Therapeutic Alliance in the Personal Therapy of Graduate Clinicians: Relationship to the Alliance and Outcomes of Their Patients

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This is the first study to explore the relationship between aspects of a therapists’ personal therapy and the subsequent psychotherapy process and outcome they perform. The participants were 14 graduate clinicians with various experiences in personal therapy, who treated 54 outpatients engaged in short-term psychodynamic psychotherapy at a university-based community clinic. Results demonstrated non-significant relationships between the duration of personal therapy as well as a graduate clinician’s overall alliance in their personal therapy with alliance ratings made by themselves as therapists and their patients, as well as the number of psychotherapy sessions attended by patients. However, the clinician’s personal therapy alliance was significant and positively related to their patients’ rating of outcome. Additionally, a significant negative correlation was observed between the degree of perceived helpfulness in their personal therapy and how these clinicians rated alliances, as the therapist, with their patients. The current findings suggest a relationship between a clinician’s personal therapy alliance and the outcome of treatments they conduct. Implications for clinical training and practice as well as future research are discussed. Copyright © 2014 John Wiley & Sons, Ltd.

Key Practitioner Message:
- While graduate clinician’s personal therapy alliance was not significantly related to their patients’ ratings of alliance, it was related to their patients’ ratings of outcome.
- Trainee satisfaction with or quality of their personal therapy may be a more relevant than the amount or duration of their treatment in regard to the process and outcomes of their patients.
- The findings from retrospective clinician surveys on the helpfulness of their personal therapy may not be entirely consistent with empirical examination of these issues.
- The relation of personal therapy and outcome may work through improving the therapist’s level of adaptive functioning (i.e., psychological-relational-emotional health) and future research should examine this simpler, more parsimonious, explanation for our findings.

Keywords: Personal Therapy, Graduate Trainees, Therapeutic Alliance, Outcome

The idea of personal therapy as a part of training for psychotherapists begins with Freud (1958, 1964) in his Recommendations to Physicians Practicing Psycho-Analysis (1958). There, Freud proposed that the analyst should not only engage in a self-analysis but also that, ‘everyone who wishes to carry out analysis on other people shall first himself undergo an analysis by someone with expert knowledge’ (p. 116–117). According to Freud, the results would be undoubtedly positive: ‘impressions and convictions will be gained in relation to oneself which will be sought in vain from studying books and attending lectures’ (Freud, 1958).

Similar statements have been made since. In response to the notion that other activities besides personal therapy may be sufficient to prepare the therapist for practice, Wampler and Strupp (1976) suggested that personal therapy is the superior option: ‘nor can sensitivity training, encounter groups, or similar experiences be regarded as meeting the student’s need for adequately exploring his personal history and difficulties in living that may impede his optimal functioning as a psychotherapist’ (p. 200). McWilliams (1994) follows the same track when stating: ‘a textbook cannot substitute for a depth of personal insight. Nor can it provide the profound and contagious conviction about the efficacy of treatment that personal training can’.
that compared with therapists who had not been in personal therapy, therapists who had received personal therapy provided interventions to patients that were more consistent with the optimal recommendations found in the literature for the therapeutic situations presented. In a second related process study, Strupp (1973) found that experienced therapists who had not undergone personal therapy had more than three times the number of negative empathy ratings from external raters as compared with those who had undergone personal therapy. An additional analysis showed that therapists who had undergone personal therapy showed a greater ability to empathize, regardless of their attitude towards the patient. However, among therapists at the lower experience levels, there was no difference between therapists with or without personal therapy in terms of empathy ratings.

In a study of advanced graduate clinicians, Garfield and Bergin (1971) found that trainees who had personal therapy facilitated equivalent or less change in their patients than trainees who had not received personal therapy. Although no tests of significance were carried out, the descriptive data showed that patients of graduate trainees who had no personal therapy had the greatest decreases in depression and the most increases in coping resources. The study also showed that patients of graduate clinicians with moderate levels of individual therapy had positive changes, and patients of graduate trainees with more than 4 years of personal therapy remained relatively unchanged on depression. The authors also analysed what effects the clinician’s degree of psychiatric problems has on patient outcomes. Not surprisingly, they found that less disturbed clinicians effected greater positive changes in their patients. It is reasonable to believe that trainees reporting greater problems would have had more therapy and thus account for the finding that more personal therapy leads to poorer outcomes. However, no differences in amount of therapy received by the more and less disturbed trainees where found in the study. These results suggest that less disturbed trainees, not necessarily personal therapy, lead to better outcomes. Also of note, Schauenburg and colleagues found that when working with the most severely impaired patients in their sample, higher attachment security of the therapist was associated with both better alliance and outcome (Schauenburg et al., 2010).

Further examination of the length of personal psychotherapy by Sandell and colleagues found a curvilinear relationship between the length of a therapist’s personal therapy and their patient’s improvement (Sandell et al., 2006). Their results showed that patients of therapists with very long psychoanalyses (equal or greater than 13 years) showed the least improvement in treatment and even had non-significant trend towards greater levels of patient deterioration. Related, it was a graduate trainees’ satisfaction with, but not the length of, personal therapy that was
found to have a moderating effect on changes in a graduate trainee’s sense of affiliation or self-efficacy (Taubner et al., 2013). Furthermore, these positive changes in affiliation were significantly related to increases in trainee self-efficacy only if they expressed high levels of satisfaction with their personal therapy. This interaction effect was not found to be significant for trainees who described their personal therapy as fairly, somewhat, little or not at all satisfying.

