The Relationship between Counselor Trainees’ Personal Therapy Experiences and Client Outcome

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THE RELATIONSHIP BETWEEN COUNSELOR TRAINEES’ PERSONAL THERAPY EXPERIENCES AND CLIENT OUTCOME

by

Bonnie L. VanderWal

A dissertation submitted to the Graduate College in partial fulfillment of the requirements for the degree of Doctor of Philosophy
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Research on mental health professionals’ use of personal psychotherapy indicates that a majority of practitioners have participated in their own personal therapy for both personal and professional reasons (Bike, Norcross, & Schatz, 2009; Norcross & Connor, 2005). Psychotherapists typically suggest that engaging in their own personal therapy has aided in their professional development and clinical effectiveness in their work with clients (Orlinsky, Norcross, Ronnestad, & Wiseman, 2005); however, researchers have been unable to conclude that such evidence exists (Clark, 1986; Greenberg & Staller, 1981; Macaskill, 1988; Macran & Shapiro, 1998; Orlinsky, Norcross et al., 2005). Studies often included psychotherapists already established in their careers where levels of experience may have influenced their performance and/or subjective reflections of the benefits of personal therapy (PT) experience. One reason past studies are inconclusive is that the methods employed lacked the capabilities of current statistical techniques to detect small effects. Additionally, client outcome was measured in a variety of ways including supervisor ratings of therapist effectiveness, client reports of satisfaction levels, and client termination patterns. The current study addresses these problems by using a counselor trainee population (i.e., to control for levels of experience), more sophisticated methods (i.e., growth curve analyses capable of examining both the amount and rate of change), and advanced measures of outcome (i.e., repeated measures of client
Thirty counselor trainees completed a counselor information questionnaire regarding their experiences in personal therapy. Client outcome data from participating counselor trainees were obtained from archival measures of psychological distress. Hierarchical linear modeling (HLM; Raudenbush & Bryk, 2002) was used to analyze client growth trajectories to predict relationships between counselor trainee PT experiences and reductions in client psychological distress. Results indicated that counselor trainee PT experience was associated with the rate at which clients reported changes in psychological distress over the course of therapy. That is, clients of counselor trainees who reported PT experience showed faster rates of distress reduction compared to clients of counselor trainees who denied PT experience. Moreover, group differences in client distress levels over the course of therapy were found to be greater for clients who met with trainees who reported experience in personal therapy compared to clients who met with trainees who reported no PT experience. Additionally, counselor trainees identified if PT experiences occurred during graduate training. Results indicated that clients of counselor trainees who participated in personal therapy during their graduate training reduced distress more quickly than clients of counselor trainees indicating either no PT experience or PT experience occurring prior to training. Likewise, clients showed greater total reductions of psychological distress when their respective counselors reported PT experience during graduate training compared to no reported PT experience or PT experience occurring prior to graduate training. Suggestions for future research focus on replicating the study using a larger counselor trainee sample size with more clients per counselor trainee and increased observations (i.e., sessions) per
client. Implications for the training of psychotherapists include focusing on how personal therapy may enhance counselor growth and development.
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My journey to this point has been much longer than I ever anticipated or expected. I envisioned a route much more flat and direct in reaching my destination. Although I encountered obstacles requiring an occasional detour, my belief in my ability to accomplish this goal remained consistent and firm. In addition, whereas my journey at times felt frustrating and difficult, it provided for valuable self-discovery and enhanced my growth and development. Moreover, I had the opportunity to create many new connections with wonderful people who I admire and respect, while also preserving life-long relationships with those closest to me. It is here that I wish to acknowledge some of them who have been integral in this process.

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and in honor of Dr. Duncan, whole-heartedly believe that they have cultivated “the #1 program in the field.”

Third, I am thankful for the many friends and family that have rooted for me along the way. I often didn’t feel like saying much about this process but their words of encouragement and support have always been appreciated. To Karen, who has been by my side for the most important parts of this journey, words fall short of describing the incredible blessing she has been in my life. I know this has been a challenging road for her too, yet her ability to take it in stride with such optimism, laughter, and that comforting smile has truly given me my most-treasured accomplishment. It’s finally time to set that date!

