Psychotherapy with Psychotherapists

The Interface of Personal Treatment and Clinical Training for Psychotherapist Trainees

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THE INTERFACE OF PERSONAL TREATMENT AND CLINICAL TRAINING FOR PSYCHOTHERAPIST TRAINEES

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Although it is very common for psychotherapists-in-training to obtain personal treatment during their training years, there is little exploration in the professional journals of issues related to the experiences either of being a student in concurrent training and treatment or of being the therapist of these patients. This relative gap in the literature reflects at least two factors. The first is that trainees, who tend to regard themselves as a special class of patients by virtue of the temporal contiguity of their treatment and training, publish few nonresearch articles until they achieve professional status.[2] By then, both the clarity with which they have seen and the intensity with which they have felt the interlocking effects of the treatment and training they have undergone have diminished appreciably. The second is that experienced psychotherapists simply have not tended to view patients who are psychotherapists-in-training as being either a different enough or a problematic enough subclass of patients to warrant discussion in the literature.

After reviewing the sparse existing literature that is relevant to the treatment of psychotherapist trainees as a class, we present the information we obtained and the impressions we formed from interviewing a number of clinical psychology doctoral students who were simultaneously being seen in psychotherapeutic treatment and some experienced psychologists and social workers who customarily treat such patients.[3] Although we limited our sample of students to clinical psychology doctoral candidates, we assume that most issues relevant to their training and concurrent treatment are equally germane both for master's level social work candidates and psychiatric residents. However, we do not assume great similarity between our sample and analytic candidates for two reasons. The first is that analytic training requires personal analyses of its students, whereas the more generic programs mentioned above do not. The second is that most analytic candidates have already had considerable experience as therapists prior to undertaking postgraduate work. They therefore constitute a different subclass of trainees from the more naive, less-skilled group who have a choice about entering treatment and on which we have focused our attention. Hence, we do not review in any detail the psychoanalytic literature that discusses the indispensable role of the training analysis or the realms of interplay between the training analyst, the analytic candidate, and the analytic institute. (See Chapter 2.)

Garfield and Bergin (1971) argue against ongoing personal therapy for

psychotherapists-in-training. In a study they conducted, they found that trainees who had a great deal of personal treatment were able to facilitate less change in their own patients (as measured by MMPI indices) than were trainees who had had little treatment themselves. This was true despite the fact that the high-therapy trainees did not appear to be more disturbed on the MMPI (scales D, Pt, Sc) than did the low-therapy trainees. Garfield and Bergin speculate that treatment disrupts the learning process all too often by maximizing trainees' tendencies to self-absorption. As others have pointed out, these findings are consistent with Strupp's (1960) conclusions that the personal treatments of less experienced therapists tend to have either no effect or negative effects on their empathic abilities, while the personal treatments of more experienced therapists tend to enhance their sensitivity to their patients. The dominant counterargument to this point of view outside the analytic journals is voiced by Szurek and Berlin (1966). These authors take the position that personal treatment helps trainees modulate their reactions to the conflicts the training process itself stirs up in them and, as a consequence, it enhances their psychotherapeutic effectiveness.

There is considerable controversy in the literature about whether personal psychotherapy, regardless of whether it is obtained before, during, or after training, is a prerequisite for being a good therapist. Three major views have emerged (for a review see Fisher & Greenberg, 1977; Parloff,

Waskow, & Wolfe, 1978). The first view is that personal therapy is either indispensable to, or very helpful in, doing effective treatment (Baum, 1973; Buckley, Karasu, & Charles, 1981; Fromm-Reichman, 1950; McNair et al., 1964; Peebles, 1980; Rubinfine, 1971; Wexler, 1971). Those who take this position cite the following expectable professional benefits: experientially derived knowledge of what it is like to be a patient, reduced tendency to develop undetected countertransference problems, enhanced listening ability as a result of freed-up defenses and increased cognitive flexibility, and more stable and elevated self-esteem. Rubinfine admits that the therapist's personal treatment can have temporary negative effects on the treatment he or she simultaneously conducts. These negative consequences arise by virtue of the overwhelming anxieties with which therapists in treatment (indeed, any patients) are sometimes flooded. Rubinfine asserts, however, that these temporary difficulties are later compensated for by the improved functioning of the therapist-patient as his or her personal treatment progresses.

The second position is that personal therapy is necessary only for some therapists at some times (Burton, 1973; Fierman, 1965; Leader, 1971). According to this view, therapists should and do enter treatment in much the same way that nonmental health professionals do: when they are feeling stressed by their personal lives and unable to cope effectively. For those individuals whose coping abilities are satisfactory, however, treatment is

unnecessary (Burton, 1973; Rubinfine, 1971).

The third view is that personal psychotherapy either has limited utility for the treating therapist or is altogether unnecessary (Holt & Luborsky, 1958; Katz, Lorr, & Rubinstein, 1958; McNair, Lorr, & Callahan, 1963). In their study of psychiatric residents at the Menninger Foundation, Holt and Luborsky found no relationship at all between supervisors' ratings of residents' clinical competencies and the existence or length of residents' personal treatment histories. In commenting on this study, however, Fisher and Greenberg (1977) questioned the extent to which supervisory ratings can be regarded as valid indices of therapeutic competency *as it affects the patient*. Finally, in one study focusing on patient improvement rates (Katz, Lorr, & Rubinstein, 1958) and in another study examining premature termination rates (McNair et al., 1964), the findings were that there was a positive correlation between treatment outcome and experience level of the therapist, but not between treatment outcome and personal treatment history of the therapist.

