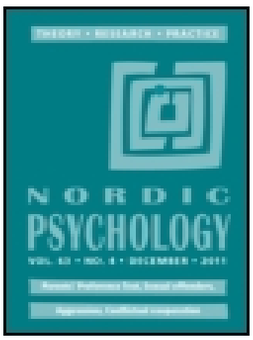

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REVIEW ARTICLE

Personal therapy and the personal therapist

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Abstract

Personal therapy has been proposed as an aid in promoting the professional development of psychotherapists by increasing their self-awareness, self-reflexivity, and self-knowledge of the therapy process and of personal characteristics. Psychoanalysis/psychodynamic therapies, cognitive-behavioral therapies, humanistic/experiential therapies, and systemic/family therapies argue that working with the personal and professional self of the therapist is valuable in this respect. The objective of the present study is to summarize the theoretical and empirical literature on personal therapy and its effects on the professional development of therapists and on patient treatment. A systematic review of the literature was conducted and demonstrated a convergence between reported benefits from personal therapy and therapist qualities. Psychotherapists have rationales (e.g. improvement of emotional and mental functioning and a better understanding of the dynamics between therapist and patient) for attending personal therapy, and self-report studies indicate that they experience benefits related to the important characteristics of effective therapists (e.g. empathy, genuineness, formation of a working alliance). Studies of personal therapy and therapist development find no causal connection or correlation with or effects on patient treatment. However, these studies exhibit methodological weaknesses, such as inadequate controls and small sample sizes, making conclusions equivocal.

Keywords: personal therapy, self-knowledge, therapist effects

Introduction

How do psychotherapists progress in their professional development? Undoubtedly, the question is essential and probably has many answers. The present study will examine one such possibility: personal therapy. In the literature, a distinction is made between personal analysis and personal therapy, where the former concerns psychoanalytic treatment, and the latter refers to personal therapy within other psychological disciplines (Geller et al., 2005). In the current study, personal therapy will be used as an overarching concept that includes personal psychotherapy and personal analysis. Additionally, therapists and psychotherapists will refer to the same concept and will only be differentiated when necessary. The same will apply to personal therapy and to whether personal therapy is mandatory or voluntary. Personal therapy may be an arena where characteristics that are central to

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psychotherapy develop, since the person's *self* is the focus of exploration. Maybe the Greek postulate that self-care, *empimeleia heauton*, is necessary for awareness, and development of self-knowledge, *ghnoti seatuon* (Foucault, 2005), is still relevant. In recent years, there has been increased interest in personal practice (PP), self-reflection and their relationship to the development of effective therapists (Bennett-Levy, 2019). PP refers to "[F]ormal psychological interventions and techniques that therapists engage in self-experientially over an extended period of time (weeks, months or years) as individuals or groups, with a reflective focus on their personal and/or professional development" (Bennett-Levy, 2019, p. 133). Bennett-Levy (2019) argues that PP influences therapist characteristics, claiming that there is a correspondence between the characteristics of effective therapists and what therapists report from PPs.

The present study also focuses on self-awareness, self-knowledge, and self-reflection. *Self-awareness* is consciousness about one's feelings, behaviors, and characteristic abilities (Self-Awareness, 2014, Collins English Dictionary – Complete and Unabridged), while *self-knowledge* is defined as the understanding of one's limitations and abilities (Self-Knowledge, 2011, American Heritage® Dictionary of the English Language). Thus, self-awareness is the insight into one's reactions during therapy with the patient, based on a self-knowledge of historical events where limitations and abilities regarding one's feelings, behaviors, and characteristics have shown themselves. *Self-reflection* is the contemplation of one's thoughts, feelings, and sensations. To enhance readability, the term "self-awareness" will be used most of the time in this article, as one must be aware of different aspects of one's self to acquire knowledge and understanding.

Can personal therapy increase one's awareness and reflexivity of those qualities that are crucial to achieving good outcomes in psychotherapy? This notion may be associated with so-called "common factors", a trans-therapeutic term explaining why evidence-based psychotherapies are effective at a general level – for example, alliance, empathy, therapist – and not specific to one method (Wampold, 2010). It has been suggested that the treatment outcome in therapy is mostly due to common factors, estimated to comprise 46% of the variability in outcomes. The treatment method has been suggested to account for approximately 1% of the total outcome variance (Laska et al., 2013). However, these estimates differ in other studies (Imel & Wampold, 2008) and do not imply that "method" is unimportant (Tilden, 2013). This topic is interrelated with the dodo bird verdict, which states that psychotherapies are equally effective (Luborsky et al., 2006). One could argue that when the psychotherapist begins personal therapy, the main agenda is to deepen her understanding of psychotherapy and perhaps the specific framework she is interested in (Grotstein, 2009; Lasky, 2005); for example, cognitive therapy or psychodynamic therapy. Increased theoretical understanding may also be the reason for attending PP (Bennett-Levy & Finlay-Jones, 2018). Other reasons might include increasing her knowledge of the specific framework's theory of therapy in practice, and of how patients change or improve. Personal therapy entails the personal experience of how therapy affects one's intrapsychic functioning: how it influences one's emotions and mind as an indication of the potency of treatment. It could be argued that the general rationale for changes in therapy is exposure to unresolved or painful feelings or conflicts (Frederickson, 2013; Greenberg, 2015).

Personal therapy is common in psychoanalytic and psychodynamic therapies (Orlinsky, 2013). Orlinsky (2013) conducted a survey in which he compared strongly psychoanalytic