In closing, I would like to dedicate this work to those who inspired this project: the supervisees who were so honest in their process by reflecting on how their own therapy contributed to their work with clients; my therapist whose work with me enhanced my work with others; and the graduate student participants who shared personally about their own experiences in therapy, putting this project in motion. I would also like to dedicate this to my grandmother, an education professor who earned her Ph.D. at the age of 65; my mother, who would have loved to see me accomplish this goal; and my father, the first and only Dr. Vander Wal I ever knew… until now.

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CHAPTER I

INTRODUCTION

Research in the area of personal therapy for mental health professionals has received increasing attention over the past few decades. Mental health providers across disciplines, both in the United States and abroad, report having engaged in personal therapy and have rated it as very important to both personal and professional development (Geller, Norcross, & Orlinsky, 2005). Moreover, in a study that asked about the greatest influence on professional development, many psychotherapists cited their own personal therapy experiences as the first or second greatest influence (Orlinsky & Ronnestad, 2005). Although many mental health professionals perceive personal therapy as professionally beneficial, the idea that the impact on professional development actually translates to an effect on client outcome is not substantiated. Reviewers of research that attempted to link psychotherapist personal therapy experience and the effect on client outcome have determined that there is not enough evidence to support the notion that therapist personal therapy leads to more effective client outcome (Clark, 1986; Greenberg & Staller, 1981; Macaskill, 1988; Macran & Shapiro, 1998; Orlinsky, Norcross, Ronnestad, & Wiseman, 2005). Researchers have even offered compelling arguments for why it would be nearly impossible to find any measurable effect on client outcome based on the personal therapy experiences of psychotherapists (Macran, Stiles, & Smith, 1999; Orlinsky, Norcross, et al., 2005). As a result, research in the area of psychotherapist personal therapy and the effect on client outcome has suffered nearly into nonexistence.
Despite the continued assigned value of personal therapy to the professional development of mental health practitioners, to what extent it truly contributes, especially in terms of a benefit to clients, has been left to outdated studies to inform contemporary discussions on the topic. A major problem exists in the lack of consideration for the drastic advancement in measuring client outcome. For example, a popular archaic method for evaluating client change included post-treatment therapist ratings. Given the improvements made to outcome assessment, that which includes routine monitoring of client progress and the ability to track the rate of change during treatment (Lambert, 2010), it is imperative to update the research base with newer, more sophisticated approaches. Current knowledge in the field is based on outdated methods when advanced measures in tracking client change might offer new evidence and stronger conclusions.

The purpose of the following study was to examine the degree to which therapist personal therapy might be associated with client outcome. The use of advanced methodology and current measures to track client change were expected to contribute new knowledge on a long-held debate. This chapter provides a review of literature exploring the use of personal therapy by psychotherapists, followed by exploring the notion that personal therapy adds to psychotherapist professional development. Past attempts at concluding whether a relationship between psychotherapist personal therapy and client outcome exists are also explained. Thus, the ensuing discussion on the need for current research on psychotherapist personal therapy and the relationship to client outcome is divided into four major sections. The first section introduces ideas related to mental health practitioners engaging in personal therapy and provides a broad summary of the findings resulting from studies about psychotherapists in psychotherapy. For example, research has been synthesized to provide a general picture of the prevalence, rationale,
and outcomes relevant to mental health providers who have engaged in personal therapy. The second section focuses inward on the perceived outcomes reported by psychotherapists as a result of their own personal therapy. That is, research that has explored professional benefits to participating in personal therapy by psychotherapists is presented. The third section critically reviews conclusions made regarding past studies that attempted to measure the effects of psychotherapist personal therapy on client outcome, which includes a critique of the original studies referenced in the reviews. Finally, the fourth section integrates the information presented in the preceding three sections and provides a rationale for current research. Notably, current research needs to explore the potential impact of personal therapy on the training of psychotherapists, especially that which updates and contributes to current knowledge in this area.