In an effort to elucidate some of the heretofore unexplored issues related to the psychotherapy of psychotherapist trainees, we employed an open-ended, semistructured interview format in speaking with clinical psychology graduate students about their simultaneous experiences of being in training and in treatment (see Appendix 1, the "Trainee Questionnaire").

To balance our perspective, we also spoke with psychotherapists who had each treated substantial numbers of clinical psychology graduate students over the years. Here, too, we used an open-ended, semistructured interview format to elicit their thoughts about this process (see Appendix 2, the "Therapist Questionnaire"). What follows in this chapter is the description of the perspectives of the psychotherapist trainees and the experienced professionals whom we interviewed. Rather than present the specific data in detail, we have chosen to highlight some of the more prominent issues that emerged from our discussions with these individuals.

THE TRAINEES' PERSPECTIVE

Fourteen clinical psychology graduate students from six well-respected, APA-approved clinical psychology Ph.D. programs in the United States were interviewed. All of these individuals were in treatment concurrently with their training. Although most claimed to be in psychodynamic psychotherapies, a few mentioned other orientations as well, notably Gestalt, eclectic, and phenomenological. The theoretical orientations of the programs these students were enrolled in spanned the continua from the cognitive-behavioral to the more traditionally psychodynamic approaches and from the more empirical to the more clinical emphases. The least advanced students were in their second year of training; the most advanced had completed internship but not the dissertation.

Of the fourteen therapists-in-training, eight had been in treatment prior to entering graduate school. Of these eight, however, six had had to terminate and then begin treatment again with new therapists in order to attend their graduate schools, which were located in other parts of the country. Of the eight trainees interviewed at or beyond internship level, five had had to terminate treatment in order to relocate to their internship sites. This striking multiplicity of moves and the consequent therapist/therapy shifts are not at all unusual among clinical psychology graduate students who live and train outside the New York City or Los Angeles areas, where clinical programs and solid internships abound. Thus, the conflict between the desire for first-rate professional training and the preference for continuous personal treatment is a common and ongoing one for many clinical trainees. Within our sample, compromise measures adopted to resolve the career-versus-therapy dilemma were as follows: preservation of treatment continuity by not moving and, instead, limiting professional options; preservation of treatment continuity by continuing with regular therapy sessions over the phone (see Chapter 9 for further description of this mode of treatment), thereby keeping professional options open; leaving therapy on a temporary basis for a year's internship and then returning; or opting from the beginning for a time-limited treatment designed to coincide with academic turning points.

By and large, the trainees who entered treatment during their training

claimed to have done so for personal reasons rather than for professional ones. Most chose to go into treatment in response to the exacerbating stresses of relocating and adapting to graduate school demands. Typically, these were cited as having brought chronic problems into clear view. One individual, however, said he entered therapy primarily in response to "peer pressure." According to this trainee, who evidently felt tyrannized by the process, his classmates had refused to take him seriously as a student unless he entered treatment. It seems of some interest that although numerous psychodynamic writers have espoused the necessity of personal therapy/analysis for the conduct of effective treatment, we found little evidence that clinical psychology graduate students actually enter therapy for predominantly professional purposes.

We asked members of our trainee sample what it was that they had requested of their referral sources when seeking a therapist. We learned that until approximately the end of the second year, students' requests are not very different from those nonprofessionals make when they decide to embark upon treatment. As training progresses and naiveté decreases, however, referral requests become more pointed and tend to include specifications about the sex, theoretical orientation, personality features, and techniques of the prospective therapist.

Many of the clinical graduate students feel it is important to them that

their own therapists hold Ph.D.s in clinical psychology. In our sample, taking into account only the trainee's current therapist, eight trainees were in treatment with Ph.D. psychologists; one with a psy.d.; three with M.D.s; and two with M.S.W.s. However, the majority of the participants, including several in current treatment with other than Ph.D. psychologists, asserted that all things being equal, they would have preferred treatment with Ph.D. clinical psychologists. Trainees indicated two reasons for this preference. The first, articulated directly by almost everyone in the sample, was the wish to have a professional role model with whom to identify. The second, expressed less directly, involves an acute sensitivity to professional status issues, particularly for students in the early years of training: social workers and non-PH.D. psychologists are viewed as lower-class citizens and M.D.s are viewed as upper-class citizens.

In addition to the wish to be in therapy with Ph.D. psychologists, a high percentage of the female students in our sample, frustrated by the relative scarcity of women on their graduate school faculties, expressed preferences for female therapists (by whom few of them were in fact being treated). This quest for role models in the service of constructing a sense of professional identity that we found among members of our sample has been similarly observed among psychiatric residents (Ford, 1963; Kernberg, 1968; Menninger, 1968).

As it does for most patients, the matter of psychotherapy fees poses a considerable problem for psychotherapist trainees. Some students took out loans, some borrowed from family members, some went to low-fee clinics, and some worked out special payment arrangements with their therapists (such as reduced fees or extended payment periods). Like all patients, students had a variety of reactions to therapists' reducing fees for them. The one common response that seems specific to psychotherapist trainees, however, is the sense of responsibility this arrangement has reportedly created in them to make it a practice themselves eventually to treat a number of low-fee patients (students) in the private-practice setting.