therapists to minimally analytic-oriented therapists. The results showed that 92.7% of strongly analytic-psychodynamic therapists underwent personal therapy in contrast to 72.7% of minimally analytic-psychodynamic oriented therapists. The prevalence of personal therapy as it relates to professional discipline showed similar results. Ninety-one percent of humanistic therapists and 73% of cognitive-behavioral therapists have tried personal therapy at least once (Orlinsky et al., 2011). Freud (1937/1976) claimed that personal analysis is essential to becoming an exceptional analyst. There appears to be a consensus about this notion in the psychoanalytic literature (Lasky, 2005). The arguments are both professional and personal; for example, learning about transference, self-conscious, countertransference, and difficulties in life. Fromm-Reichmann (1960) stated that the therapist must know her interpersonal history and processes for the patient to utilize therapy. The rationale is that difficulties in interpersonal relationships in adulthood originate from relational experiences in childhood. A general theme in the psychoanalytic literature but also in psychodynamic therapies is that personal therapy enhances self-awareness for the therapist in ways that are useful for psychotherapy (Fromm, 1992; Yalom, 2003). However, Fromm (1992) also recommended other forms of self-development; for example, self-analysis. Yalom (2003) stated that the type of personal therapy chosen may differ based on the type of problem and life stage. It could be argued that Melanie Klein and post-Kleinians (Grotstein, 2009), Lacanian psychoanalysis (Fink, 2009; Lacan, 1988), ego-psychology (Freud, 1936/1992), and Erik Erikson (Mitchell & Black, 2016) also differ in the type of focus employed in personal therapy. Kleinians, post-Kleinians, and Lacanians prioritize unconscious and preoedipal conflicts more than do ego-psychologists and Eriksonians, who focus on ego and oedipal conflicts. We would claim that, based on Erikson's writings, it seems likely that he would focus more on how social and cultural aspects influence the ego's development through the eight stages of psychosocial development that he formulated. Cognitive-behavioral therapy (CBT) does not have the same history of prioritizing personal therapy, although CBT does not neglect the person of the therapist in relation to the therapeutic process (Bennett-Levy et al., 2009; Kanter et al., 2010; Laireiter & Willutzki, 2005; Safran & Segal, 1996). CBT has a focus on the self-awareness (*Selbsterfahrung*) of the therapist and how interpersonal aspects of the therapist influence therapy but argues that activities other than personal therapy are also valuable (Bennett-Levy & Finlay-Jones, 2018; Bennett-Levy & Thwaites, 2007; Bennett-Levy et al., 2015; Schön, 1983). Humanistic (Rogers, 2012), gestalt (Perls, 1969), and existential therapy (May et al., 1994) value activities that influence the therapist's personal and professional development and assume that this value leads to better outcomes for the patients. Within systemic and family therapies, the person of the therapist is considered essential, but activities other than personal therapy are favorable, e.g. personal workshops (Lebow, 2005; Scharff & Scharff, 1977; Storm et al., 2003; Whitaker & Bumberry, 1988; Whitaker & Keith, 1981).

The APA policy statement for evidence-based practice in psychology acknowledges the importance of the therapist's self-awareness for positive outcomes in psychotherapy under the headline *clinical expertise* (American Psychological Association, 2006). This expertise entails the psychotherapist *knowing* about how her characteristics and professional erudition influence therapeutic practice. It is conceivable that therapists' personal self influences their professional self (Gerson, 2013). Moreover, it could be that a therapist's self-awareness of how to build an alliance with her patients increases the likelihood of creating successful

alliances. Meta-analytic findings indicate that there is a robust correlation between alliance and treatment outcome (Flückiger et al., 2018). One objective of the present study was to investigate whether benefits reported from personal therapy in qualitative studies are associated with therapist characteristics that are central to forming an alliance. Bennett-Levy (2019) mentions how some therapist attributes are associated with treatment outcomes, such as empathy and alliance building qualities. Muran et al. (2018) discuss how training programs may enhance the ability to create an alliance. Hence, personal therapy may be an arena for learning abilities that facilitate creating a good alliance.

Thus, the aim of the present study was to examine the theoretical and empirical literature on personal therapy and therapist effects and to discuss whether personal therapy may promote beneficial qualities in therapists. More specifically, the present study sought to answer the following questions: 1) What are the rationales for psychotherapists to pursue personal therapy? 2) What is the effect of personal therapy on the treatment outcome? 3) Does personal therapy develop therapist characteristics associated with good treatment outcomes? 4) Is there a convergence between studies on personal therapy and therapist effects?

Method

Systematic searches on PsycInfo and Web of Science were conducted to select the research literature. Preferred reporting items for systematic reviews (PRISMA) procedures were adopted (Liberati et al., 2009). The authors also followed the key stages in conducting a systematic review formulated by Siddaway et al. (2019). In January 2019, we used the following search queries: "personal therapy," "personal analysis," "self-practice," "common factors," "therapist qualities/characteristics," "therapist development," and "therapist effect." The authors limited the literature searches to journals that were considered relevant for clinical psychology. Journals including the words development, psychology, psychotherapy, psychiatry, counseling, and behaviour therapy in their title were included. The objective was to find articles that reflected research on personal therapy or therapist effects, either through experiments, self-reports, or theoretical papers. In our opinion, these research topics and definitions are the most appropriate to answer the research question in the present study. We also followed Baumeister's (2013) and Siddaway et al. (2019) suggestion that newer articles could contain older relevant references for the current study. Therefore, we made a list of other relevant articles for further investigation. These articles are referred to as "additional records identified through other sources" in Figure 1. The exclusion criteria were case studies of personal therapy/analysis, personal therapy for a specific diagnosis, the common factors of effectiveness for particular treatments, barriers to personal therapy, articles written in languages other than English, Norwegian, or Swedish, or that were not accessible through the university's library. We selected articles that contained relevant keywords in their title and then read the abstracts of the various articles to select relevant studies.

Results

Thirty studies were included in the present study based on the selection procedure (Figure 1). Thirteen studies focused on self-reports about personal therapy. Seven studies focused on the therapist effect in psychotherapy. Seven studies investigated the effect of personal