Recently, Gold and Hilsenroth (2009) examined the impact of graduate therapists’ personal therapy on the therapeutic alliance early in treatment. In each of the two groups of trainees, with and without personal therapy, 30 outpatients were treated with psychodynamic therapy, once or twice per week. These groups of patients were matched on key demographic, diagnostic and psychiatric severity data. No significant difference was found between the personal therapy group and the group of clinicians who had not undergone therapy in regard to how their patients rated the therapeutic alliance. However, results demonstrated a significant effect on several therapist-rated alliance variables, with higher scores on overall alliance, therapist confidence, as well as goal and task agreement, from therapists who had received personal therapy. There was also a significant difference in the number of therapy sessions attended by patients, with the treatments of those therapists who had received personal therapy being twice as long as compared with therapists who did not attend personal therapy.

The aim of the current study is to extend previous work and explore what aspects of graduate clinicians’ personal therapy are related to psychotherapy process in the therapy they perform. In fact, this is the very first empirical examination of clinician ratings of therapeutic alliance from their personal therapy, as well as the relationship between those scores with standardized measures of patient process and outcome. Our hypothesis is that higher clinician ratings on alliance in their personal therapy will be related to higher patient and therapist alliance ratings in their treatments as a therapist. We also anticipate a positive relationship between clinician ratings on alliance in their personal therapy with the number of psychotherapy sessions attended by their patients. A second focus of this study is to investigate whether aspects of graduate clinicians’ personal therapy are related to psychotherapy outcomes in the treatment with their patients. We hypothesize that greater alliance ratings made by clinicians regarding their personal therapy will be related to greater amounts of change in terms of broad band multi-dimensional functioning and global psychiatric symptoms in patient outcomes across treatment. Third, on the basis of previous findings discussed above, we also aim to examine the effects of the helpfulness and duration of clinicians’ personal therapy on their patients’ therapy outcome.

METHOD

Participants

Graduate Clinicians

The graduate clinicians participating in this study were advanced doctoral students enrolled in an American Psychological Association-accredited Clinical Ph.D. programme who had taken part in a 1-year clinical research practicum, over a consecutive 6-year period. Fourteen of the 16 eligible graduate clinicians agreed to participate in the study and provided informed consent. Although personal therapy is not a programme requirement, all 14 of these clinicians had personal therapy. Of these 14 therapists, eight were female and six were male. None of the therapists was from a racial/ethnic minority group. All therapists in this study were in their 2nd or 3rd year of graduate work, generally between their middle 20’s to middle 30’s in age and had completed foundation courses in descriptive psychopathology, psychological assessment, personality theory and principles of psychotherapy when they began their training in Short-term Psychodynamic Psychotherapy (STPP). Each had on average only 1 year of previous supervised psychotherapy experience prior to her/his involvement in the STPP training and treatment programme. However, all students had thoroughly reviewed the primary training texts (Book, 1998; Luborsky, 1984; McCullough et al., 2003; Strupp & Binder, 1984) prior to beginning any clinical work on the STPP clinical research practicum (Hilsenroth, 2007). These graduate clinicians conducted both the psychological assessment (i.e., diagnostic interview, psychological testing and feedback) and psychotherapy for each of their patients in the study. (For a more detailed description of this training process, see Hilsenroth et al., 2006.)

With regard to the personal therapy for the 14 clinicians in the study, at the end of the year-long clinical research practicum, they had completed on average almost 2.5 years (number months of psychotherapy: \( M = 28.8, \text{Mdn} = 24, \text{standard deviation [SD]} = 25.1 \)) and 160 sessions (number sessions: \( M = 160.6, \text{Mdn} = 114, \text{SD} = 145.7 \)) of treatment. Eleven clinicians had been involved in personal therapy prior to beginning this clinical research practicum; three clinicians had only begun to receive therapy once they had started. Thirteen graduate clinicians were in personal therapy during the clinical research practicum. One clinician had completed therapy immediately prior to, none during, the clinical research practicum. During the clinical research practicum, one clinician had no sessions, five clinicians met more than once per week and eight clinicians were in therapy once per week. In their most recent or current personal treatment, 12 clinicians identified their treatment as insight oriented, one as integrative and one as cognitive–behavioural. Additionally, eight graduate clinicians
had been in a previous treatment, with two having had two previous treatments. In these prior personal therapies, five of these treatments were identified as insight oriented, four as cognitive–behavioural and one as integrative.

After the completion of this year-long clinical research practicum, all graduate trainees were asked to rate overall how helpful their current or most recent personal therapy was in their treatment of patients during the clinical research practicum on a 1 (not at all helpful) to 7-point (extremely helpful) Likert scale, with the midpoint of 4 labelled as moderately helpful. On average, these graduate clinicians believed that their personal therapy was slightly better than moderately helpful in their work with patients ($M = 4.6, SD = 1.0$).

**Patients**

These 14 graduate clinicians treated 54 individuals seeking outpatient treatment at a university-based community clinic. All cases were assigned to treatment practice and clinicians in an ecologically valid manner based on real-world issues regarding aspects of clinician availability, case load etc. Moreover, patients were accepted into treatment regardless of disorder or co-morbidity. All patients included provided informed consent.

Table 1 displays demographic and clinical information as well as the distribution of Axes I and II diagnoses for total sample in accordance with the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). Demographically, the total sample was 78% female, had an average age of 30 years, 74% were single, 10% were married and 7% were separated or divorced. Overall, these patients were pre-dominantly suffering from DSM-IV Axis I mood disorders (44%) often with co-morbid Axis II personality disorder diagnoses (65%) or clinically relevant Axis II traits/features (20%). An examination of both clinician rated (Global Assessment of Functioning = 59.3) and patient self-report (Global Severity Index of the Brief Symptom Inventory [BSI-GSI] $T$ score = 65) of psychopathology revealed a mild-to-moderate range of severity. The patient sample was pre-dominantly (≥90%) White.