Students presented a broad range of attitudes about the often problematic borderland that lies between the domains of personal therapy and supervision. Surprisingly, some expressed the belief that clinical case discussions fall outside the realm of their personal treatments. Others, constituting the bulk of our sample, consider talk about their work, with a primary emphasis on countertransference problems, as being integral to their therapies. In the context of their personal treatment, these trainees do not seem to feel at all confused about what constitutes therapy and what constitutes supervision. The one possible exception is an individual who found it helpful to concretize the boundary between treatment and supervision by formally negotiating with her own therapist for supervision and consultation hours scheduled apart from her own therapy sessions.

In the context of their supervisory experiences, however, trainees said they have considerably more difficulty defining for themselves what the boundaries actually are or should be in the supervision relationship. The most common problem people have is in knowing “just how far to go" in discussing countertransference issues with their supervisors. This problem has been described as problematic by various authors (Campbell, 1982; Halleck & Woods, 1962). In general, the trainees expressed a preference for focusing in supervision on how to use their own countertransference reactions effectively with patients and for reserving for their personal therapies any deep scrutiny of the specific sources of their own reactions. Some trainees said that their supervisors are very helpful in teaching them to set comfortable limits for themselves in supervision; others said that their supervisors are often insensitive to their personal boundaries. In both cases, however, trainees commonly believe they are in the process of learning to take increased responsibility for setting supervision limits themselves. Interestingly, there is a greater tendency for advanced students than there is for less advanced students to regard countertransference-based supervision as a less intrusive and more helpful means of increasing therapeutic efficacy with patients. There is uniform agreement in this regard that supervisory suggestions and explanations are most needed in the early years and that supervision that is heavily countertransference-based during the first two years of clinical training serves more to confuse and create excessive anxiety

in the trainee than it does to facilitate the training process.

Speaking with trainees from diverse clinical programs highlighted the reality that different clinical departments have very different collective attitudes about the necessity for and/or desirability of their students' being in treatment. At one extreme is a department that, reportedly, overtly ignores the whole issue but covertly conveys the notion that a student's need to be in treatment reflects negatively on the department's ability to choose emotionally stable, hence adequate, graduate students. In this program and others with similar leanings, peer support in the form of a pro-treatment attitude typically emerges. In addition, nonuniversity-based supervisors play a more active role in encouraging students to seek treatment and helping them find appropriate therapists. At the other extreme is a department that actively encourages all students to enter therapy. In this situation and those that approximate it, student collusion with the faculty point of view seems normative. The outcome is peer pressure on resistant classmates to enter treatment. Apparently, a number of programs that do encourage students to embark upon personal therapy facilitate the process by locating experienced, but low-fee, clinicians for them.

A surprisingly large number of trainees (n = 7) reported seeing therapists who are affiliated in some capacity with the clinical psychology

programs at their respective universities. The personal interrelationships underlying the resultant treatment situations are so complex that they defy clear categorization. Within our sample, one of the easier situations to describe is as follows: Trainee a is in treatment with Therapist b. b is a good friend of a's clinical supervisors, socializes with and is on the doctoral committees of a's peers, and, finally, is on the internship admissions committee at the site to which a has applied. Again, this is one of the *least* complex of the treatment relationships we discovered.

Some students stated that their therapists' outside knowledge of significant people in the trainee's world facilitates the treatment process. They believe that the therapist's capacity to help them reality test more than compensates for the loss of privacy that they experience. Others, however, feel seriously inhibited by the various loyalty conflicts that are thereby activated within treatment. These conflicts are felt to be particularly problematic when the not uncommon circumstance arises in which the trainee has negative reactions to someone known to be the friend, colleague, student, or therapist of the trainee's therapist. Although a number of trainees seemed to sense intuitively that their own negative reactions to people in the therapist's professional and social sphere are, at least in part, manifestations of transference phenomena, they complained that the blurred boundaries between their own and their therapists' worlds render these phenomena awkward and intractable.

Additionally, a number of students complained of problems they have in dealing with the multiple forms of unsolicited information about their therapist that they receive from faculty (in the classroom), supervisors, and classmates. Often, putting a stop to this flow of information requires stating openly that one is in an ongoing or past treatment relationship with a particular therapist. This is experienced by the trainees as a violation of their right to privacy.

Students also stated that peer relations are often negatively affected when classmates are in treatment with, being supervised by, or are friends of a given trainee's own therapist. Although only some students articulated the value of dealing openly with these issues in treatment and with their friends, a large number expressed irritation with the additional pressures that being part of the therapist's professional and social communities imposes upon them.

The extent to which trainees are preoccupied with questions concerning their own diagnoses very much reflects the diversity of attitudes within the field of psychology itself about the value and meaning of diagnosis. There seems to be a trend for students from predominantly empirical and cognitive-behavioral programs to be less concerned about such questions than are their counterparts from predominantly applied and psychodynamic programs. Those who are most caught up in the medical

school syndrome ("You name it, I've got it") expressed considerable anxiety about being "found out" and, as a consequence, asked to leave their programs. Of these, a number claimed to have eventually taken heart from their evolving recognition that select faculty members carry diagnoses either similar to or "worse than" their own. Among this group, the most commonly voiced concern is the fear of being "borderline."