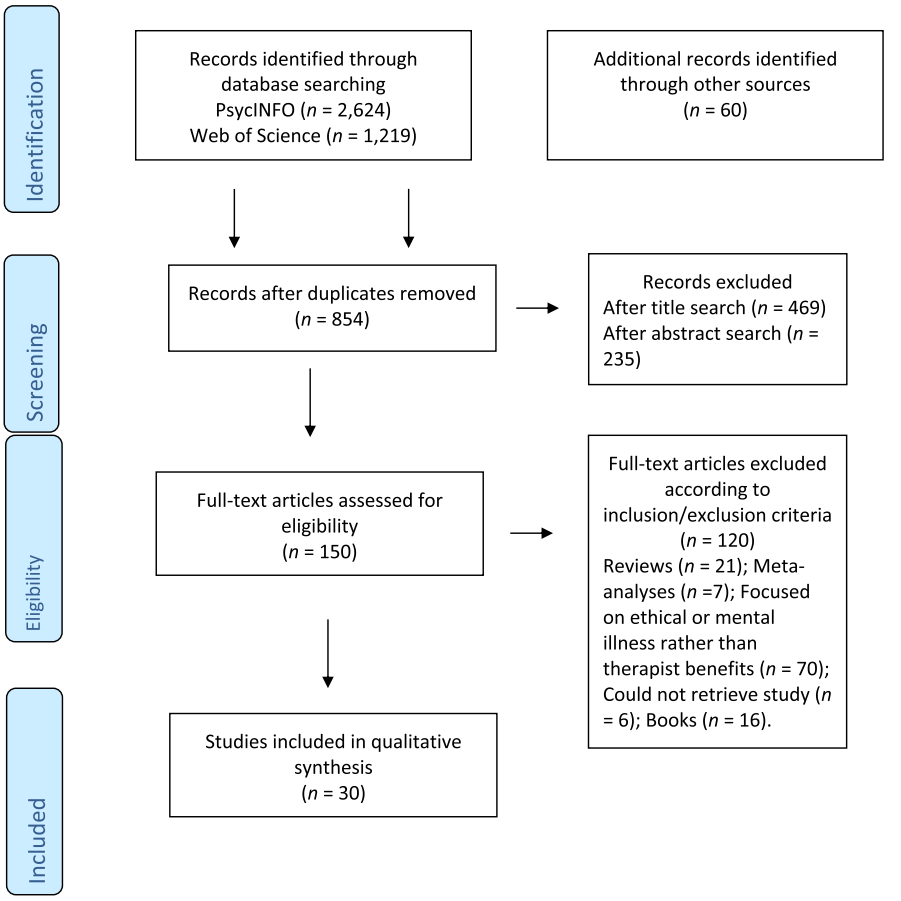

Figure 1. PRISMA diagram of study selection process. From: Moher et al. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine* 6(7), e1000097. https://doi.org/10.1371/journal.pmed1000097.

therapy and three studies explored alliance in psychotherapy. The studies on alliance are considered to belong to therapist effects. Table 1 summarizes the included studies and presents information on the objective of the study, the number of research participants (patients, therapists, age, and sex), the method and results. The included studies were chosen because of their focus on therapist characteristics, personal therapy, and treatment outcome. The studies are grouped according to self-reports about personal therapy, therapist effects/characteristics, the effect of personal therapy, and alliance.

Therapists' rationales for and experiences with personal therapy

The reasons for undergoing personal therapy are diverse and vary depending on one's life stage or stage of professional development (Geller et al., 2005; Norcross & VandenBos, 2018). Norcross, Strausser-Kirtland, and Missar (as cited in Geller et al., 2005) conducted a national survey of 234 psychologists, 104 psychiatrists, and 171 clinical social workers and

Table 1. Summary of articles in the results section.

Therapists' self-reported attitudes toward, use of and experiences with personal therapy				
Study	Objective	No. of research participants (gender and age)	Method	Results
Buckley et al. (1981)	Investigated what therapists report from their personal therapy (PT).	97 American psychotherapists, age range: 30–60 years, 86% male. Return rate: 74%.	Questionnaire.	Most of the respondents reported benefits (e.g. increased self-esteem and interpersonal relationships). Negative effects were destructive acting out, negative impact on marriage, withdrawal from the social world.
Norcross et al. (1988)	Obtained information on professional activities and experience with PT.	710 psychotherapists: 314 psychologists, 159 psychiatrists, 237 social workers, 60% male. Only mean age when beginning PT was reported (mean age was 27.6 years for first therapy, 30.5 years and 38.6 years for second and third therapies). Response rate: 50%.	Questionnaire.	71% reported at least one episode of PT. 55% entered PT for personal reasons, 10% for professional reasons, 35% for both. 90% reported improvement of symptomatology. 8% reported PT was harmful.
Patterson and Utesch (1991)	Explored students' attitudes about PT as a component of training.	51 students, 38 women, mean age: 33 years.	Questionnaire.	Most of the students believed that PT is an important part of the training.
Pope and Tabachnick (1994)	Investigated psychologists' beliefs, problems, and experiences with PT.	476 American psychologists, 52.3% women. Age 40 years or under: 17.2%; 40–50 years: 42.6%; over 50 years: 34.2%. Response rate: 59.5%.	Questionnaire.	84% had been in therapy. 2 participants described PT as unhelpful, 22% as harmful. The most harmful experiences were therapists' sexual acts or attempted sexual act with participants. The

(*Continued*)

Table 1. (*Continued*).

Therapists' self-reported attitudes toward, use of and experiences with personal therapy				
Study	Objective	No. of research participants (gender and age)	Method	Results
				most beneficial were self-awareness or self-understanding.
Mahoney (1997)	Investigated self-care patterns, personal problems and attitude toward PT.	155 psychotherapists, 54.5% women (1 respondent did not report gender). Age range: 24–83 years. Response rate: approx. 48%.	Questionnaire.	87.7% had been in PT; most reported PT as helpful. Less concern about negative effects by the respondents.
Wiseman and Shefler (2001)	Investigated the impact of PT on the professional and personal development of experienced psychotherapists.	5 psychoanalytic psychotherapists, two men, three women. Age range: 40–50 years.	In-depth interviews.	The qualitative analyses yielded 6 domains: importance of PT; impact of PT on professional self; impact of PT on one's being in the session; the therapist as patient; learning.
Daw and Joseph (2007)	Explored qualified therapists' experience of PT.	48 qualified therapists, 38 women. Age range: 23–63 years. Response rate 22%.	Questionnaire. Interpretive Phenomenological analysis of open-ended items.	66.7% had been in PT. Reasons for attending PT were personal growth or personal distress; other reasons were mentioned.
Bellows (2007)	Investigated psychotherapists' perception of how PT has influenced their clinical practice.	20 psychoanalytically oriented therapists.	Semistructured interviews.	6 major findings: 1) importance of role modeling; 2) improvement of interpersonal relationships and professional identity; 3) low levels of harmful effects on their treatment; 4) working through; 5) acceptance of ideals and challenges; 6) satisfactory termination. The results indicated that PT was positive for the therapists' clinical practice.

(*Continued*)

Table 1. (*Continued*).

Therapists' self-reported attitudes toward, use of and experiences with personal therapy				
Study	Objective	No. of research participants (gender and age)	Method	Results
Rizq and Target (2008)	Investigated how experienced counseling psychologists describe the significance of PT in clinical practice and training.	9 participants, six women. Age range: 42–65 years.	In-depth semistructured interviews.	Five master themes and 13 subthemes. Three master themes were about PT and the relevance of PT to self-experience, professional learning, and training.
Norcross et al. (2009)	Investigated how mental health professionals (MHP) choose their psychotherapists.	727 psychotherapists, 68% women. Age range: 25–89 years. Response rate: 35%.	5-page questionnaire.	84% had personal therapy once. MHPs tried to repeat aspects from their PT in their treatment of their own patients.
Bike et al. (2009)	Investigated MHPs' reasons for entering PT.	This study used the same sample as the study by Norcross et al. (2009), but studied different research questions.		Reasons for entering PT were: personal reasons (60%), professional reasons (5%), personal and professional reasons (35%).
Orlinsky et al. (2011)	Investigated PT among psychotherapists from six English-speaking countries.	3,955 therapists, 68.3% women. Mean age: 50.5 years.	DPCCQ	87% had PT once.
Orlinsky & Society for Psychotherapy Research Collaborative Research Network (2013)	Investigated reasons for PT given by psycho-analytically oriented therapists, and PT's effect on personal wellbeing and professional development.	10,080 therapists, 64% women. Age range: 21.4–90.7 years.	DPCCQ	Psychoanalytically oriented therapists attended PT more than minimally analytically oriented therapist.