**Measures**

**Combined Alliance Short Form–Patient Version**

The Combined Alliance Short Form–Patient Version (CASF-P; Hatcher & Barends, 1996) is a patient-rated alliance measure created from a factor analysis of the responses of 231 outpatients at a university-based community clinic from three widely used measures of alliance: (a) the Penn Helping Alliance Questionnaire (Alexander & Luborsky, 1986; Luborsky et al., 1983); (b) the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989); and (c) the California Psychotherapy Alliance Scales (Gaston, 1991). The CASF-P consists of 20 items rated on a 7-point Likert-type scale consisting of 1 (never), 2 (rarely), 3 (occasionally), 4 (sometimes), 5 (often), 6 (very often) and 7 (always). For the current sample, coefficient alpha was 88, and the mean CASF-P rating was 6.2 (SD = 0.59).

**Combined Alliance Short Form–Clinician Personal Therapy**

The CASF-Clinician Personal Therapy (CASF-CLIN) version is an adaptation of the CASF-P (Hatcher & Barends, 1996), to measure the graduate clinician’s alliance in his or her personal therapy. The questions and statements on this measure are the exact same as those on the CASF-P, except the instructions were modified directing the graduate clinician to retrospectively rate the nature of their alliance in their personal therapy during the period when she or he was a member of the clinical research practicum (13 graduate clinicians were in personal therapy during the clinical research practicum). And for the one graduate clinician whose personal therapy ended immediately before this period, the nature of the alliance in their personal therapy completed immediately prior to beginning the clinical research practicum. For the current sample, the mean CASF-CLIN rating was 5.1 (SD = 0.8).
Working Alliance Inventory—Therapist Version

The WAI-Form T (WAI-T; Horvath & Greenberg, 1986, 1989) is a therapist-rated alliance measure. The total scale score for the WAI-T used in this study was derived from a recent psychometric adaptation (Hatcher, 1999) using responses from two samples. The first was a national sample consisting of practicing therapists’ ratings on one patient from their current practice (n = 251). The second was a clinical sample consisting of 63 therapists who completed ratings on 259 different patients. Previous research has found alphas ranging from 75 to 86 (Hatcher, 1999) and examining a subset of the current participants’ coefficients alphas range from 74 to 91 (Clemence et al., 2005). Ratings on the WAI-T are reported on the same 7-point scale as described for the CASF-P, ranging from 1 (never) to 7 (always). For the current sample coefficient alpha was 72, and the mean WAI-T rating was 5.7 (SD = 0.45).

Brief Symptom Inventory (Derogatis, 1993)

The BSI is a 53-item self-report inventory that assesses symptom distress in a number of different domains/problems areas using a Likert scale of 0 (not at all) to 4 (extremely). The psychometric properties, reliability and validity of this measure, specific symptom subscale scores, as well as a summary score, the Global Severity Index (GSI), are provided in the manual (Derogatis, 1993). The mean GSI for a normal population (n = 719 non-patients) is 30 (SD = 0.31), and test–retest reliability utilizing an outpatient sample is 90. Coefficient alphas for BSI subscales range from 71 to 85, overall 80. The mean pre-treatment BSI-GSI-T score for the current sample was 65 (SD = 7.3).

Patient’s Estimate of Improvement (Hatcher & Barends, 1996)

The Patient’s Estimate of Improvement (PEI) is 16-item questionnaire assessing improvement during psychotherapy across a broad range of patient functioning (i.e., beyond only symptomatic change). This measure is modelled after items developed by Alexander and Luborsky (1986) to assess the degree of the patient’s change that was due to psychotherapy. Questions assess change in one’s general functioning, symptom distress, intimate and social relationships, work or school, feelings about oneself, behaviour, control of life, tolerance for and ability to share painful feelings, as well as the helpfulness, benefit, productivity and satisfaction with psychotherapy. Fourteen of these items were rated on a 9-point bipolar scale ranging from 1 (very much worse), 5 (no change) to 9 (very much better); one item (‘to what extent have your original complaints or symptoms improved?’) was rated on a 7-point scale ranging from 1 (not at all) to 7 (very much), and one free response item regarding treatment (not analysed here) with higher ratings indicative of better functioning. The PEI was administered to patients at post-treatment (coefficient alpha = 0.92), and the average rating on this measure was 104.7 (SD = 14; possible range 15.00–133.00).

Procedure

Therapeutic Model of Assessment

All clinicians received a minimum of 3.5 h of supervision per week (1.5 h of individual and 2—h of group) on the Therapeutic Model of Assessment (TMA; see Hilsenroth, 2007), clinical interventions, the organization of collaborative feedback, psychodynamic theory, group discussion and a review of videotaped case material. All clinicians were trained in psychodynamic psychotherapy using guidelines delineated by Book (1998), Luborsky (1984), McCullough et al. (2003), Strupp and Binder (1984) and Wachtel (1993), as well as selected readings on psychological assessment, psychodynamic theory and psychodynamic psychotherapy. All patients received a psychological evaluation from a TMA that includes a collaborative and broadened focus of attention beyond the scope of basic information gathering assessment. The evaluation method of the TMA used in this study consisted of four steps including three meetings between the clinician and patient and one patient appointment to complete a battery of self-report measures. The three meetings included the following: (a) a semi-structured diagnostic interview; (b) interview follow-up; and (c) a collaborative feedback session.