Trainees enumerated several ways in which they feel their personal treatments are (or had been) impacting positively on their clinical work. The first is in the growth of their own respect for the struggles their patients have in therapy. The second is in the diminished need to "do for" patients and the simultaneously enhanced ability to "be with" them instead. The third is in an increased capacity to differentiate their own affective states from those of their patients. The fourth is in the development of a more realistic time perspective in relation to treatment processes and goals. And the fifth is in the growth of the capacity to attend to untoward countertransference reactions.

In reciprocal fashion, the trainees also believe that their clinical training experiences promote growth in and of themselves, and that, further, they increase both a trainee's responsivity to and investment in his or her personal treatment. On the whole, they seem to feel that their academic courses, outside readings, clinical practice, and supervision all serve to

increase their openness to scrutinizing transference manifestations in their personal therapies. Equally, they are grateful for the self-discoveries that have been prompted by exploration of their countertransference reactions to patients. In particular, a number of trainees referred to the unexpected unearthing of their own rescue fantasies. In another vein, they mentioned the increasingly accurate perspectives they believe they are developing regarding their own pathology by virtue of observations drawn from their own patient contacts. And, finally, several trainees who described themselves as being characterologically "too tight" and "overcontrolled" expressed gratitude toward their more relaxed patients, whose examples of "being" in treatment serve as models for them in their personal therapies.

Trainees are equally aware of negative effects on their clinical work as a result of being in concurrent training and treatment. Overidentification with the patient role was cited as a problem. Also mentioned was despair regarding the efficacy of clinical work at times when the trainee feels at an impasse in his or her personal therapy. More commonly, however, students spoke of the problem of their own flooding affects, newly freed up in treatment, which reduce their capacity to think clearly and attend well to their patients. A number reported overwhelming stress from having, as a consequence, to invent facades of competency and adequacy in order to manage the work with their patients. The problem seems simply to be that having to perform a function one has not yet learned at the same time that

one is existing in the graduate school environment (described variously by members of our sample as "paranoia inducing," "regression promoting," and "like a yearlong IQ test") *and* undergoing the affectively stimulating experience of personal treatment, is often "just too much."

Trainees commonly referred to complications in their personal therapies that they feel are brought about by their trainee status. They pointed to their own heightened tendencies to intellectualize as being, at least in part, a function of having access to a great deal of technical information. In addition, knowledge about regression derived from clinical training activities seems to create pressure on many students involved in psychodynamic treatments to "be good patients" by regressing "appropriately." Conversely, a number of trainees in relatively nonpsychodynamic treatments and training programs reported the fear that any recognizable regression implies incipient psychosis. It may well be that regression-anxious trainees preselect nondynamic forms of treatment and training and that regression-eager trainees steer themselves into more dynamic treatment situations and programs. Nevertheless, the point seems worth making that the training students receive in their clinical programs about what is and is not expected, useful, and interesting in patients is perceived as influencing the way trainees conduct themselves in their own personal treatment, at least during the first year.

Furthermore, a preponderance of the sample reported feelings of inhibition at some point in their personal treatment about describing to their therapists their work with their own patients. The assumption made is that the therapist, an experienced worker in the same profession as the trainee-patient, will be more acutely aware and critical of the trainee's errors than would someone who is in a different field. Most students, however, reported that their anxieties about discussing their professional work in treatment abate in inverse proportion to the growth of their feelings of competency and professional rootedness.

Another complication cited by trainees involves manifestations of their struggles with differentiation rather than with competency issues. Students mentioned inhibitions about openly describing or discussing with their therapists those areas of their professional lives about which they and their therapists presumably differ. These areas typically include trainees' theoretical orientation, therapeutic techniques and personal style, and career goals.

In an effort to gauge the extent to which trainees view their personal therapies as an overall asset in the training experience, we asked students to rank-order the educative value of the following: outside readings, academic coursework, clinical practice, supervision, and personal treatment. Only one student ranked "readings" at the top of the list. The others, regardless of

number of years of training, ranked clinical practice, personal treatment, and supervision, in descending order, as having had (or having) the most impact on them as clinicians.

THE THERAPISTS' PERSPECTIVE

The eight psychotherapists with whom we spoke ranged in experience from seven to thirty years, post degree. A number of them indicated that their caseloads are composed primarily of mental health professionals, including clinical psychology trainees. Most of the therapists we interviewed are psychodynamic in orientation, but one or two described themselves as having an essentially phenomenological slant.

Commonly, the therapists denied at the outset of the interviews that they see psychotherapist-trainees as a distinct class of patients. However, it became evident as they talked and thought about the issue more that this is not the case. Most of the therapists soon recognized that there are either characteristics of trainees or features of the treatment of this group of patients about which it is possible for them to generalize. In addition, some came to realize that they have long been in the habit of making such generalizations about this group.

There was consensus that, like many non-mental health professionals and most experienced psychotherapists, clinical psychology trainees fall in

the category of the motivated and psychologically minded yavis (young, attractive, verbal, intelligent, successful) patient. Some therapists, however, who treat large numbers of graduate students from cognitive-behavioral and/or empirical programs, said they find the sophistication levels regarding dynamic concepts (in particular, transference, somatization, the value of dreams) to be so low among such students that they exclude these trainee-patients from the category into which they place students from more dynamically oriented programs.