**History and Research on Personal Therapy for Psychotherapists**

The first major section begins by exploring ideas related to the use of personal therapy by mental health practitioners. This section consists of two subsections. The first subsection explains the historical context from which the notion of psychotherapist personal therapy was launched, how it became part of the mainstream psychology training conversation, and how differing psychological schools of thought approach the therapists’ psychotherapy. The second subsection is a broad presentation of synthesized knowledge from an aggregate of studies in the larger area of personal therapy for psychotherapists. A summary of the reviewed research regarding psychotherapists’ use of psychotherapy concludes the section.

**Historical context.** The idea that people providing mental health services might also engage in their own personal therapy has a long history. It is rooted in the training realm of those preparing to become psychoanalysts. Sigmund Freud, credited as the founder of psychoanalysis, is often cited as the inaugural advocate on this matter. His contention was that
one could not sufficiently evolve to provide psychoanalysis to others without first going through it oneself (Freud, 1937/1964). He believed that without personal analysis, an analyst could only journey into the unconscious so far, limited by the analyst’s own experience (Freud, 1915/1958). This personal analysis became known as training analysis and is often considered to be the most important part of the tripartite psychoanalytic training model, which also includes coursework and supervised practice (Lasky, 2005). Engaging in one’s own analysis is still required in analytic training institutes today. To understand why there is a question of personal therapy for mental health practitioners in training is to understand the historical context in which personal therapy for trainees was launched. Psychoanalysis focuses on making the unconscious conscious by exploring and discovering inner conflicts, motives, and desires. Clients’ pathologies or personal distresses are seen as unresolved unconscious conflicts. For the analyst to be a tour guide in this process of resolution, the analyst must have the experience of his or her own self-discovery. That is, the analyst must have experienced bringing his or her own elements of the unconscious into the conscious world, examining and resolving inner conflicts. Therefore, to consider that analysts in training would not participate in their own personal analysis/therapy contradicts the philosophy of the psychoanalytic treatment approach. The analyst is to be the primary tool in resolving clients’ unconscious conflicts.

Over the course of time, the notion of personal therapy for psychotherapist trainees has crossed over into other schools of thought on psychotherapy training. According to Raimy (1950), the topic of personal therapy as a program requirement was discussed at the Boulder Conference on Graduate Education in Clinical Psychology; however, it was concluded that there was not enough evidence of the effectiveness of personal therapy to support its inclusion as a training requirement. Wampler and Strupp (1976) speculated that the more practical reason for
not implementing the personal therapy requirement was likely the financial costs to training programs. It seems that if training programs would not absorb the cost of personal therapy for students, then they would also not burden their students with this cost by making therapy a requirement.

More importantly though, as explained above, the philosophical tenets that make up a theoretical orientation must be understood in terms of how pathology or clinical issues are viewed and treatment is approached to appreciate the need for personal therapy of trainees. For example, cognitive-behavioral therapy aims to correct problematic behaviors through therapeutic learning experiences. Personal therapy as part of training is not deemed as necessary because treatment consists of providing technically sound therapeutic methods (Laireiter & Willutzki, 2005). Therefore, in theory, a cognitive-behavioral therapist does not need to experience transformation via a particular model in order to learn how to implement treatment with clients. Nevertheless, training programs in cognitive-behavioral therapy do support the use of personal therapy for trainees, but not as a training standard. Another example is in how the person-centered approach views therapy for trainees. Person-centered therapy focuses on supporting clients’ personal growth in a nondirective fashion. It aims to provide an empathic relationship that is genuine and authentic between therapist and client. To require therapy of trainees would not be consistent with this approach known for its facilitating and fostering of personal agency and development; however, to offer multiple resources for how trainees can engage in personal growth is more common and encouraged (Elliott & Partyka, 2005).

