciprocally to negativistic patient behavior. Russell and Snyder (1963) also concurred that therapists' anxiety levels are raised by client negativity and that this anxiety is related to fewer positive or approach responses on the part of the therapist. Longs (1984) extends the concept; personal therapy not only focuses on possible deficiencies but also opens up the analyst's own creative potential. Kohut (1977) had earlier advocated personal analysis as a means of enhancing one's skills and development in addition to working through unresolved conflicts. Therapy does not have to be viewed merely as a response to illness; Rogers (1957) viewed therapy as growth oriented, while May (1953) stressed the interrelationship of personal and professional development. Rogers (1969) elaborated on the necessity of "learning by doing" in terms of developing therapeutic competence. Traux and Carkhuff (1967) delineated "necessary and sufficient conditions" for client growth and

believed that these conditions were better communicated to clients by therapists that had been involved in therapy. Theorists such as Perls (1951), Yalom (1975), Kaslow (1977), Bowen (1978) and Sahakian (1984) bridge orientations in espousing a growth-orientation in psychotherapeutic training that goes beyond amelioration of dysfunctions.

Counseling Psychology appears to espouse such a view. Division 29 of the APA highly recommends personal growth and therapy experiences as training, regardless of level of perceived necessity due to personal difficulties. Tipton (1983) reports that Counseling Psychologists perceive "therapy with normals for personal growth" as an area of professional responsibility and expertise. Kagan (1980) agrees that therapy need not be viewed as an indication of chronic psychic disturbance and behavioral dysfunctions, but as a means of prevention and enrichment.

Theoretically, then, one might expect Counseling Psychologists to strongly advocate such experiences for members of their profession. Enhancement of personal abilities and potentials would seemingly be recommended for all, and personal therapy might be viewed as a legitimate means of contributing to the achievement of such a goal. Such an orientation requires a "leap of faith", with regard to beliefs and practices in training, however. Psychotherapy outcome research incorporating personal therapy for the therapist has generally been inconclusive and confusing. It is notable, however, that this study indicates that there is a growing awareness and acceptance of the value of such experiences for the student. Compared to Wampler and

Strupp (1976), graduate programs today offer far more available and wide-ranging opportunites for experiential training than in the recent past.

The value of personal growth experiences and personal therapy as a component of graduate training will continue to be debated. This study corroborates previous findings that many educators value the process, and that a majority have been personally involved. Personal growth experiences are required or recommended for all students in three of four Counseling Psychology Departments, with over 50% of the departments requiring such experiences. While personal therapy is required or recommended for all students in approximately half of the programs, the emphasis is on recommending therapy, with only two percent (one program) requiring such experience. Reasons most often cited for not including personal growth or therapy components of training were privacy and confidentiality. Concerning therapy requirements specifically, affordability and ethical concerns were more frequently mentioned.

Thus, Program Directors are reporting that one of the major factors influencing the possible requirement of such experiences is concern for the students' privacy and respect for the nature of confidentiality. It is reasonable to wonder, however, whether this concern might possibly inhibit or prevent participation in training experiences that, according to this survey, Program Directors highly value for themselves and their students. Perhaps the unspoken assumption remains that the student will be working with areas of personal dysfunction or problems as opposed to issues of growth and

development. Kagan (1980) states that we, as Counseling Psychologists, focus on individual development and enrichment as a highly valued component of our professional roles; we do nt focus merely on dysfunction. Tipton (1983) concurs in reporting the results of attitude surveys mailed to both Counseling and Clinical Psychologists; Counseling Psychologists rated "therapy with normals for personal growth" as number 3 in a list of 50 activities involved in the clarification of Counseling Psychologist´s roles. Since Counseling Psychologists value therapy experiences as a productive means of gorwth and development, it is helpful to know whether such a view regarding the nature of therapy is communicated to graduate students. While over 65% of Program Directors have undergone personal therapy only one would require and only 45% would recommend such experience for all students.

Department recommendations thus delineate between the nature of personal growth experiences and therapy, with therapy being viewed as a more personal, private and protected experience that may focus on dysfunction or remediation. Program Directors stated clearly that personal work aids in the development of the therapist; approximately 75% indicated supervision to be a personal growth experience, while 25% indicated it to be a therapy experience. Thus, if personal awareness or personal growth or personal therapy occurs in a less formalized fashion it appears to be more accepted. Results of this survey indicate that many Program Directors are unclear as to the appropriate nature and extent of programmatic involvement or expectations with regard to personal growth or therapy experiences.

Fully one of three responding Directors felt the issue was important and not adequately addressed, possibly implying the desire for a more clearly defined, standardized policy within the profession.