The latter observation provokes questions about why it is that trainees with cognitive-behavioral orientations would seek treatment from psychodynamic therapists in the first place. At least part of the answer seems to lie in the reality that the more classically cognitive-behavioral clinicians, at least in the communities from which we drew our sample, work professionally in academic rather than clinical sectors. They are therefore unavailable to students as potential treatment agents. Those practicing psychotherapists who do employ cognitive-behavioral treatment techniques tend to do so within the context of more psychodynamic relationship-oriented frameworks.

Approximately half of our sample stated the belief that there is no normative diagnosis among clinical psychology trainees. Many of the therapists did refer to the superficial obsessional defenses that clinical

trainees typically manifest early in treatment, but none described trainees as being preponderantly obsessional in the classical sense. However, almost half of our sample did suggest that there is a greater tendency for such students to be borderline narcissistic characters than there is for members of the general population to be. Several therapists who expressed this belief pointed to the selection standards of clinical programs as being responsible for the situation. The unusually high standards of achievement by which clinical admissions committees rate their applicants (made possible by the very large numbers of applicants to the top programs, which accept very small classes) has led to the eventual acceptance into the field of a high percentage of students whose superior cognitive development is just the visible flag for what one therapist in our sample termed the "superb" false self constructions (Winnicott, 1965) of many clinical students. Some therapists further stated that not only do trainees tend, as a rule, to have more "primitive" internal structures than people in the general population, but they also tend to be psychologically less intact than most professional therapists who are seen in treatment. The reason offered to account for this phenomenon is that experienced therapists, by virtue of age alone, have had more years of productive personal therapy than trainees have had and are, therefore, a higher-functioning group.

However, a number of therapists with whom we spoke were of the opinion that it is easier to treat trainees than more experienced

psychotherapists. They see trainees as less difficult to work with owing to the following three factors: their enthusiasm for and hopeful attitude toward the change process, their relatively less rigid character defenses (as a function of their youth), and their less fixed identifications with the role of "healer."

Other differences between trainee-patients and therapist-patients were noted. One hinges on the fact that, as a group, trainees tend to be in their mid- to late twenties, whereas practicing professionals are generally older. As a consequence, identity issues are typically more salient for the student group than for the professional group. Another difference is in the nature of the impetus that prompts both trainees and professionals to question whether or not they are in the right field. Usually, students worry that they are "too crazy" or not bright enough to be effective psychotherapists. Many who explore their motives for choosing to become therapists while they are still in training develop concerns about the neurotic nature of that choice. In contrast, experienced therapists tend to question the rightness of their professional choice in response to the combined effects of mid-life crises and the burnout syndromes that overwhelm them. Most often, members of the latter group complain of the daily isolation from peers, the perpetual need to maintain careful control of their emotions, the heightened awareness of their own personal problems, the frustrated omnipotence wishes, the relentless ambiguity of the

treatments they conduct, the lack of immediate gratification in their work, and the overexposure to both depressed and borderline patients (Bermak, 1977; Chessick, 1978; Fine, 1980).

Although the literature suggests that there is a range of attitudes regarding the value of personal psychotherapy for psychotherapists, there was unanimous agreement among members of our sample that personal treatment is integral to the training of mental health professionals. There was also agreement that the therapist plays many roles in relation to his or her trainee-patients, including those of supervisor, teacher, and role model. Most of the therapists said they offer occasional didactic explanations to their trainee-patients and also provide some form of supervision for them from time to time. Only one therapist said that he does not engage in anything that resembles supervision. In this particular case, the therapist, whose various activities in the training community include the assignment of trainees to supervisors at a major training site, scrupulously avoids providing trainee-patients with supervision in the treatment context in deference to his supervisory staff, whose authority he does not want to undermine.

Oddly, almost all of the other therapists we interviewed hastened to assure us that they regard "too many" requests for supervision during treatment as a sign of "resistance" from the patient. This assurance was

offered so spontaneously and with such regularity that we can only assume that therapists are commonly defensive about this point. In only a single case did a therapist in our sample directly articulate her concern that her willingness to provide some form of supervision to her patients might be symptomatic of her own untoward countertransference problems.

There was a moderate degree of agreement among the therapists with whom we spoke that aspects of the training milieu place inordinate stress on students. There was, however, little agreement about what the source of the stress actually is. Some therapists stated that they see the continual direct scrutiny and evaluation of students' work during the early years of training as responsible for the high degree of chaos their trainee-patients typically evince. One said he believes that it is not so much the supervision and evaluation processes but the intensely charged nature of peer group interactions that sustains the competitive frenzy often noted among clinical students (for example, vying for "favorite child" status, "gifted" status, "most likely to succeed" status). Still another said he sees the sheer length of the training programs as being problematic by virtue of the dependency and sibling conflicts that are kept prominent for so many years. This therapist stated that, in his opinion, clinical students stay in the grips of transference longer than other patients because the training programs elicit and then sustain interminably so many areas of conflict.

Although there was no agreement among the therapists about what in the training milieu is so disruptive for clinical students, there was consensus that feelings of immobility and manifestations of generalized defensiveness are common trainee responses to the pressures of clinical graduate programs. The therapists were also uniform in their perceptions that as students increasingly develop feelings of competency about their work, the immobility and defensiveness lessen.