Semi-structured diagnostic interview. Each participant in the TMA completed a semi-structured clinical interview lasting approximately 1.5–2 h. The diagnostic interview focused on salient therapeutic topics such as presenting complaints, past psychiatric history and past medical history, as well as family, developmental, social, educational, vocational history and an assessment of DSM-IV symptom criteria. The interview included collaboration, alliance building, exploration of factors contributing to the maintenance of life problems (often relational) and potential solutions to these problems. Furthermore, there was an emphasis on the factors that contributed to the clinician–patient interaction during the assessment process. An additional goal of this initial interview was to gather relevant information to facilitate the diagnosis of a DSM-IV disorder. The desired outcomes of this initial meeting was for the clinician to develop empathic connections with the clients’, ‘work collaboratively with clients to define individualized assessment goals’ (Finn & Tonsager, 1997, p. 379; Fischer, 1994), as well as identify an initial Core Confictual Relational Theme (CCRT; Book, 1998; Luborsky, 1984; Luborsky & Crits-Christoph, 1997). The CCRT is one manner in which to formulate an interpretation, and it is presented as a statement that contains three key components: a statement of the patient’s wish (W), an expected (imagined) or actual response from another (RO) and a subsequent response
from self (RS) (Book, 1998; Luborsky, 1984; Luborsky & Crits-Christoph, 1997). The development of an initial CCRT at this time in the therapeutic assessment is designed to help build rapport by demonstrating to the patient that the clinician has been attentively listening for key relational concerns throughout the diagnostic interview. In addition, the initial CCRT helps the clinician, and patient begins to develop a relational focus for the present and future therapeutic work.

**Interview follow-up.** Prior to the start of the follow-up session, the clinician had scored the self-report measures, and he or she used the interview follow-up to inquire about any deleted, missed or critical items from these measures. In the initial part of this meeting, the clinician spent approximately 30 min responding to any acute stressors that may have developed since the last meeting, building rapport, reviewing the goals formulated in the first interview and clarifying any symptom information that was lacking or missing from the semi-structured diagnostic interview.

**Collaborative Feedback Session**

Each collaborative feedback session was guided by the principles of a TMA (Finn & Tonsager, 1997; Fischer, 1994) that include collaboration, alliance building, exploration of factors contributing to the maintenance of life problems (often relational) and potential solutions. Additionally, during the feedback session, there is an emphasis on the factors that contribute to the clinician–patient interaction. The goal of the collaborative feedback session is to provide the patient with a new example of thinking and feeling about self and others. In addition, the patient is given the opportunity to explore this new understanding and apply this to his or her current problems in living.

It is recommended in a TMA ‘clients should first be given feedback that closely matches their own preconceptions and then be presented with information that is progressively more discrepant from their self-concepts’ (Finn & Tonsager, 1997, p. 380; Fischer, 1994). Additionally, in a TMA psychological test, measures are viewed as ‘opportunities for dialogue between assessors and clients about clients’ characteristic ways of responding to usual problem situations and tools for enhancing assessors’ empathy about clients’ subjective experience’ (Finn & Tonsager, 1997, p. 378; Fischer, 1994). This viewpoint facilitates an empathic connection between the clinician and patient and will help the clinician work collaboratively with the patient while continuing to cultivate the therapeutic alliance.

In the present study, the patient was initially given feedback related to his or her presenting complaints and symptoms (ego–syntonic). Next, the clinician and patient engaged in an exploration of prominent inter/intrapersonal themes from the testing results. Specifically, the predominant relational themes were explored to foster the development of the patient’s initial CCRT interpretation during the feedback session prior to treatment (see also Malan, 1979). The exploration of the CCRT may help the clinician focus on collaboration, alliance building, examination of factors contributing to the maintenance of life problems (often relational) and potential solutions. During this exploration, the clinician often expands the patient’s understanding of relational themes. The use of relational data in this manner may increase the patient’s self-understanding and contribute to the patient feeling even more understood by the clinician.

At this time, the patient and clinician reviewed a Socialization Interview (SI) developed by Luborsky (1984). The SI reviews what to expect in psychodynamic psychotherapy and outlines the patient’s and clinician’s role during formal treatment. More specifically, it emphasizes that the clinician will try to understand the patient and work collaboratively towards actualizing treatment goals. The SI also reviews with the patient that he or she may become aware of issues that were not known before the start of psychotherapy and outlines potential outcomes (both positive and negative) of this new insight (Luborsky, 1984). The presentation of the SI at this time enhanced the patient’s understanding of psychotherapy and highlights the relational focus of the therapeutic process. Finally, the clinician and patient worked together to develop treatment goals and frame (i.e., scheduling session times, frequency of treatment session(s) and payment plan).