(*Continued*)

Table 1. (*Continued*).

Therapists' self-reported attitudes toward, use of and experiences with personal therapy				
Study	Objective	No. of research participants (gender and age)	Method	Results
Therapist effects on treatment outcome				
Study	Objective	No. of research participants	Method	Results
Lafferty et al. (1989)	Investigated the differences between more and less effective trainee psychotherapists.	30 trainee therapists, nineteen men. Age range: 23–38 years. 60 outpatients, 49 women. Age range: 19–68 years.	Cross-sectional study. Patient and therapist self-report: SCL-90-R, EPI, BLRI, Therapeutic Participation factor of the 74-item Psychotherapy Process Inventory, TCS, TOQ, TRVS.	Lower levels of empathic understanding were associated with less effective therapists. Less effective therapists had a tendency to rate their patients as more involved in therapy and rated themselves as more supportive than effective therapists did. Effective therapists did not value comfort, stimulation and intellectual goals in the same way as less effective therapists did.
Wampold and Brown (2005)	Estimated the variability in outcome attributable to therapists.	6,146 patients, 72.3% women. Mean age: 39.8 years. 581 therapists, 72.3% women. Mean age: 51.5 years.	Naturalistic study. Patient self-report: LSQ.	Approximately 5% of the variation in outcomes was due to therapists when the initial level of severity was taken into account.
Lutz et al. (2007)	Investigated the amount of variance in across-session change in symptom intensity scores explained by therapist differences in a large naturalistic data set.	1,198 patients, 60 therapists. 53% of the patients were women. Mean age: 36.4 years. 65% of the therapists were women.	Naturalistic study. Patient and therapist self-report: CTS, SWS, CSS, CLFS, SW, GAS.	Approx. 8% of the total variance and approx. 17% of the variance in rates of patient advancement could be attributed to the therapists.
Dinger et al. (2008)	Investigated therapist	50 therapists, 2,554 inpatients. 23 of	Naturalistic study. Patient self-	The results indicated that therapists

(*Continued*)

Table 1. (*Continued*).

Therapists' self-reported attitudes toward, use of and experiences with personal therapy				
Study	Objective	No. of research participants (gender and age)	Method	Results
	variability in a large inpatient psychotherapy sample.	the therapists were women. Mean age: 40.3 years. 51.7% of the patients were women. Mean age: 37.9 years.	report: SCL-90-R, IS, HAQ.	accounted for greater variability on alliance than on outcome.
Saxon and Barkham (2012)	Investigated the size of therapist effects to compare therapists' outcome and to identify key variables.	10,186 patients. Mean age: 42.1 years. 71.5% women. 119 therapists.	Naturalistic study. Patient self-report: CORE-OM.	The therapist effect was estimated to be 6.6% for average patient severity. Recovery rates for individual therapists varied from 23.5% to 95.6%. Patient severity and accumulated patient risk was associated with poorer outcomes.
Laska et al. (2013)	Investigated the therapist effect in the treatment of PTSD with Cognitive Processing Therapy.	192 patients, 172 males. Mean age: 50 years. 25 therapists, 15 women.	Naturalistic study. Patient self-report: PCL.	Approximately 12% of the variability in the PCL at the end of treatment was due to therapist effects.
Effect of personal therapy on treatment outcome				
Study	Objective	No. of research participants	Method	Results
Katz et al. (1958)	Investigated the remainder of patient attributes and their relation to subsequent improvement in psychotherapy.	232 patients.	Cross-sectional study. Patient self-report: BDS, TMAS.	1) No/little relation between PT and improvement rating. 2) The therapists' years of experience was related to the improvement rating. 3) The therapists' diagnostic classification of the patient was not related to years of experience, but to the improvement rating.

(*Continued*)

Table 1. (*Continued*).

Therapists' self-reported attitudes toward, use of and experiences with personal therapy				
Study	Objective	No. of research participants (gender and age)	Method	Results
McNair et al. (1963)	Investigated factors related to why people quit or remain in therapy.	282 patients. 168 therapists, 21% women.	Cross-sectional study. Patient and therapist self-report: TR-BD, TR-A, TR-F, TMAS, Motivation for treatment rated by the therapist.	Found no difference between therapists with PT and no PT in relation to keeping patients in therapy.
McNair et al. (1964)	Investigated the effect of psychotherapy through a three-year follow-up study of psychotherapy patients.	81 male patients. Age range: 21–51 years. 40 therapists.	Longitudinal study. Patient self-report: Research test battery and semistructured interviews. Tests in the battery were: TMAS; ICL, ISBC, rating of improvement.	Therapists with more PT kept their patient in therapy longer. However, there seemed not to be an effect on treatment effectiveness.
Garfield and Bergin (1971)	Assessed whether personal therapy is associated with patient outcome and therapist variables.	18 therapists (advanced graduate students). 38 patients.	Cross-sectional study. Patient and therapist self-report: Examined the number of hours of PT the therapist had. MMPI.	Found that the amount of PT was negatively associated with outcome, indicating that the more PT the therapist had, the more likely s/he had poorer treatment outcome.
Peebles (1980)	Investigated whether the amount of personal therapy was positively associated with therapist's ability to display warmth, empathy, and genuineness.	17 therapists (advanced graduate students), 11 males. Age range: 23–33 years. 29 patients, age range: 15–44 years.	Cross-sectional study. Therapists self-report: Therapists completed the MMPI and their therapy sessions were tape-recorded. Two raters used Truax and Carkhuff scales of Accurate Empathy, Genuineness and Nonpossessive Warmth to evaluate the therapists.	The number of hours of personal therapy experience was significantly associated with empathy and genuineness, but not with warmth.

(*Continued*)

Table 1. (*Continued*).