The question of whether to require therapy for psychotherapist trainees in various theoretical perspectives is largely dependent upon how personal problems are conceptualized and the ways from which treatment is approached. Another factor, at least internationally, is that
licensing boards may require it. Many European countries specify a number of personal therapy hours that must be met before one can be licensed or accredited as a psychotherapist (Geller et al., 2005). For example, the Division of Counselling Psychology of the British Psychological Society (BPS) mandates at least 40 hours of personal therapy for trainees on an accredited training course (BPS, 2010). Rizq (2011) points out that mandatory personal therapy has been controversial in the U. K. with the British Association for Counselling and Psychotherapy (BACP) dropping a previously held requirement for psychotherapists seeking accreditation on ethical grounds. It appears that this controversy over whether a psychotherapist should or should not have to seek therapy in order to practice it is largely responsible for numerous U.K.-based studies on the topic of psychotherapist trainees’ personal therapy. Regardless of the rationale base of these international studies, the findings provide important insights into the professional benefits of receiving psychotherapy during training. A review of some of this research is presented in the next major section of this chapter.

To review, the question of whether to engage in personal therapy extends back to Freud’s assessment that personal analysis was necessary for a trainee in order to learn it and perform it. Psychoanalysis has a long history of requiring personal therapy. Based on the theoretical context of various treatment approaches and the lack of supporting evidence related to outcome, personal therapy is likely not required of psychotherapists in training, but is highly encouraged. Some accrediting organizations in the U. K. have mandated psychotherapists to engage in personal therapy before obtaining licensure. This may be an influential force contributing to research on personal therapy and psychotherapists in training. The U. S. however, is lacking in research on psychotherapist trainees and the effects of personal therapy, especially on client outcome. This could be due to not having mandates on this practice in training to be a mental health practitioner
Psychotherapists and the use of personal therapy. The following paragraphs focus on a recent edited volume, *The Psychotherapist’s Own Psychotherapy* (Geller et al., 2005), which provides a useful summary of the current state of knowledge on the topic of personal therapy use by psychotherapists. The editors organize what is known regarding psychotherapists and mental health from a series of published studies and include personal accounts from psychotherapists about their experiences in psychotherapy as well as from psychotherapists who have treated fellow therapists. Of particular interest here is the synthesis of knowledge regarding the prevalence, rationale, and outcome of psychotherapists’ personal treatment, as well as what has been found in a large scale international study. Research published after Geller et al. (2005) that extends the trends reported below is reviewed following the synthesis presented from this edited volume.

Prevalence. Norcross and Guy (2005) looked across 14 studies in which U.S. mental health professionals were surveyed about their experiences in psychotherapy. The studies used self-report questionnaires and surveys to illustrate the prevalence of personal therapy among psychotherapists. The authors noted that response rates varied across studies, but generally half of all potential participants responded. Although response data were not verified for accuracy,
some useful information could still be extracted. Samples included predominately psychologists, and trends across findings revealed that approximately 75% of participants indicated they have undergone personal therapy. Females, married persons, and insight-oriented therapists were shown to be slightly more likely to have received therapy in comparison to their peers. Moreover, the authors found that participation rates varied depending upon theoretical orientation. For example, 98% of psychoanalysts reported having treatment versus 53% of behaviorists. Professional role also varied in terms of treatment rates. That is, mental health professionals in treatment type positions (e.g., practicing therapist) were more likely to also seek treatment than those in non-treatment positions (e.g., academic). As far as the length of time spent in therapy, there has not been a consistent standardized measure for these data. Studies have included length of time data reported in terms of number of hours of therapy, sessions, episodes, and overall total time. Trends across studies indicate that despite the variation in time, frequency of therapy overall is lengthy and intensive, often with session numbers in the hundreds and lasting over several years. Additionally, findings show that therapy tended to occur on more than one occasion or episode over time and involved the individual format for treatment, most often in the private sector.