In spite of such a lack of clarity, awareness and acceptance of personal growth and therapy experiences as a valuable component of training has increased in the past 10 years. Program Directors reported additionally that their own involvement was most often due to a combination of personal difficulties and a desire for personal growth. If these Directors were encouraged to become involved during graduate school, and, in fact, did undergo therapy they were far more likely to work in departments that require or recommend such experience for their students. Those that experienced therapy valued it more highly in terms of professional development and were more likely to recommend it.

It is difficult, however, to make strong general statements based on these results. Only Counseling Psychology Program Directors were surveyed; 46 of 57 departments responded, providing a return rate of 81%. It should be noted, however, that this survey is the first to be undertaken involving only Counseling Psychology programs and that further data will enable more solid conclusions to be drawn.

In conclusion, therapy, as a training paradigm, is not routinely recommended for graduate students, while personal growth experiences are recommended in a majority of programs. Previous experience in therapy seemed likely to predispose Program Directors to advocate inclusion of such a component as an optional involvement for students. Also, Program Directors were more likely to recommend therapy

involvement for all students at a much higher rate than Program

Directors who have not had therapy. In addition, Program Directors

who were practicing therapists were more likely to believe that

therapy was necessary for competency as a therapist or that it was a

prerequisite to maximizing potential as a therapist. The experience

of having had therapy in graduate school, with the encouragement of a

faculty member or advisor, was also seen to positively affect views

regarding the value of therapy in training.

<div align="center">Recommendations for Further Study</div>

1) Future research should investigate responses of Program

Directors of Clinical Psychology programs in universities and

Professional schools. Comparisons of theoretical views and

programmatic practices with Counseling Psychology programs would be

enlightening in terms of similarities or differences between related

disciplines.

2) Students from graduate Psychology programs should be polled in

order to correlate their beliefs and practices with their departments'

orientation.

3) It has been found that previous personal experience in

therapy, and currently practicing therapy are influential factors in

the formation of positive attitudes regarding therapy as a helpful

component of training. A meta-analysis of personality traits and

other relevant life experiences might clarify differentiating factors

between professionals who value such experience as "healthy" and those

that believe such experience should be "remedial".

4) Finally, outcome studies with stricter control of variables

must be designed and implemented. Many of the outcome studies cited (Silverman, 1972; Derner, 1960; Garfield and Bergin, 1971; Strupp, 1973) employed students or highly inexperienced therapists when attempting to evaluate patient improvement and the factors involved. If the student or therapist were currently involved in therapy while also involved in training, further contamination of results could also be expected. Ideally, future outcome studies would focus on experienced therapists with and without personal therapy and the integral components of clients' improvement or lack of improvement.

Psychologists appear to believe personal growth and therapy experiences are valuable components of training; a majority of psychologists have undergone personal therapy. It is important to know whether these beliefs and behaviors are founded on perceived value or experimental evidence or some combination of both.

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APPENDIX A

Dear

  An issue of growing interest in psychological teaching and training concerns psychotherapy and/or personal growth experiences as a part of training. We wish to determine to what extent Counseling Psychology programs concur with and implement the "Recommended Standards for Psychotherapy Education in Psychology Doctoral Programs" as published by Division 29 of the American Psychological Association. Standard 21 states:

    "Methods for enhancing the student's self-awareness, sensitivity and personal growth should be an integral part of psychotherapy education. The personality of the student has not traditionally been a concern of university psychology departments. However, the student's interpersonal skills, awareness of his own personality and of his effects upon others, sensitivity to both verbal and nonverbal communication, tolerance to emotional stress, and emotional maturity play a significant role in his learning and practice of psychotherapy. Individual supervision will help to accomplish these goals, but in addition, the program might include appraoches such as T-group experience, sensitivity training, marathon encounter group, group supervision, human relations laboratory, or personal psychotherapy.

  As a Program director, you are in a position to influence various aspects of training; we are very interested in both your views and your program's recommendations or requirements regarding the above-mentioned Standard.

  We would greatly appreciate your spending approximately 10 minutes completing the enclosed questionnaire. we wish to assure you of full confidentiality with regard to any information you may include. A brief copy of results will be sent to all Program Directors. Thank you for your assistance; it is greatly appreciated.

        Sincerely,

Manuel Silverman, Ph.D.   Eric Visokey, M.A.
Professor   Research Associate
Department of Counseling Psychology Department of Counseling
and Higher Education   Psychology and Higher Education

PERSONAL GROWTH EXPERIENCES IN COUNSELING PSYCHOLOGY PROGRAMS

A NATIONAL SURVEY

INVESTIGATORS: MANUEL SILVERMAN, PH.D.
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PH.D. PROGRAM IN COUNSELING PSYCHOLOGY

DEPARTMENT OF COUNSELING PSYCHOLOGY AND HIGHER EDUCATION

LOYOLA UNIVERSITY OF CHICAGO

QUESTIONNAIRE

SECTION A: PERSONAL GROWTH EXPERIENCES

1. My department <u>requires</u> a personal growth experience of <u>all</u> students.

    ____ Yes   ____ No

    If Yes, skip to question #3.