**Data Collection**

Patients who consented were given the CASF-P to complete after the collaborative feedback session and were informed both verbally and in writing on these forms that their therapist would not have access to their responses. After the collaborative feedback session, therapists of consenting patients were also asked to independently complete the WAI-T. Thus, each member of the patient–therapist dyad completed these alliance questionnaires immediately after the collaborative feedback session. Eight of the 54 patients completing the TMA process were seen only for this psychological assessment consultation and were referred to treatment outside of this clinic research practicum. Forty-six of these patients began individual psychotherapy with the graduate clinician with whom they had just completed the TMA. The average number of individual psychotherapy sessions completed by this group was 25.5 (SD = 18), and 8 (17%) of these patients prematurely withdrew from therapy leaving data from 38 completed treatments available for outcome analyses. The BSI was given to patients both pre-treatment (prior to the first meeting) and post-treatment (after the final session). The PEI was completed by patients following the final therapy session. Finally, the CASF-CLIN was given to therapists to fill out anonymously after completion of their participation as therapists in this year-long clinical research practicum.
Data Analysis Plan

Often that patients were nested within therapists, it typically violates the assumptions of traditional statistical methods—primarily assumption of independence in the scores. Accordingly, multi-level modelling (MLM) would be most ideally suited to correct for this data structure as MLM properly addresses the hierarchical structure of psychotherapy data by accounting for the lack of independence in patients’ scores (Raudenbush & Bryk, 2002). At the same time, we recognize that our sample is relatively small for conducting MLMs. For instance, several researchers have suggested that sample sizes of 50–100 therapists would be needed to properly estimate the random components of the models (e.g., Mass & Hox, 2005). Accordingly, we took two approaches to address our research questions. First, we tested the bivariate association between the variables in the model without accounting for the interdependencies in the data, and then, we tested whether those results would be replicated after accounting for therapist effects in the MLMs. For the MLM, we created a series of random intercept models, wherein the predictor variables were fixed effects (set to not vary across therapists), but the outcome variable was free to vary across therapists.

Calculation of Reliable Change

Prior to investigating the relationship between clinician total alliance ratings from personal therapy and clinician demographics with patient outcomes, patients’ baseline scores on the BSI-GSI were mathematically adjusted to control for the effects of regression to the mean. To control for baseline scores’ regression to the mean, adjusted baseline scores were calculated using the formula suggested by Speer (1992, 1994). These adjusted baseline scores were then used to calculate a reliable change index (RCI; Jacobson and Truax, 1991) score for the BSI-GSI. Utilizing the RCI as a measure of clinically relevant change allows the investigator to determine whether the level of patient improvement is enough to exceed the margin of measurement error (i.e., >1.96; Jacobson et al., 1999). Our sample demonstrated significant, positive, pre-post-treatment change on BSI-GSI (n = 38, df = 37, t = −3.80, p = 0.0005), with a mean BSI-GSI RCI score for the current sample of 1.1 and a SD of 2.4. For the current study, the RCI of the BSI-GSI was used as a dimensional outcome variable assessing the amount of change on the BSI-GSI controlling for measurement error and regression to the mean.

RESULTS

Prior to addressing the research questions, we initially examined the degree to which therapists accounted for the variance in the variables by Intraclass correlation coefficients (ICC). More specifically, the ICCther is the proportion of total variance in patient alliance scores, therapist alliance scores and outcome (GSI and PEI), that is attributable to therapists. For the following analyses, the sample size for patients was 54, and the sample size for therapists was 14. The therapists in the sample saw an average of 3.9 patients each (M = 3.9, SD = 1.4, range = 1.0–6.0). All statistical analyses were conducted using Hierarchical Linear Modelling Version 6 (HLM6) (Raudenbush et al., 2005).

The ICCther for these four models were BSI-GSI (0.002, <1%, p > 0.50), PEI (0.300, 30%, p = 0.005), patient alliance (0.019, 2%, p = 0.308) and therapist alliance (0.053, 5%, p = 0.25). Although these ICCs need to be examined within the context of the sample size, what is notable here is that patients who were treated by the same therapist were more likely to have similar outcome ratings on the PEI than those who saw different therapists. The lower ICCs for patient and therapist alliance and BSI-GSI suggest that most of the variance in patient and therapist ratings of alliance rest within the therapy dyad or are patient specific.

Are aspects of graduate clinicians’ personal therapy related to indicators of psychotherapy process in the therapy they perform?

One of our primary hypotheses was that the higher a clinician rated the alliance in their personal therapy (CASF-CLIN), the higher alliance ratings would be made by their patients (CASF-P), the higher they would rate alliance regarding their own treatments as a therapist (WAI-T) and the greater number of psychotherapy sessions that would be attended by patients (number of sessions). Results for these analyses reported in Table 2 showed non-significant, negative, relationships between a graduate clinicians alliance in their personal therapy with all three of these variables of interest. Likewise, the

| Table 2. Relationship between clinician personal therapy alliance and clinician treatment demographics with patient alliance, therapist alliance after TMA feedback session and number of sessions |
|-------------------------------|-----------------|-----------------|-----------------|
| CASF-patient | WAI-therapist | # sessions |
| (n = 54) | (n = 54) | (n = 46) |
| CASF-CLIN | r = −0.10 | r = −0.14 | r = −0.01 |
| | p = 0.45 | p = 0.33 | p = 0.91 |
| TOT # mo ptx | r = −0.09 | r = −0.18 | r = −0.19 |
| | p = 0.51 | p = 0.20 | p = 0.22 |
| TOT # sess ptx | r = 0.03 | r = 0.11 | r = −0.16 |
| | p = 0.81 | p = 0.43 | p = 0.28 |
| Overall ptx help | r = −0.07 | r = −0.32 | r = −0.04 |
| | p = 0.63 | p = 0.02 | p = 0.79 |

CASF-CLIN, Combined Alliance Short Form–Clinician; TOT # mo ptx, total number months of personal therapy; TOT # sess ptx, total number of sessions of personal therapy; Overall ptx help, overall rating of personal therapy helpfulness; CASF, Combined Alliance Short Form–Patient; WAI, Working Alliance Inventory–Therapist; # sessions, number of psychotherapy sessions attended by patient.
duration of their personal therapy, both in number of months and sessions attended, revealed non-significant relationships with patient and therapist ratings of alliance or duration of the treatments they performed. The more helpful clinicians found their personal therapy to be was not significantly related to their patient ratings of alliance or number of sessions they attended. Although, this degree of perceived helpfulness in their own personal therapy was significant and negatively related, moderate effect, to how these clinicians rated alliances with their patients \((r = -0.32, p = 0.02)\). In other words, clinicians who found their personal therapy to be more helpful in conducting treatment actually rated their own alliance with their patients lower compared with clinicians who found their personal therapy to be less helpful.