**Rationale.** The question of why mental health professionals seek personal treatment as well as why not, and for what reasons was examined by Norcross and Connor (2005). The literature reviewed included studies primarily surveying U.S. mental health professionals that used personal therapy on a voluntary basis. The authors looked across five studies that reported on whether psychotherapists sought treatment for personal or professional reasons. Although the potential for overlap between these two domains seems likely, personal reasons are cited well ahead of professional reasons. For example, the majority in all studies (50-67%) reported
personal reasons whereas the minority (10-35%) cited professional reasons. The authors also reviewed five studies that asked respondents to report on reasons for not entering therapy. In general, the reasons across studies were concerns related to confidentiality, finances, fear of being exposed, wanting to remain self-sufficient, not having enough time, and not being able to find a therapist outside of their personal and professional circles. Furthermore, many reported that they had other means available to deal with personal problems such as strong support networks. In terms of presenting problems of therapists who enter therapy, four studies listed depression, couple conflicts, and anxiety most frequently. Notably, few psychotherapists reported professional problems such as a problematic client as a reason therapy was sought. Again, the professional and personal are certainly intertwined, yet it appears that respondents have perceived their concerns to be personal issues.

**Outcomes.** Orlinsky, Norcross, et al. (2005) reviewed research exploring the impact and outcomes of mental health professionals having sought psychotherapy including research from the U. S. and abroad. Generally, respondents have indicated that their therapy experiences were positive and helpful both on the personal and professional level. Personal outcomes across six studies indicated that 90% or more of respondents were satisfied with their treatment and deemed it helpful. Positive benefits included improvements in many areas such as self esteem, work functioning, and social life, as well as reductions in symptom severity. Alternatively, the authors reported on a few studies that asked respondents about any negative effects of therapy. They indicated that negative outcomes of personal treatment are infrequent, and generally occurred in less that 10% of respondents in therapy studies. Some factors associated with negative outcomes were age, theoretical orientation, level of experience, dual therapeutic relationships, incompetence, and boundary violations. The authors also evaluated the professional outcomes of
personal therapy for psychotherapists. Findings generally suggest that personal therapy had a strong positive influence on psychotherapist professional development in terms of increased self-awareness and self-understanding, performing the therapeutic role, and progressing through the therapeutic process. Specific findings related to the perceived professional benefits of engaging in personal therapy are addressed in the next major section of this chapter.

An important highlight from the Geller et al. (2005) synthesis of research on psychotherapist personal therapy use is the inclusion of data from a large-scale international study that supports the trends listed above. In exploration of how psychotherapists develop, Orlinsky, Ronnestad, et al. (2005) reported on research via the Collaborative Research Network of the Society for Psychotherapy that in part examined the personal therapy use of mental health professionals from around the world. Questionnaire response data from over 5000 therapists in 14 countries showed similar trends to the U. S. studies on the prevalence of personal therapy use. The countries included Belgium, Denmark, France, Germany, Israel, New Zealand, Norway, Portugal, Russia, South Korea, Spain, Sweden, Switzerland, and the United States. In all countries except for South Korea, the majority of therapists reported having at least one course of personal therapy. The use of personal therapy between men and women was relatively equal and personal therapy was also related to theoretical orientation. The most commonly cited reason for attending therapy (in 10 of 14 countries) was for personal growth, and personal growth was mentioned by at least half of the therapists (in 13 of 14 countries). The majority of data from this international research supports and extends knowledge about the use of personal therapy by mental health practitioners around the world. Furthermore, personal therapy has been listed consistently as a top rated influence in exploring key factors related to therapist development (Orlinsky & Ronnestad, 2005).
Following the Geller et al. (2005) integrated volume of research on psychotherapists in psychotherapy was an exploratory study by Bike, Norcross, and Schatz (2009) regarding the processes and outcomes of psychotherapists’ personal therapy. The authors replicated and extended an earlier study (Norcross, Strausser-Kirtland, & Missar, 1988) in effort to compare similarities and/or differences found in current trends of therapy use by mental health professionals. The national sample consisted of 727 practicing psychotherapists including psychologists, social workers, and counselors that were asked to complete a questionnaire which had been adapted from the earlier study. Findings from this contemporary study indicated that 84% of the sample reported at least one episode of personal therapy with gender differences diminishing (i.e., 84% of women and 81% of men). Theoretical orientation was significantly related to personal therapy experience with psychodynamic (98%), psychoanalytic (96%), and interpersonal (92%) therapists leading the ranks, and cognitive (76%), behavioral (74%), and multicultural (72%) therapists following behind all other categories. Of those seeking treatment, individual therapy in the independent practice setting was the norm. In terms of time spent in therapy, participants reported on the frequency, length, and career stage of their first and second (if existed) episodes of therapy. On average, participants reported 2.8 episodes of therapy with the first episode averaging 103 session hours and the second episode averaging 110 session hours. Interestingly, 61% of the sample that sought personal therapy had done so first in their pre-career stage and this was significantly related to the likelihood to seek therapy multiple times throughout their career.