Therapists said they believe that the training programs have both positive and negative impact on students' personal therapies. One dynamically oriented therapist claimed that the regressions prompted by the clinical training environment increase the probability that trainee-patients will have to confront in treatment their feelings about authority figures, sibling relationships, and dependency/autonomy issues. Another therapist, in contrast, sees the uncontrolled nature of the graduate school regression as requiring him to provide a considerable amount of containment and to engage in other ego-supportive work with his trainee-patients.

This same therapist, who treats numerous students from a clinical program that stresses an object relations point of view, spoke of a phenomenon he has often encountered among such students. Reportedly, course work exposure to Guntrip (1969) and Balint (1958; 1979), among

others, often leads students to become enamored of the notion of "regression as 'cure'." As a consequence, the wish to regress in an effort to achieve a magical sense of wholeness and newness is intensified in these students. The treatment implication is that this therapist, who happens to be object relational in orientation himself, finds it necessary to take a protectively antiregressive stance in these cases in order to counteract the potentially hazardous pulls of the training.

Several therapists were of the opinion that clinical programs provide optimal backdrops before which trainees can play out their developmentally appropriate separation-individuation dramas. Inevitably, people new to a field bring with them idealized conceptions of the profession they are entering and, equally inevitably, grow disillusioned as the realities of the situation intrude. As Flamm (1971) has noted, the disillusionment and mourning processes often visible in trainees through their fluctuating states of anger at and emotional withdrawal from their programs are natural manifestations of separation/individuation phenomena (Mahler, Pine, & Bergman, 1975).

Some therapists, however, stated that the clinical programs their patients attend are disruptive forces in the treatment as a result of the premature autonomy or false self functioning that training tends to promote. As the trainees in our sample pointed out, clinical students must defensively

adopt facades of self-assured and competent functioning when they begin treating patients prior to having amassed more than the most rudimentary skills and knowledge required for the task. For those therapists who view the gradual unmasking of the false self defense as integral to treatment, this aspect of mental health training clearly runs counter to treatment goals.

There are numerous ways in which therapists share trainees' concerns about unclear treatment boundaries. There was uniform agreement among the therapists, however, that the task of managing those boundaries is their own. Boundary issues mentioned differed from therapist to therapist, as did the decisions about how to handle them. Among the more common professional questions raised were the following: whether or not to write letters of recommendation for patients who have also been students or supervisees of the therapist, whether or not to supervise someone who had previously been one's patient, whether or not to interrupt the treatment of a trainee whose program requires a course taught by the therapist, and whether and how to withdraw tactfully from decision-making capacities on admissions or evaluations committees without violating the trainee's right to confidentiality regarding the fact of his or her treatment.

During their early graduate school years, trainees are frequently concerned that they will be found unfit for the field by their therapists, who they fear will report this news to the training and/or professional

communities. Practically speaking, however, no therapist with whom we spoke admitted to having ever considered doing so. Two of the more experienced therapists in our sample independently shared their observations that such a practice is unnecessary. In their view, a process akin to that of natural selection typically occurs in clinical training programs; trainees who seem the least well suited for the field eventually recognize this themselves and opt to avoid clinical practice.

It was apparent from talking with the therapists that there are common countertransference-provoking situations that arise with some frequency when they are treating trainees. One group of such issues concerns the therapist's colleagues who also have some sphere of interaction with the trainee-patient. Since it not infrequently happens that trainees speak unfavorably about authority figures in the professional world, therapists reported that they sometimes find themselves feeling identified with the colleague and therefore counterattack via silent (or not so silent) denigrations of the patient's judgment and perceptiveness. Equally often, the countertransference is rooted in identification with the student and is manifested by the therapist's too-hearty appreciation of the patient's anger at reportedly poor supervision or unfair academic practices. Similarly, when it occurs that the patient speaks highly of and/or idealizes a colleague of the therapist's, it is not unusual for the therapist either to feel competitive with or to identify with the valued supervisor/academician. These kinds of

reactions are certainly commonplace in any treatment; the point here is that because the training and treatment worlds often overlap so extensively, especially in small communities, the situations arise more frequently and therefore have more palpable potential consequences in the treatment of trainees. All of the therapists with whom we spoke, however, noted that these problems seem to dissipate as their experience in working with this group of patients increases.

A number of the therapists described occasional untoward feelings of competitiveness with their trainee-patients. Envy of the patient's youth and excitement about the profession are not uncommon when the novelty of and illusions about the field have long since diminished for the therapist. In addition, a number mentioned their envy of the diverse and easily accessible learning opportunities available to their trainee-patients. Still others referred to competitive feelings when listening to a patient describe a particularly well-handled case.

Countertransference problems that originate outside the consulting office were also discussed by a few therapists. Some acknowledged feeling quite uncomfortable when they learn that a trainee-patient has indulged in a character assassination of the therapist While speaking with either a colleague, student, patient, or social acquaintance of the therapist. Most acutely painful are the instances in which trainee-patients do so without

informing the listener that the object of the vilification is someone with whom the trainee happens to be in treatment. Somewhat less often, it happens that the therapist is present when colleagues or friends discuss a patient negatively from the point of view of a social or training context. A few of the therapists with whom we spoke admitted to boundary lapses of their own that prompt them to feel personally attacked as a consequence of such discussions.