Are aspects of graduate clinicians’ personal therapy related to psychotherapy outcomes in the treatment they provide?

A second area of primary interest was the hypothesis that the higher a clinician rated the alliance in their personal therapy (CASF-CLIN), the greater amounts of change would be observed in their patient outcomes across treatment. Patient outcomes were examined both in terms of broad band multi-dimensional facets (PEI) and global psychiatric symptoms (BSI-GSI), the results for these analyses reported in Table 3. Clinician rated alliance in their personal therapy was not found to be significantly related to a measure of broad band outcome represented in the PEI. However, the degree of alliance in their personal therapy was significantly related, moderate effect, to the patients’ reliable change in symptoms on the BSI-GSI \((r = 0.34, p = 0.04)\). The duration of their personal therapy, in number of months and sessions attended and the overall perceived helpfulness of their therapy, revealed non-significant relationships with both outcome measures.

The results in the MLM context demonstrated that the association between CASF-CLIN and PEI was marginally significant \((p = 0.09)\). This suggests that higher CASF-CLIN ratings may be associated with better outcome as measured by the PEI after accounting for therapist effects (which was notably large for the PEI). The intercept coefficient for the PEI was 105.30, \(p < 0.001\), and the unstandardized coefficient for the CASF-CLIN was 3.89, standard error = 2.22, \(p = 0.088\).

**DISCUSSION**

This is the very first study to investigate aspects of graduate clinicians’ personal therapy in relation to indicators of psychotherapy process and patient outcomes. Our findings showed non-significant relationships between a graduate clinicians’ overall alliance in their personal therapy with alliance ratings made by their patients and alliance ratings regarding their own treatments as a therapist, as well as the number of psychotherapy sessions attended by patients. Duration of personal therapy, in terms of number of months in personal therapy and number of sessions of personal therapy, was not significantly related to these three process variables (# patient sessions, CASF-P and WAI-T). However, we did find a significant and negative correlation between degree of perceived helpfulness of their personal therapy and how these clinicians rated alliances with their own patients as therapists, i.e., the more helpful clinicians felt their personal therapy had been, the lower they rated their own alliance with their patients. Regarding patient outcome, our results demonstrated that a clinician’s personal therapy alliance was related to their patients’ rating of outcome on a global symptom measure (BSI-GSI). The higher the clinician rated her personal therapy alliance, the more that clinician’s patient felt that her symptoms had improved. Since several therapists in the study treated more than one patient, it was also of interest to investigate any potential therapist effects in the results. We found that patients who saw the same therapist were no more likely to have similar ratings on the BSI-GSI, patient alliance measure and therapist alliance measure than those who saw different therapists. However, we did find a therapist effect on the PEI, meaning that patients from the same therapist were significantly more likely to evidence similar outcomes on this measure than patients across therapists. After accounting for this therapist effect, we found a positive trend between how clinicians rated their personal therapy alliance and how patient’s estimated their improvement across a broad range of social, occupational and relational outcomes, suggesting that the higher therapeutic alliance in a clinician’s personal therapy, the better outcome rated by patients. Past research shows that the therapeutic alliance is related to treatment outcome (Horvath et al., 2011; Martin et al., 2000), and perhaps the clinician’s personal therapy alliance may operate in the same way.

### Table 3. Relationship between clinician total alliance ratings from personal therapy and clinician treatment demographics with patient outcomes

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<thead>
<tr>
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<th>PEI ((n = 38))</th>
<th>BSI-GSI RCI ((n = 38))</th>
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<tbody>
<tr>
<td>CASF-CLIN</td>
<td>(r = 0.22; p = 0.19)</td>
<td>(r = 0.34; p = 0.04)</td>
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<tr>
<td>TOT # mo ptx</td>
<td>(r = -0.07; p = 0.68)</td>
<td>(r = 0.04; p = 0.83)</td>
</tr>
<tr>
<td>TOT # sess ptx</td>
<td>(r = 0.03; p = 0.86)</td>
<td>(r = 0.04; p = 0.80)</td>
</tr>
<tr>
<td>Overall ptx hlp</td>
<td>(r = 0.12; p = 0.46)</td>
<td>(r = 0.18; p = 0.27)</td>
</tr>
</tbody>
</table>

CASF-CLIN, Combined Alliance Short Form—Clinician; TOT # mo ptx, total number months of personal therapy; TOT # sess ptx, total number of sessions of personal therapy; Overall ptx hlp, overall rating of personal therapy helpfulness; PEI, Patient’s Estimate of Improvement—scores collected at termination; GSI-RCI, Global Severity Index of the Brief Symptom Inventory—Reliable Change Index.
We hypothesized that clinician personal therapy alliance ratings (CASF-CLIN) would be significantly and positively correlated with the therapist alliance rating of treatment with patients (WAI-T). This hypothesis was not supported in our results. We based this hypothesis on prior research by Norcross et al. (2009) that found that when asked to identify one positive feature from their personal therapy that they attempt to repeat with patients, psychotherapists tried to replicate a therapeutic relationship characterized by warmth, empathy, acceptance, equality, positive regard and good listening with their own patients. We believed that a therapist may model the relationship from his personal therapy in his treatment of patients (Geller, 2005) and expected a significant positive relationship between these alliance ratings. However, our findings suggest that this was not the case for our sample. It is possible that clinicians in training do in fact model their own therapeutic relationship, but perhaps, it is the difference in the amount of training between the clinicians in training and post-doctoral therapists that led to no significant correlation between these variables. In other words, the lack of a relationship between the clinician trainee’s view of his personal therapy alliance and the alliance of the treatment she or he delivers may be due to the experience level of the therapist in this study.