2. My department <u>requires</u> a personal growth experience <u>only</u> for those
    students whose personal difficulties are interfering with
    productive participation in the program.

    ____ Yes   ____ No

3. If personal growth experiences are <u>required</u> they are: (Please
    check as many as appropriate)

		Yes	No
A.)	T-Group		
B.)	Communication Skills Training		
C.)	Assertiveness Training		
D.)	Relaxation Training		
E.)	Desensitization Training		
F.)	Group Supervision		
G.)	Curriculum course with experiential component		
H.)	Other (List) _____		

4. If a personal growth experience is <u>not required</u> of any students, it
    is because: (Please check Yes or No for <u>each</u> response.)

		Yes	No
A.)	It is deemed unnecessary to the development therapeutic competence.		
B.)	It is considered an infringement of privacy to require such participation.		
C.)	Issues of confidentiality make such a requirement unfeasible.		
D.)	Issues of affordability make such a requirement unfeasible.		
E.)	Appropriate resources are not available.		
F.)	Other--Elaborate _____		

5. My department <u>recommends</u> a personal growth experience for <u>all</u>
    students.

    ____ Yes   ____ No

    If Yes, skip to #7.

6. My department <u>recommends</u> a personal growth experience <u>only</u> for
    those students whose personal difficulties are interfering with
    productive participation in the program.

    ____ Yes   ____ No

7. If personal growth experiences are <u>recommended</u> they are: (Please check as many as appropriate)

	Yes	No
A.) T-Group		
B.) Communication Skills Training		
C.) Assertiveness Training		
D.) Relaxation Training		
E.) Desensitization Training		
F.) Group Supervision		
G.) Curriculum course with experiential component		
H.) Other (List) _____		

_____

8. If a personal growth experience is required or recommended, have APA Division 29 recommendations (stated in cover letter) been influential in your policy formation?

. ____ Yes   ____ No

If No, what other factors have influenced policy formation? _____

_____

_____

9. Student's possible involvement in a personal growth experience is addressed: (Please check Yes or No for <u>each</u> response)

	Yes	No
A.) In class		
B.) Through "general information" sources such as a bulletin board		
C.) At Department meetings open to students		
D.) Through referral sources available to students		
E.) Other--Elaborate _____		

_____

SECTION B: INDIVIDUAL AND GROUP THERAPY EXPERIENCES

10. My department <u>requires</u> an individual or group therapy experience of <u>all</u> students.

____ Yes   ____ No

If Yes, skip to question #12.

11. My department <u>requires</u> an individual or group therapy experience <u>only</u> for those students whose personal difficulties are interfering with productive participation in the program.

____ Yes   ____ No

12. If therapy experience is <u>required</u> it is: (Check Individual and/ or Group if applicable. State number of sessions.)

                                                     # of sessions

A.) Individual Therapy _____   _____
B.) Group Therapy _____   _____

13. If a personal therapy experience is <u>not required</u>, it is because: (Please check Yes or No for <u>each</u> response)

                                                Yes   No

A.) It is deemed unnecessary to the development of therapeutic competence.
B.) It is considered an infringement of privacy to require such participation.
C.) Issues of confidentiality make such a requirement unfeasible.
D.) Issues of affordability make it unfeasible.
E.) Appropriate resources are not available.
F.) Other--Elaborate _____

14. My department <u>recommends</u> an individual or group therapy experience for <u>all</u> students.

   _____ Yes   _____ No

If Yes, skip to #16.

15. My department <u>recommends</u> a personal therapy experience <u>only</u> for those students whose personal difficulties are interfering with productive participation in the program.

   _____ Yes   _____ No

16. If therapy experience is <u>recommended</u> it is (Check Individual and/ or Group if applicable. State number of sessions)

                                                     # of sessions

A.) Individual Therapy _____
B.) Group Therapy _____

17. If an individual or group therapy experience is required of recommended, have APA Division 29 recommendations (stated in cover letter) been influential in your policy formation?

   _____ Yes   _____ No

If No, what other factors have influenced policy formation?

_____

18. Student's possible involvement in an individual or group therapy experience is addressed: (Please check Yes or No for <u>each</u> response.)

4

	Yes	No
A.) In class		
B.) Through "general information" sources such as a bulletin board.		
C.) At Department meetings open to students.		
D.) Through referral sources available to students		
E.) Other--Elaborate _____		

19. Actual resources available to graduate students in your department include: (Please answer Yes or No for each response).