A large proportion of our therapist sample admitted feeling a greater impulsion to monitor countertransferences with trainees and experienced psychotherapists because of how much they and the patients have in common by virtue of shared professional interests and forms of livelihood. One therapist spoke of the enhanced sense of pride and specialness she feels when working with trainees because such treatments increase her awareness that she herself has chosen a craft that requires personal transmission. Several mentioned the narcissistic gratification they experience upon getting referrals from colleagues in the academic setting. The wish to be part of the training of new therapists apparently culminates in covert status issues related to being the therapist of trainees. On the basis of the remarks of our sample, it appears that the prestige associated with being known in the community as a therapist who treats trainees approaches that associated with being known as a "therapist's therapist."

COMMENTS

In the course of gathering the data on which this chapter is based, we became increasingly intrigued by the difference of opinion between the trainees and the therapists regarding the following question: are psychotherapist-trainees a unique subgroup of patients? It will be recalled that although trainees responded "yes" to this question, most of the therapists initially responded "no." (It is, perhaps, revealing that members of the latter group were nevertheless quite willing to be interviewed about the subject.)

As we collated our interview material, it became evident that the trainees and therapists are not actually as divergent in their thinking as it had originally seemed that they were. Trainees and therapists in our sample agree that personal treatment is a necessary and integral part of the training process for mental health practitioners. Neither group asserts that the personal dynamic issues of trainees are any different from those found among members of other patient groups such as other graduate/professional students or any bright patients embarking upon new careers. But trainees and therapists do believe that the interrelatedness of trainees' professional training and personal psychotherapy experiences lends a distinctive character to their treatments. On the basis of the data we collected, the most visible distinctive features are these: the expanded range

of the therapist's functions, including dispensing professional advice and serving as a professional role model; the shared personal and professional communities of therapist and patient, replete with sensitive boundary problems; and the nature and frequency of the therapist's countertransference reactions.

Trainees and therapists also tend to agree that the training in which the student is engaged is, in the long run, a growth-promoting process in and of itself. The consensus that emerged from our interviews supports Ford's (1963, p. 476) notion that the "developing psychotherapist acquires large portions of his own personal identity and self-concept collaterally with his acquisition of professional and therapeutic role and identity." In short, clinical training and psychotherapeutic treatment work simultaneously to stimulate the progress of students' internal development.

There was also agreement among students and therapists that clinical training is a highly stressful process that can have significant negative impact on the immediate emotional functioning of students. This point of view has previously been expressed by Campbell (1982, p. 1405), who regards the stresses inherent in clinical training as having the "potential for exacerbating or reactivating latent conflict" in students, thereby "contributing to the development of overt psychopathology." Although this is evidently a painful situation for trainees, there are nevertheless some

potentially positive corollaries that flow from it. The first is that students' conflict areas are brought more sharply into focus by the clinical training and may therefore be more accessible because they emerge in such an ego dystonic fashion. The second is that the personal therapies to which students tend to turn for help eventually facilitate their gaining greater knowledge and control of themselves and, as a result, increasing their interpersonal effectiveness with patients, faculty, family, and friends.

There is one point, however, about which trainees and therapists strongly disagree. Trainees expressed the belief that their knowledge of psychological processes (e.g., transference, resistance, regression) renders them, almost by definition, more interesting or less resistant patients than most. The therapists, in contrast, do not see trainees as having a particularly sophisticated knowledge base and, further, believe that some of the knowledge they do have serves more to impede treatment (via resistance) than promote it.

Why trainees base their assumption of specialness on the erroneous belief that they are highly informed about matters of pathology and treatment is not difficult to understand. As a group, clinical students typically have extensive histories of being labeled "special" by virtue of their superior cognitive abilities and capacities to outperform others in a wide variety of life situations. That their narcissism should find an unrestrained

focus on their cognitive skills is more or less in synchrony with some of the reality features of their collective histories. It is also mild evidence in support of the opinions of those therapists in our sample who view clinical trainees as being a relatively narcissistic group.

Given that our data lend support to the idea that there are, indeed, some distinctive features of the therapies of clinical trainees (perhaps the least of which is trainees' technical knowledge of the field), a more provocative question to ask is why therapists are so reluctant to acknowledge this fact either to themselves or to others. One rather bland hypothesis is that for the most part, clinicians think predominantly in diagnostic categories and are therefore unaccustomed to organizing their thoughts along the lines of occupational groups. But it has also occurred to us that the narcissism of the therapists themselves and the defenses they have erected against it are to some extent responsible for their immediate rejection of the idea that clinical trainees comprise a particular (that is, "special") subgroup of psychotherapy patients. Specific features of the treatment of trainees that exert a narcissistic pull on therapists include the following: therapist identification with trainee-patients who view themselves as "special," implicit and discomforting status issues prevalent in the professional community related to who conducts the treatment of other professionals (both experienced and inexperienced), and power and status needs of therapists that are met through their association with the academic

community or by signs of approval from it via referrals. It appears that the dominant way in which therapists deal with these sensitive matters is by outright denial that trainees are "special" enough to warrant subgroup status at all. This denial then facilitates therapists' disavowal of their own feelings of specialness.