Therapists' self-reported attitudes toward, use of and experiences with personal therapy				
Study	Objective	No. of research participants (gender and age)	Method	Results
Greenspan and Kulish (1985)	Investigated factors related to premature termination in long-term psychotherapy.	718 patients, 70% women. Age range: 6–50 years. 27 therapists. Age range: 29–68 years.	Cross-sectional study. Patient self-report:	Found a positive relationship between therapists who have had PT and premature termination rates. Indicated lower termination rates for therapists' who had PT.
Gold et al. (2015)	Investigated the relationship between therapists' personal therapy and the ensuing psychotherapy process and treatment outcome.	14 graduate clinicians (doctoral students), eight women. Age range: 25–35 years. 54 patients, 42 females; mean age: 30 years.	Cross-sectional study. Patient and therapist self-report: CA-SF–Patient Version, CA-SF–Clinician Version, WAI–Therapist Version, BSI, Patient's Estimate of Improvement.	Found a positive relationship between clinicians' alliance in personal therapy and their patients' rating of the outcome. There was also a negative association between clinicians' perceived helpfulness and how they rated their alliance with their own patients. There was a nonsignificant correlation between the duration of PT and alliance ratings of their PT with alliance ratings as therapists and patients.
Therapist effects on the therapeutic alliance				
Study	Objective	No. of research participants	Method	Results
Dunkle and Friedlander (1996)	Investigated the contribution of therapist experience and personal characteristics to the working alliance.	73 therapists, 39 females. 73 patients, 39 women. Age range: 18–52 years.	Cross-sectional study. Patient and therapist self-report: WAI, INTREX Introject Questionnaire, SPS.	The degree of self-directed hostility, perceived social support, and the level of intimacy in relationships was significantly associated with the bond component of the working alliance. Therapists' experiences were not predictive of patients' alliance ratings on the goal and task components of the alliance.

(*Continued*)

Table 1. (*Continued*).

Therapists' self-reported attitudes toward, use of and experiences with personal therapy				
Study	Objective	No. of research participants (gender and age)	Method	Results
Nissen-Lie et al. (2015)	Investigated which therapist characteristics are relevant for alliance building and development.	370 patients, 74.4% women. Age range: 18–65 years. 70 therapists.	Longitudinal study. Patient and therapist self-report: WAI, DPCCQ.	Therapist factors that predicted the working alliance were rated differently by therapists and patients. Therapist factors that influenced patient ratings were therapists' in-session anxiety and negative reactions to patients. Therapist factors that influenced therapists' ratings were their experience of flow.
Nissen-Lie et al. (2017)	Investigated the assumption that the therapist effect lies between the therapist's personal and professional functioning.	70 therapists. 370 patients, 74.4% women; age range: 18–65 years.	Longitudinal study. Patient and therapist self-report: DPCCQ, IIP-64, SCL-90-R.	Therapists who scored higher on professional self-doubt evoked more change in their patients if they also had a self-affiliative introject.
Atzil-Slonim et al. (2019)	Investigated therapists' empathic accuracy (EA) toward patients' changing emotions and EA's relation to treatment outcome.	93 patients, 56% women. Age range: 19–70 years. 62 therapists, 77% women.	Longitudinal study. Patient and therapist self-report: HSCL, Profile of Mood States.	Therapists' inaccurate assessment of their patients' positive emotions was associated with increased symptoms in the ensuing session. Therapists were more accurate for negative emotions than positive emotions.

Note. BDS = Behaviour Disturbance Scale. BLRI = Barrett-Lennard Relationship Inventory. CA-SF = Combined Alliance Short Form. BSI = Brief Symptom Inventory. CLF = Current Life Functioning scale. CORE-OM = Clinical Outcomes in Routine Evaluation– Outcome Measure. CSS = Current Symptoms Scale. CTS = Compass Tracking System. DMI = Defense Mechanism Inventory. EPI = Eysenck Personality Inventory. GAS = Global Assessment Scale. HAQ = Helping Alliance Questionnaire. HSCL = Hopkins Symptom Checklist–Short Form. ICL = Interpersonal Checklist. IIP = Inventory of Interpersonal Problems. IS = Impairment Score. ISBC = Inventory of Specific Behaviour Change. LSQ = Life Status Questionnaire. MMPI = Minnesota Multiphasic Personality Inventory. PCL = PTSD Checklist. SCL-90-R = Symptom Checklist-90 Revised. SPS = Social Provisions Scale. SW = Subjective Wellbeing. SWS = Subjective Wellbeing scale. TCS = Therapist Credibility Scale. TMAS = Taylor Manifest Anxiety Scale. TOQ = Therapist Orientation Questionnaire. TR-BD = Terminator-Remainer Behaviour Disturbance. TRVS = The Rokeach Value Survey. WAI = Working Alliance Inventory.

identified six goals of personal therapy and six mechanisms through which personal therapy improves clinical work. The goals for therapy identified by Norcross et al. (as cited in Geller et al., 2005) were 1) an improvement in the therapist's emotional and mental functioning, 2) a better understanding of the dynamics between therapist and patient, and their interpersonal relationship, 3) a reduction in emotional stress about work, 4) an important socializing experience, 5) an experience in the role as patient, and 6) an observation of clinical tools. The proposed mechanisms for enhanced clinical work by the therapist include 1) a less neurotic and more satisfying life by improving the therapist's emotional and mental functioning, 2) an enhanced perception regarding the conduct of treatment and a reduction in the potential for countertransference, 3) an increased sense of competence in handling main problems within the field, 4) greater persuasion about psychotherapy's healing effect and facilitation in the role as a healer, 5) increased alertness and respect for the patients' problems, and 6) an ability to model interpersonal and technical skills (Norcross et al., as cited in Geller et al., 2005).

Norcross and Connor (2005) also differentiated between personal and professional reasons in examining the research literature on psychotherapists' rationales for seeking personal therapy. However, they noted that these rationales are intertwined and that some therapists report both reasons. Nevertheless, Norcross and Connor (2005) claimed that, based on their findings, the main reason for seeking personal therapy was personal difficulties rather than professional motives. Surveys have documented that therapists pursue personal therapy to develop professionally and personally (Orlinsky et al., 2005), and this notion is supported by in-depth interviews (Wiseman & Shefler, 2001). A survey by Orlinsky et al. (2011) of 3,955 therapists, with a mean duration of clinical experience of 14.3 years, yielded that the main reasons for attending personal therapy were 1) enhancing professional development and relational skills and 2) improving one's personal development, skills, and wellbeing as a therapist. Psychotherapists who did not seek personal therapy reported the following reasons: economic concerns, concerns regarding confidentiality, fear of exposure, self-management, time limits and the efforts required to find a good psychotherapist outside of one's network (Norcross & Connor, 2005). Additionally, some therapists found other ways of coping than seeking personal therapy. Other surveys have reported similar results (Norcross et al., 2008; Orlinsky et al., 2011).