	Yes	No
A.) University counseling center staffed independently of the psychology department		
B.) Referral list of therapists in private practice who will see students free or at reduced rates		
C.) Group or workshop experience provided by the department		
D.) Community mental health centers		
E.) Exchange programs in which faculty members serve as therapists for students at neighboring universities		
F.) Supervision and faculty-student relationship cited as therapeutic		
G.) Nearby psychoanalytic institute		
H.) Nearby non-analytic institute e.g. Center for Rational Living, Gestalt Institute, etc.		
I.) Faculty members serve as therapists for trainees		
J.) Psychiatry department provides therapists		
K.) Special therapists hired part time by the department to see students		
L.) Loan fund available to finance therapy		
M.) Other--Elaborate _____		

20. Some models of supervision incorporate experiences of a personal growth or therapeutic nature. Do you think the individual supervision experience of the students in your department qualify as: (Please check Yes or No for each response)

	Yes	No
A.) A personal growth experience		
B.) A therapy experience		

21. Do you think the group supervision experiences of the students in your department qualify as:

	Yes	No
A.) A personal growth		
B.) A therapy experience		

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SECTION C: PROGRAM DIRECTOR'S PERSPECTIVE

This next section refers to your own personal involvement with therapy.
It will be extremely helpful to collect this information regarding one
facet of your professional development. Should you not feel comfortable
disclosing this information you may stop here.

22.   I have been involved in personal therapy.

    ____ Yes   ____ No

    If No, skip to question #26.

23.   If you have been involved in therapy it was (Please check all that
    apply and indicate # of sessions).

	1st Therapy Experience	# of Sessions
A.) Individual Therapy		
B.) Marital Therapy		
C.) Family Therapy		
D.) Group Therapy		
E.) Other		

	2nd Therapy Experience	# of Sessions
A.) Individual Therapy		
B.) Marital Therapy		
C.) Family Therapy		
D.) Group Therapy		
E.) Other		

24.   The reason for your involvement was (Please check all that apply).

               1st Therapy Experience
A.) Required for Ph.D. or other advanced degree
    (Specify) _____   _____
B.) Personal Growth   _____
C.) Personal Difficulties   _____
D.) Part of Supervision Process   _____
E.) Other (Specify) _____   _____

               2nd Therapy Experience
A.) Required for Ph.D. or other advanced degree
    (Specify) _____   _____
B.) Personal Growth   _____
C.) Personal Difficulties   _____
D.) Part of Supervision Process   _____
E.) Other (Specify) _____   _____

25.   Indicate the time period(s) of your involvement in personal
    therapy by checking Yes or No for each response:

	Yes	No
A.) Pre-graduate school		
B.) During graduate school		
C.) 1-3 years immediately following graduate school		
D.) 3-10 years following graduate school		
E.) More than 10 years following graduate school		

26. The reason I have not been involved in therapy
    Yes or No for <u>each</u> response)

A.) I did not view it as necessary to my
    professional development.
B.) I desired involvement but just never took
    the steps.
C.) I viewed it as too expensive.
D.) I was not encouraged to become involved
    during training.
E.) I believe one should not become involved in
    therapy unless he/she is seriously
    dysfunctional.
F.) Other--Elaborate _____

27. My attitude toward therapy is (Please check Yes or No
    response)

                                                    Yes
A.) It is necessary for maximizing one's
    potential as a therapist.
B.) It is necessary for developing competency as
    a therapist.
C.) Other--Elaborate _____

28. I am currently a practicing therapist.

    ____ Yes   ____ No

29. I would describe my therapeutic orientation as (Please che
    many as applicable)

    _____ A.) Rogerian
    _____ B.) Psychodynamic
    _____ C.) Cognitive-Behavioral
    _____ D.) Behavior Modification
    _____ E.) Gestalt
    _____ F.) Eclectic
    _____ G.) Other--Specify _____

30. The question of "therapy as training" (Please check Ye
    <u>each</u> response)

                                                    Yes
A.) Is overworked and unimportant
B.) Has its place only with a psychoanalytic
    orientation
C.) Is fairly important but not high on a list
    of priorities for students.
D.) Is important and is adequately addressed in
    my program.
E.) Is important and is not adequately addressf
    in my program.
F.) Other--Elaborate _____

APPROVAL SHEET

The dissertation submitted by Eric Visokey has been read and approved by the following committee:

    Dr. Manuel S. Silverman, Director
    Professor, Counseling and Educational Psychology, Loyola

    Dr. Steven D. Brown
    Associate Professor, Counseling and Educational Psychology,
    Loyola

    Dr. Marilyn Susman
    Assistant Professor, Counseling and Educational Psychology,
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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

_4/16/87_
Date

Director's Signature