While this chapter was still in preparation we received information from a number of people we had interviewed regarding some of the consequences the interviews themselves had had for them. Numerous trainees reported that afterward they were able to bring material into their personal treatments that they had not previously presented. They felt that the legitimation of their perspectives on concurrent personal treatment and training freed them to explore some of their own related issues in more depth with their therapists. Simultaneously, a number of therapists reported afterward that thinking about these issues had increased their sensitivity to the complex nature of the interactions they have with their trainee-patients. It therefore seems clear to us that further publications about the training and personal therapy interface would be welcomed by experienced and inexperienced psychotherapists alike.

Similarly, it appears that it would be equally helpful to have access to more information about the transition phase trainees in treatment undergo as they emerge from trainee standing to full professional status. Just as the

training/treatment processes largely promote individuation phenomena, the eventual emergence into professional adult status signals and entails reunion, albeit on a new footing, with the parent community from which the ex-trainee is presumably now more clearly differentiated. We wonder about the impact of this professional transition on the ongoing personal treatment of therapists, and look forward to seeing descriptions and examinations of this process in print.

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APPENDIX 1 TRAINEE QUESTIONNAIRE

1. When, why, and with whom did you enter treatment (treatment history)? How did this arrangement come about (e.g., referral source, referral request)? How are fees handled?

2. Discuss the boundary problems associated with being a trainee in treatment (e.g., supervision versus therapy, overlapping professional and social communities).

3. What are the reciprocal effects of the treatment and the training processes (e.g., effects on: development of your theoretical orientation, your functioning as a therapist/supervisee, your functioning as a patient)?

4. Rank in order of importance how each affected your clinical work: personal therapy, supervision, reading, coursework, clinical experience.

APPENDIX 2 THERAPIST QUESTIONNAIRE

1. Are psychology trainees a definable group and, if so, what defines them (e.g., personal characteristics, diagnoses)? How do they differ from the general population? How do they differ from experienced therapists?

2. Is psychotherapy an integral component of the training process? What does this imply about your role as therapist?

3. What is the impact of the patient's training on the psychotherapy process (e.g., student's knowledge of regression, affective impact of university setting)? How does this influence your behavior?

4. Discuss the boundary problems associated with your trainee patient's treatment (e.g., supervisory issues, overlapping professional and social communities). What kinds of management techniques have you adopted to deal with these? What kinds of countertransference manifestations do you typically encounter?

EDITOR'S COMMENTARY
THE FLIP SIDE OF THE COIN—THE FRESHNESS OF STUDENTS' PERCEPTIONS

Florence Kaslow Ph.D.

In attempting to put together a collection of analytic, insightful papers about why, how, and from whom therapists themselves seek treatment, it seemed that a possibly productive route of inquiry was to request an article from several students about to complete their graduate-professional training. The quest for an innovative response to these queries came to fruition in this chapter by N. Kaslow and Friedman. Judiciously, they drew up and administered an open-ended questionnaire so that their ideas and interpretations would be grounded in data acquired through a base of thoughts and perceptions broader than their own. They interviewed students and interns as well as practicing clinicians to ascertain viewpoints from patient and therapist alike.

What emerges here is the centrality of concerns over boundaries—what they are and what they should be—particularly when this special patient/therapist dyad is involved in one or more other intertwined roles such as student/teacher or research assistant/mentor. In addition, sometimes the trainee raises questions about his or her own work as a fledgling therapist and receives quasi-supervision from the senior therapist.

N. Kaslow and Friedman elucidate some of the same dilemmas that Lazarus and Fay do and seem to report similar resolution, that is, rarely are the roles kept "pure." Apparently, in small communities and/or in close-knit graduate and medical school environments there may not be enough well-trained mental health professionals available to avoid these overlapping roles. What a different scene than in large metropolitan areas like New York, Chicago, Philadelphia, and Boston, where analytic institutes, psychiatric residency programs, psychology, marriage and family therapy, and social work graduate programs can insist that students be treated by someone outside the faculty and supervisory staff, because there are hundreds of licensed and respected therapists nearby. Perhaps we can no longer expect guidelines formulated in and for huge urban communities to be adhered to as rigidly in smaller towns and suburban settings where they are inapplicable.

These two incisive young women show logically that therapy trainees constitute a special subset of the therapy population and exhibit some specific differences from nontherapist patients. Although initially some of the psychotherapists interviewed negated the validity of this assumption, as they gave the matter more concentrated attention, many agreed. N. Kaslow and Friedman's hypothesis about this concurred with what J. Coché found in her group therapy with therapist-patients—that they do indeed constitute a special population, with an additional propensity for utilizing the therapist as a professional role model and for trying to extrapolate substantive

theoretical material and therapeutic skill from their personal treatment experience. It may be that much of the field, of varied persuasions, has come full cycle, with trainees and young therapists spontaneously seeking something akin to the didactic (content inclusive) analysis (discussed in Chapter 2) long held to be an essential, vital part of the making of the analyst.

With sparkling vision, these authors tell us what they and their young colleagues seek and treasure in their therapists, thereby providing an antidote to the overvaluing of the more jaded, who coast on their laurels, expecting others to revere them because of their prestige and not their current therapeutic performances.

1. The order of the authors is random.

2. This chapter was written when one of the authors (N.K.) was still in graduate school and the other (D.F.) had just been granted her degree..

3. We wish to thank the trainees and therapists who participated in this study. For reasons of confidentiality, they must remain anonymous.