Orlinsky et al. (2005) reviewed the research on the benefits of personal therapy reported by therapists. The results from four surveys showed that between 73% and 97% experienced personal therapy as helpful or efficient (Buckley et al., 1981; Norcross et al., 1988; Patterson & Utesch, 1991; Pope & Tabachnick, 1994). Surveys by Liaboe, Guy, Wong, and Deahnert (as cited in Orlinsky et al., 2005) and Norcross, Dryden, and DeMichele (as cited in Orlinsky et al., 2005) showed that 90% of British and 95% of American psychologists were satisfied with their personal therapy. However, lower satisfaction rates among psychotherapists, ranging from 68% to 71%, have been found (Henry et al., 1971). Similar results were obtained by Mahoney (1997) regarding how satisfied therapists were with their personal therapy. One hundred and fifty-five psychotherapists completed a questionnaire anonymously that asked about their personal problems, self-care patterns, and attitudes to personal therapy. A total of 87.7% of respondents had attended personal therapy, and their average rating of personal therapy was positive. However, the response rate was only 48%. Thus, it is possible that those who answered had a positive predisposition toward personal

therapy. In general, surveys of psychotherapists in America and Europe have obtained similar findings, ranging from 72% to 90% (Orlinsky et al., 2005). Daw and Joseph (2007) used a semistructured questionnaire that was completed by 48 psychotherapists. Two-thirds of respondents attended personal therapy because of personal growth and personal problems. Other reasons included an opportunity for self-care, personal development, and experiential learning about being a patient.

In self-report studies, therapists also reported adverse events (Bellows, 2007; Pope & Tabachnick, 1994). In one study, Buckley et al. (1981) found that 21% of respondents experienced personal therapy as harmful, while Norcross et al. (1988) reported that 8% suffered some degree of harmful infliction from their personal therapy. Orlinsky et al. (2005) claimed that the proportion of psychotherapists who experienced personal therapy as harmful and not helpful is approximately 1% to 10%, but this proportion varies among studies, as illustrated above. Buckley et al. (1981) found that the practice of a psychotherapist dreaming about her therapist and considering the therapist to be the most important person in her life was correlated with adverse experiences in personal therapy.

When psychotherapists reported on what benefits they have derived from their personal therapy, Buckley et al. (1981) found that they experienced improvement regarding self-esteem, work function, social/sex life, character change, and symptom reduction. In other studies, psychotherapists reported advances in cognitive insight, reduction in behavioral symptoms, and emotional relief – as well as increased knowledge of the interpersonal bond and psychotherapy dynamics (Norcross et al., 1988). Additionally, therapists reported that personal therapy gave them an insight into how essential qualities such as warmth, empathy, transference, countertransference, patience, tolerance, and therapeutic subjectivity were part of psychotherapy (Norcross et al., 1988). Norcross et al. (2009) replicated a national survey of psychotherapists from 1987 (Norcross et al., 1988). Their results were similar to those previously mentioned regarding how many attended personal therapy, its usefulness, why therapists attend personal therapy, and adverse experiences.

The effect of personal therapy on psychotherapists' treatment of their own patients

The results from research on the effect of personal therapy on the treatment of therapists' own patients are ambiguous (Paulsen & Peel, 2013). In their review, Macran and Shapiro (1998) presented nine outcome studies on the effect of personal therapy on the treatment outcome of the therapist's patients. One study showed a negative relationship (Bergin & Lambert, 1971) and four showed no significant difference (Derner & Monroe, 1960; Katz et al., 1958; McNair et al., 1963; McNair et al., 1964). Similar results were found in two other studies by Holt and Luborsky (as cited in Macran & Shapiro, 1998) and Strupp, Fox, and Lessler (as cited in Macran & Shapiro, 1998). One study indicated that patients treated by therapists who had attended personal therapy had a lower probability of terminating their treatment earlier than patients who received therapy by therapists who had not received personal therapy (Greenspan & Kulish, 1985). Of the nine studies, only Kernberg's indicated a positive relationship (as cited in Macran & Shapiro, 1998). However, Kernberg did not control for the therapist's experience. One study indicated that personal therapy may impact client outcome (Gold et al., 2015). They found that the higher the clinician rated their

personal therapy alliance, the more the clinician's patient felt that her symptoms had improved.

Macran and Shapiro (1998) argued that results are inconsistent regarding what type of influence personal therapy has on the treatment of psychotherapists' own patients. The authors suggested that personal therapy could enhance therapist characteristics such as warmth, genuineness, and empathy, which are associated with treatment outcome. Peebles (1980) tested the hypothesis that the number of hours of personal therapy would be positively correlated with psychotherapists' ability to display genuineness, empathy and warmth during the therapy session. The results were significant for empathy and genuineness. However, only therapists were asked. Furthermore, no studies indicated that personal therapy has a direct effect on the treatment outcome of patients (Paulsen & Peel, 2013; Bennett-Levy, 2019; Norcross & VandenBos, 2018). Wigg et al. (2011) developed a theory of reflective practice whereby they tried to explain the parallax between therapist development from personal therapy, as conveyed through qualitative research, and the lack of evidence of a direct effect. Bennett-Levy and Finlay-Jones (2018) appear to have developed this framework further when they created the PP model. The model asserts that PP influences four therapeutic domains: personal development and wellbeing, self-awareness, interpersonal beliefs/attitudes/skills, and reflective skills, as well as self-reflection. Therapists that reflect upon how PP influences their therapist self positively impact conceptual and technical skills relevant to psychotherapy (Bennett-Levy & Finlay-Jones, 2018). Bennett-Levy (2019) compared the PP model to conventional training methods and how the reflective component may unite the personal self and therapist self, thus increasing therapist effectiveness. Such theorization is important when outcome studies of personal therapy have suffered from small samples, lack of experimental controls, lack of randomization, and prospective designs (Norcross & VandenBos, 2018). As shown in Table 1, most outcome studies are cross-sectional, have small sample sizes and are conducted with students/postgraduates. These characteristics limit the generalizability of the findings.

Therapist qualities associated with treatment outcome

It is of interest to know why therapists who often achieve good results with one patient can achieve similar results with other patients (Luborsky et al., 1997; Wampold, 2017; Barkham et al., 2017; Norcross & Lambert, 2018). Lambert (1989) found that therapists conducting the same treatment obtain different results. Therefore, it is possible that treatment outcome is influenced more by therapist characteristics than treatment method and theoretical orientation. It is estimated that the therapist effect contributed to approximately 3% to 5% of the variability in patient outcomes (Baldwin & Imel, 2013; Johns et al., 2019), although these values have varied in other studies from 1% to 12%. For example, Wampold and Brown (2005) estimated the variability of the therapist effect in a large clinical sample. They found that the variability of the therapist accounted for 5% of the treatment outcome. Lutz et al. (2007) explored the therapist effect on patient symptom intensity in a large naturalistic data set. Their results implied that almost 8% of the total variability in patient outcome could be accounted for by the therapist. Dinger et al. (2008) investigated therapist variability in a large inpatient psychotherapy sample. Their findings indicated that the therapist effect is greater on alliance than on treatment outcome. The authors estimated that

the therapist effect accounted for 3% of the variability in patient outcomes. Saxon and Barkham (2012) examined the therapist effect using a large practice-based data set. They found that when they modeled for therapist risk caseload, they obtained a therapist effect of 6.6% for the average patient. Laska et al. (2013) studied the therapist effect in the treatment of posttraumatic stress disorder using Cognitive Process Therapy. Their results indicated that the variability of the therapist accounted for approximately 12% of the treatment outcome.