We also hypothesized that clinician personal therapy alliance ratings (CASF-CLIN) would be significantly and positively correlated with client alliance rating (CASF-P). This hypothesis was also not supported. We based this hypothesis on past research by Patton and Kivlighan (1997) that showed that the trainee’s perception of the supervisory alliance was significantly related to the client’s perception of the therapeutic alliance. We understood this finding might suggest that the alliance in a relationship where the clinician in training is on the receiving end of services (e.g., supervision, personal therapy) may have an effect on the alliance between that trainee and his or her clients as it is seen from the client’s perspective. Perhaps a difference in the supervisory alliance versus the personal therapy alliance accounts for the differences in findings. This is possible given that the focus in supervision is spent discussing personal issues that may likely include a broader array of personal and professional concerns.

We hypothesized that clinicians with more personal therapy would have higher therapist-rated alliances (WAI-T) with their patients than clinicians who had less personal therapy. This hypothesis was not supported. We based this hypothesis on the finding that clinicians with personal therapy had higher therapist-rated alliances with their patients than clinicians with no personal therapy (Gold & Hilsenroth, 2009). We reasoned that based on that finding, which was based on examination of categorical group differences, that a significant relationship might also emerge when examining the degree of that relationship in a dimensional analysis. Comparing our non-significant results with the results from the Gold and Hilsenroth study suggests that the fact of being in personal therapy is more meaningful with regard to therapist ratings of alliance per se than the amount (number of sessions) of personal therapy. In addition, it may be that a trainee’s satisfaction with or quality of their personal therapy may be a more relevant variable to assess in regard to process and outcomes of their patients rather than simply the amount of time spent in treatment (Taubner et al., 2013).

When examining clinician demographics with therapist-rated alliance, we found something unexpected: a negative correlation between how helpful clinician’s found their personal therapy with their therapist-rated alliance of their own patients. In other words, the more helpful the clinician’s found their personal therapy to be, the lower those clinicians rated alliances with their patients. This could be because trainees who seek therapy might be more self-critical, less confident or have higher standards for themselves. Williams and Hill (1996) found that the impact of negative self-talk on therapy process was significant in the way that as therapists reported greater degrees of negative self-talk, they assumed their clients had an equivalent negative experience. They also found that therapists higher in negative self-talk rated their own performance as less helpful. However, the data in the current sample showed a range in scores from clinicians regarding their personal therapy alliances (3.2–6.4), which suggests that clinicians in this sample had a range of reactions to their personal treatment. One may therefore hypothesize that different trainees idealizing their personal therapy and subsequently viewing the treatment they deliver as ‘falling short’. Conversely, those with less successful personal therapy would have a ‘low hurdle’ to surmount, and both would contribute to the finding of this negative correlation between clinician’s rating of personal therapy helpfulness and therapist-rated alliance.

We found that the higher the clinician rated his or her personal therapy alliance (CASF-CLIN), the more that clinician’s patient felt that his symptoms had improved at the end of treatment (GSI-RCI). The idea that the clinician’s personal therapy alliance is related to the outcomes of treatments she delivers is quite remarkable. It seems that something about the personal therapy relationship may be related to the treatment that the clinician delivers in some way that relates to patient symptom distress. The current findings suggest that this is not occurring through the mechanism of the therapeutic alliance between therapist and patient but rather through a different mechanism that has not yet been identified. The fact that no therapist effects were found for the GSI-RCI suggests that this finding is not a result of some effect that the therapists were having (i.e., a given therapist who is better at treating
symptoms also tends to rate his personal therapy alliance as higher). The fact that patient outcome variables were related to
clinician personal therapy alliance, and neither patient nor
therapist alliance was related to the clinician’s therapy al-
liance, implies that these changes in outcome were a result
of some mechanis of change that is not a result of the
patient–therapist therapeutic relationship (i.e., therapist
technique, patient or therapist level of psychopathology, treat-
ment expectations, motivation and readiness for change).

We hypothesized that the amount or helpfulness of a
clinician’s personal therapy would be significantly related
with both the number of sessions patients attended and to
outcome. This hypothesis was not supported. Our find-
ings are inconsistent with the Gold and Hilsenroth (2009)
study that found significant differences in the number of
therapy sessions attended, with the treatments of those
graduate clinician’s who had received personal therapy
being twice as long. This inconsistency may be due to
methodological differences, as the Gold and Hilsenroth
(2009) study examined data from a categorical perspective
(personal therapy or none), whereas the current study
examined data from a dimensional perspective (amount
of that personal therapy in months attending treatment).
Since no relationship among perceived helpfulness,
number of sessions or months in personal therapy and
the outcome measures was statistically significant, our
findings suggest that the perceived helpfulness or length of
personal therapy is not working as a mediating variable
and the relationship between clinician-rated alliance in
personal therapy and patient-rated outcome. Perhaps the
personal therapy of graduate trainees with higher alli-
ances is more effective at lowering anxiety in the clinician
and the therapeutic setting that led to better outcomes.
Also, since personal therapy alliance was related to over-
all ratings of personal therapy helpfulness for clinicians
(n = 14, r = .59, p < .01), the clinicians’ functioning in daily
life may have improved. This improved functioning could
have been associated with improvement as a therapist. A
‘healthier’ therapist might be better able to function as a
therapist (i.e., facilitating larger outcome changes for
the patients) because she is less pre-occupied with her
own concerns. Consequently, one would then have to
wonder if a clinician’s level of adaptive functioning (i.e.,
psychological-relational-emotional health) might provide
a simpler, more parsimonious, explanation for our find-
ings (Garfield & Bergin, 1971; Schauenburg et al., 2010)?