Bike et al. (2009) also reported on the rationale and outcome of personal therapy experiences by mental health professionals. When asked whether their reasons for seeking therapy were personal, professional, or both, 60% of the sample reported seeking therapy for
personal reasons, 5% reported professional reasons, and 35% indicated both. The top four presenting problems were reported. In terms of personal outcomes of therapy, improvement was noted on all dimensions measured. For example, 86% of respondents indicated improvement in behavior-symptoms, 90% reported improvement in cognitive-insight, and 92% reported improvement in emotion-relief. Less than 1% reported deterioration on any of the three dimensions. Perceived harmfulness was also rated with 95% of respondents indicating that their therapy was not harmful in any way. As far as professional outcomes perceived as a result of therapy, respondents were asked to reflect on any lessons learned from their experiences. The authors found that the top lasting lessons were related to characteristics of the therapist (e.g., reliability, commitment, and competence), the therapeutic relationship (e.g., warmth and empathy), the experience of being the client, and that psychotherapy is effective.

The studies reviewed thus far offer important insights into trends of therapy use by mental health providers; however, some methodological issues must be considered. For example, the research presented consisted of survey data using self-reporting methods. Thus, responses were not checked for accuracy and must be evaluated cautiously. Because the population of mental health providers is so vast and varies considerably, it is very difficult to draw a representative sample of psychotherapists in which results could be generalized (Orlinsky, Ronnestad, et al., 2005). Additionally, respondents were typically seasoned professionals with varying years of experience, making it difficult to assess the particular impact of personal therapy on professional development when confounded by field experience. Moreover, response bias limits how applicable the results are. Those who responded may have done so because they resonated with the experience of engaging in personal therapy and found it to be beneficial so they wanted to report on it. Perhaps many psychotherapists who did not
respond had never engaged in personal therapy and decided the research was not relevant to them. Taking these cautions under consideration though, it is still possible to gather ideas and insights regarding the use of personal therapy by psychotherapists. The emergent trends can then inform potential research in related areas of psychotherapist personal therapy.

The first major section of this chapter reviewed the historical context from which the notion of psychotherapists engaging in psychotherapy began, followed by a broad presentation of the current state of knowledge in the larger area of personal therapy for psychotherapists. Freud asserted that one must first be analyzed before conducting analysis in the training of psychoanalysis. This led to mainstream consideration of the practice of personal therapy by mental health practitioners in training and the notion of engaging in therapy while in training is prevalent today in one way or another throughout the various psychological schools of thought. To give a general picture of the field of research in the area of therapists’ personal therapy, Geller et al. (2005) provided descriptive information and characteristics of psychotherapists who have engaged in psychotherapy as well as the reasons they pursued treatment, for what issues, and whether it proved beneficial for them. Overall, mental health practitioners seek personal therapy for what they consider personal issues, often for a long time, and on more than one occasion.