Several characteristics have been outlined as necessary for treatment outcome. Lafferty et al. (1989) showed that patients who reported their therapist as being understanding benefited more from treatment. The authors linked the understanding of the patient to the therapist's empathic ability. Several meta-analyses and reviews have stressed the importance of empathy (Elliott et al., 2018) and related qualities, including positive regard (Farber et al., 2018), interpersonal skills (Wampold, 2017), genuineness (Kolden et al., 2018), and feedback (Norcross, 2002; Lambert et al., 2018). The meta-analyses (Elliott et al., 2018; Kolden et al., 2018; Farber et al., 2018; Tryon et al., 2018) discussed below consist mainly of cross-sectional studies. This is an important shortcoming, since psychotherapy is an ongoing process that requires repeated measures. Wampold (2011), reviewing research evidence, highlighted 14 qualities and actions that characterize effective therapists; however, he stated that it was premature to draw definitive conclusions (Wampold, 2014). Nevertheless, in a recent review, Wampold (2017) suggested that effective therapists were better at forming an alliance, delivering a cogent treatment, having facilitative interpersonal skills, and professional self-doubt, and having a deliberate practice. Equally important are therapist qualities that harm treatment outcomes. Research indicates that therapists who are rigid, insecure, critical, distant, tense, and distracted have adverse treatment outcomes (Ackerman & Hilsenroth, 2003). Techniques associated with adverse outcomes include overstructured therapy, unfitting self-disclosure, inflexible interpretation of transference, and inappropriate use of silence (Ackerman & Hilsenroth, 2003). Effective therapists were aware of negative reactions toward patients, and it appears they did not display these feelings toward the patient as much as other therapists (Wolf et al., 2017).

Recent meta-analyses have related empathy (Elliott et al., 2018), congruence/genuineness (Kolden et al., 2018), positive regard (Farber et al., 2018), and goal consensus and collaboration (Tryon et al., 2018) to treatment outcome. Other therapist characteristics that may influence treatment outcome**s** were self-disclosure and immediacy (Hill et al., 2018), countertransference management (Hayes et al., 2018), and therapist and client emotional expression (Peluso & Freund, 2018). Kolden et al. (2018) claimed that genuineness entails the therapist's self-awareness in therapy and her ability to communicate her experience of the patient to the patient. The concept includes transparency and authenticity and their relationship with the therapist's ability to convey inner experiences to the patient. These elements may warrant further study. Genuineness, such as empathy, may include something different than the construct used by Kolden et al. (2018). There are indications that empathy is a moderately strong predictor of outcome (Elliott et al., 2018). There is no single, agreed-upon definition of empathy.

The conceptualization of positive regard has varied in psychotherapy research. However, the consensus is that positive regard refers to the therapist's ability to support the patient (Farber et al., 2018). The definition of positive regard includes elements of respect,

validation, nonpossessive warmth, affirmation, prizing, and support (Farber et al., 2018). A recent meta-analysis indicated a small positive association between positive regard and treatment outcome (Farber et al., 2018). After attending personal therapy, psychotherapists report an increased understanding of the role of relevant warmth in therapy, as well as the ability to show warmth (Bike et al., 2009; Macran & Shapiro, 1998; Malikiosi-Loizos, 2013; Norcross et al., 1988).

Another recent meta-analysis suggested that goal consensus and collaboration between therapist and patient are associated with enhanced treatment outcomes (Tryon et al., 2018). Goal consensus refers to the contract between the therapist and the patient that outlines their work together. Agreement between them is essential. Tryon et al. (2018) defined goal consensus as patient-therapist agreement and commitment about the goal(s) and the method for achieving them, agreement about the patient's problem and to what degree goals are discussed and clearly addressed. Collaboration is defined as the reciprocal involvement of therapist and patient in a helpful relationship (Tryon et al., 2018). There was a moderate association between goal consensus and collaboration and treatment outcome (Tryon et al., 2018). However, research weaknesses included the use of cross-sectional designs (Tryon et al., 2018).

The alliance and treatment outcome

The therapeutic alliance refers to the relationship between therapist and patient, how they cooperate relative to therapeutic goals and tasks, as well as the bond between them (Del Re et al., 2012). A meta-analysis by Flückiger et al. (2018) found a moderate relationship between the alliance and treatment outcome. Moreover, a meta-analysis of alliance rupture repair indicated a moderate correlation between rupture resolution and treatment outcomes (Eubanks et al., 2018). Since alliance is associated with successful treatment, it is of interest to know which therapist quality influences it.

Dunkle and Friedlander (1996) suggested that therapists bring into therapy their earlier interpersonal relationships, which can influence their ability to build a therapeutic alliance. Research indicated that therapists' adverse reactions toward patients and their anxiety in the therapy session affect the patients' rating of the alliance in a negative direction but not the therapists' ratings (Nissen-Lie et al., 2015). Nissen-Lie et al. (2015) found that lack of empathy and tolerance for patients' emotional needs, as well as irritability toward the patient, were associated with patients' unfavorable ratings of the therapeutic alliance. On the other hand, therapists described as warm, empathic, interested, credible, confident, open, and honest received higher alliance scores. Atzil-Slonim et al. (2019) claimed that therapists' empathic accuracy is important for facilitating patients' emotional wellbeing. Their study used patients' self-reports of their symptoms prior to and after each session, as well as therapists' rating of their own emotions and their assessment of the patients' emotions. They found a positive association between the therapists' inaccurate judgment of the patients' positive emotions and increased symptoms in the ensuing session. Nissen-Lie et al. (2017), using therapists' self-reports of their personal and professional selves and relating them to patient outcomes, found a positive association between therapists' self-doubt and self-affiliation and treatment outcome.