Despite this being the first study to examine a clinicians’
personal psychotherapy with process and outcome vari-
able in the treatment they deliver, the current study has
some potential limitations that should be addressed. The
patients in this sample primarily suffered from mild-
to-moderate levels of distress and impairments in
functioning. Further research is necessary on different
samples exhibiting a more severe level of distress and
functional impairment to extend the implications of the
present findings. Additionally, this study utilized
psychodynamic therapy and thus the findings cannot be
generalized to other modalities of treatment. It would
be useful to replicate this study in a sample of therapists de-
ivering cognitive–behavioural, experiential, humanistic
and interpersonal treatment. This would deepen our un-
derstanding of these psychotherapy processes. Moreover,
this study was conducted using advanced Ph.D. candi-
dates who were still in training. Further research is needed
using both more experienced and less experienced thera-
pists to examine how personal therapy alliance might be
linked to therapist–patient alliance and outcome. While
the graduate clinicians in this study made retrospective
ratings of alliance on their personal therapy during the
time that they were therapists in the clinical research prac-
ticum rather than after an individual session of that treat-
ment per se, it should be noted that 13 of the 14 trainees
were in personal psychotherapy during that time, and
the final trainee had completed their therapy immediately
prior to that period. In addition, while the current sample
size is adequate for detecting moderate to large effects in
direct analyses of psychotherapy process and outcome, it
is underpowered for the use of HLM analyses. As a result,
the findings of the current study were limited in that
within and between therapist effects were not able to be
specifically investigated. Future research using a larger
sample size would allow for therapist level variables
(level 2) to be examined, which would allow for within
and between therapist effects to be investigated and allow
for a better understanding of how therapist differences
may impact relationships between personal therapy alli-
ances and treatment outcome. Furthermore, it should be
noted that because of the correlational nature of this study,
readers should not view the results as causal. Finally,
the evaluation and feedback interviews were fairly structured
and contained elements designed to facilitate the working
relationship. While this is good practice for training
clinicians, in the real world will likely not have such
well-structured assessments and highly supervised
treatments, and therefore might be seen as a limitation
for generalizability of results to other therapy settings.

In balancing the limitations discussed above, it must be re-
membered that this is the very first study to explore the rela-
tionship between aspects of a therapists’ personal therapy
and the subsequent psychotherapy process and outcome
they perform. As such, the present work provides a vitally
important initial foray into this heretofore neglected area
of professional development, and our results offer some foun-
dation for future researchers to build upon. In addition, the
current study supports past findings that the therapeutic alli-
ance is a clinical phenomenon that is significantly related to
therapeutic outcomes (Horvath et al., 2011; Martin et al.,
2000). Given the current finding that graduate trainees
with higher personal therapy alliances deliver treatments that pro-
duce better outcomes, it seems that personal therapy has

mixed implications for training. On the one hand, if the graduate trainee has a positive experience in therapy, it seems this would lead to greater positive outcomes for that trainee’s patients. However, if the graduate clinician has a negative therapeutic alliance during personal therapy, it is possible that their patient outcomes would be less positive.1 As such, it seems premature based on the results of these singular findings to suggest mandating personal therapy for graduate trainees at this time. What our data do suggest is that the impact of personal therapy on the clinical work of trainees should be the focus of additional empirical research.

In addition to future research addressing limitations of the current study, there are other areas that would be useful to investigate. While therapist effects were accounted for in this study by using HLM analyses, little is known about what therapist characteristics were specifically impacting the current analyses using the PEI outcome variable. Furthermore, it would be important for future research to examine the impact of the TMA on the relationship between personal therapy alliance with patient–therapist alliance and outcome. Since it is possible that a TMA moderates any differences that might exist on patient and therapist-rated alliance scores among graduate trainees, future research should replicate this study without the use of a TMA. Moreover, given the current finding that the personal therapy alliance affects treatment outcomes, it would be interesting for future research to examine clinician outcomes in personal therapy or simply clinician level of adaptive functioning (i.e., psychological-relational-emotional health) and see if these variables are related to therapist–patient outcomes. Related, our data would suggest that retrospective clinician reports on the helpfulness of their personal therapy do not seem to have a significant impact on patient-rated outcomes that are empirically evaluated. Last, it would be useful to develop a questionnaire for clinicians in training to assess the educational aspects of personal therapy. Such a questionnaire could help to identify what aspects of personal therapy trainees identify as educative, how they make use of what they learn in their treatment of patients and to examine relationships between this information with ratings of therapeutic alliance and outcome.

REFERENCES


1We specifically use the term ‘less positive’ rather than ‘negative’ here as several studies from this larger programme on STPP have shown positive clinical outcomes (refer to Hilsenroth, 2007, for a review). That is, the vast majority of patients in this treatment programme achieved positive outcomes.