Discussion

The purpose of the present study was to explore the theoretical and empirical literature on personal therapy and effective therapists and to discuss whether personal therapy may promote beneficial qualities for therapists. Norcross (2005) and Norcross and VandenBos (2018) argued that personal therapy is the cornerstone of the therapist's training, health, self-renewal, and identity. The first research question concerned psychotherapists' rationale to pursue personal therapy. Self-report studies indicated that the majority of psychotherapists have attended or attend personal therapy and experience benefits, both professionally and personally. The majority reported personal therapy as being useful. Psychotherapists also reported the experience of becoming a better therapist. Personal therapy enhances alliance building qualities, such as genuineness and empathy, which are associated with therapist effects (Bike et al., 2009; Macran & Shapiro, 1998; Malikiosi-Loizos, 2013; Orlinsky et al., 2011; Pope & Tabachnick, 1994; Rizq & Target, 2008; Wiseman & Shefler, 2001). Psychotherapists' subjective experiences appear to be associated with a belief in increased therapeutic competence. This competence may be related to the characteristics of effective therapists. Anderson et al. (2009) claimed that therapists' ability to handle demanding interpersonal encounters in therapy differs across therapists. It may be that the therapist's ability to form an alliance is affected by earlier interpersonal relationships, which could be related to negative personal reactions that cause alliances to deteriorate (Nissen-Lie et al., 2015). We believe that these interpersonal aspects could be related to alliance building abilities and countertransference management (Hayes et al., 2018).

The second research question involved the effect of personal therapy on treatment outcome. According to Rønnestad et al. (2016), there is almost no objective evidence that psychotherapists' personal therapy has a causal effect on treatment outcome or therapeutic skills, which is in line with the present study's findings. The claim that personal therapy makes therapists more effective is tenuous. There is a strong appreciation for personal therapy among psychotherapists, but outcome studies are inconclusive. Most studies suggest that there is no direct link. Bennett-Levy (2019) concluded that there are no studies demonstrating the impact on client outcomes in a satisfactory way.

The third research question concerned the possibility of personal therapy's influence on therapist characteristics associated with good treatment outcomes. The common factors explain a significant amount of treatment outcome (Wampold, 2015), and all are related to therapist characteristics: empathy, congruence/genuineness, positive regard, goal consensus and collaboration, and the alliance. Self-awareness probably plays an important role in influencing these therapist qualities, but to what degree is uncertain. Nevertheless, since the therapist is a central element of the treatment process, any activity that enhances self-awareness of the therapeutic process is valuable. It appears unlikely that undergoing personal therapy by itself will make therapists better therapists. It is well known that therapy rests on both general and specific factors (Tilden, 2013). Thus, if therapists possess all of the common factors but perform therapy in the wrong manner, s/he will more than likely have a poor treatment outcome (Wampold, 2009). It appears that the therapist's self-awareness of how empathy, positive regard, genuineness, the alliance, and goal consensus and collaboration impact treatment outcome is essential to therapist development. For how can one know others without an understanding of one's self (Fromm, 1992)? According to

Bennett-Levy (2019), PPs have a natural place in therapist training and professional development – but what type of PP, for whom and under what conditions? It is also important to remember that 1% to 10% of therapists experienced adverse effects of personal therapy. Could it be that these experiences correlate with negative therapist characteristics, such as being rigid, being insecure, and engaging in unfitting disclosure to the patient (Ackerman & Hilsenroth, 2003) or employing inflexible techniques (Ackerman & Hilsenroth, 2003)? Hence, personal therapy is not exclusively positive. To date, no studies have found a causal connection between personal therapy and increased therapist effectiveness. However, there is an association between therapists' experience of attending personal therapy and becoming a better therapist.

The fourth research question examined the convergence between studies on personal therapy and therapist effects. Research on how personal therapy influences therapist development or treatment outcome is sparse. The qualitative material is vast, while the quantitative data are few (Bennett-Levy, 2019). The correspondence noted has not been exposed to a strong enough research design. There is a knowledge gap between experienced self-benefits from personal therapy and quantitative studies not showing a causal link (personal therapy does not seem to increase therapist effectiveness or make therapists better therapists). The PP model can be used to interpret how PP is valuable for therapist development, even though the evidence is insubstantial. Commonsensically, more experience with PP should increase therapists' knowledge about themselves as therapists and persons. The logic of the PP model is that such knowledge, self-reflection, and practice lead to increased therapist effectiveness. Self-report studies of therapists benefit from personal therapy and studies on the therapist effect imply that they share commonalities. The reported benefits obtained are similar to the therapist effects described above. Thus, there may be an indirect association between therapist development and personal therapy, leading to enhanced therapist effects (e.g. enhanced ability to show empathy).

The majority of psychotherapists emphasize the importance of personal therapy in relation to therapist development. The therapist development mentioned in qualitative research appears related to self-knowledge, which is valued in the APA policy statement about evidence-based research (American Psychological Association, 2006).

Limitations and future research

Most of the research evidence in the present study comes from qualitative designs, which weakens decisive conclusions. Furthermore, the quantitative studies had methodological weaknesses, such as low sample sizes, inadequate controls, and were often conducted in university settings, which limits their generalizability. The studies reviewed in this study are mainly cross-sectional, which prevents causal conclusions.

Moreover, most studies were based on self-reports. However, self-reports may be influenced by self-serving bias. Self-serving bias refers to any cognitive or perceptual process that is distorted by the need to maintain and enhance self-esteem (Myers, 2015). It is possible that research participants who reply wish to maintain their self-esteem and therefore rate personal therapy as more influential than it actually is. Orlinsky et al. (2005) stated that some studies have controlled for cognitive dissonance regarding what psychotherapists experience as positive from personal therapy. However, as Orlinsky et al. (2005)

did not refer to specific studies, we cannot elaborate on their findings. It is also possible that the self-reported benefits of having been to personal therapy are influenced by motivated reasoning (Kunda, 1990). Motivated reasoning considers how motivation, desires, or wishes may affect reasoning. Another cognitive bias that may influence self-reported benefits is the confirmation bias (Plous, 1993), which is the tendency for individuals to search for information that confirms their hypotheses. It may be possible that psychotherapists who pay for personal therapy or attend mandatory personal therapy experience the therapy as more useful than it is.

In terms of therapist development from personal therapy, better definitions are needed, and a consensus on the operationalization of the findings is also necessary. For example, is "self-awareness" understood the same way across studies? How is increased therapist self-knowledge from personal therapy revealed in-session in the treatment of the therapist's own patients? This is a complex question. One possible way of studying self-knowledge is to relate it to other concepts, for example empathy, and measure empathy before and after receiving personal therapy or another PP.

Research using more rigorous designs is required. Ideally, a large number of therapists would be randomly assigned to personal therapy or a control group, and the effects of personal therapy on therapist development in different areas (e.g. empathy, alliance) and on treatment outcome would be measured by self-report and patient ratings. As the changes studied occur over time, a longitudinal research design is recommended.

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