Similar trends were also shown in an international exploration of how psychotherapists develop (Orlinsky, Ronnestad, et al., 2005) and a contemporary national study (Bike et al., 2009). Notably, Bike et al. explored lessons learned from therapy experiences and found that therapist characteristics, the therapeutic relationship, being in the role of the client, and that treatment works were lasting impressions from the treatment experience. Although findings presented here offer insights into the personal use of psychotherapy by mental health
professionals, they must be interpreted with caution because of the nature of survey research. Data cannot be checked for accuracy, is difficult to generalize, and the likelihood of response bias is typical. Therefore, to delve deeper into how personal psychotherapy has an impact on mental health practitioners’ professional practice, the discussion now turns to some qualitative research in the exploration of the meaning of personal therapy on professional practice.

**Impact of Personal Therapy on Psychotherapists’ Professional Practice**

“Can you teach others to jump if you are not willing to jump?” (Norman, 2004, p. 68).

The notion that the training of mental health professionals should also include personal therapy is one that is generally accepted and encouraged across the mental health field. The discussion thus far establishes that research has repeatedly shown that many mental health providers have engaged in personal therapy and have rated it as very important to both personal and professional development (Geller et al., 2005). The value of personal therapy to professional practice, rooted in Freud’s belief that one cannot offer psychoanalysis without first being analyzed (1937/1964), is a concept that has stood the test of time. Evidence from the past decade includes increasing accounts of psychotherapists professing the benefit of engaging in their own psychotherapy to their clinical practice. For example, Sinason (1999) asserted “When the resource is your self and you are encountering a vulnerable ‘other’, you need to have the key tool of your trade as honed as possible” (p. 158). In his book to a new generation of therapists, Yalom wrote “To my mind, personal psychotherapy is by far the most important part of psychotherapy training” (2002, p. 40). In their edited volume on psychotherapists in psychotherapy, Geller et al. (2005) devoted an entire section of firsthand accounts from psychotherapists about their experiences in therapy. In Hill’s account, she stated “I would assert that my therapy was not only very beneficial for me personally but also crucial for my development as a professional” (2005, p. 143). Simms (2008)
reflected on how her experience in personal therapy as a requirement of her training program helped her learn about the process of therapy, sensitized her to the role of the client, and increased her empathy. She noted that she probably would not have engaged in personal therapy if given the choice and that the requirement ensured that she did not miss out on a critical learning experience. Likewise, Phillips (2011) describes the experience of personal therapy as “integral to a therapist’s formative training and ongoing development across disciplines and orientations” and that personal therapy allows for “expanding didactic training, clinical experience, supervision, and cultural competence” (pp. 144-145). Finally, a recent issue of the *Journal of Clinical Psychology: In Session* that chronicled the accounts of six seasoned professionals’ personal therapy experiences, emphasized a recurrent theme of personal therapy being a major influence in how they conduct psychotherapy today (Geller, 2011).

The idea of engaging in personal psychotherapy, especially as part of the training process, clearly has strong support from a myriad of mental health practitioners who tout the professional development benefits of the experience. Although research has been unable to show a clear connection between the perceptions that personal therapy makes one a better therapist and an actual effect on client outcome, evidence has emerged that the impact of personal therapy on professional development is more than just mere opinion. Qualitative inquiry has been utilized to explore how therapists perceive that personal therapy was helpful to them in the clinical realm. The second major section of this chapter focuses on a broad review of the impact of personal therapy on professional development in particular. The research reviewed here used qualitative methods which tend to be grounded in detailed exploration of a small number of people. In this case, the idea is to discover in depth the nature of personal therapy experiences and the meanings made directly from participants’ voices. The research presented in the following paragraphs
includes seven studies using both U. S. and internationally based sample sizes, followed by a summary of core findings thus far.

Macran et al. (1999) explored the perceptions of seven British therapists in practice for at least 3 years who had all engaged in personal therapy. Semi-structured interviews were used to collect detailed accounts of participants’ experience in personal therapy and its effects on their clinical work. Through the use of interpretive phenomenological analysis, a method used to form an interpretive relationship with transcript data, the authors attempted to understand the unique lived experience of each participant. Results were categorized into three broad domains: orientation to the therapist role, orientation to the client role, and the idea of listening with the third ear (i.e., more deeply at an unconscious level). In terms of orientation to the therapist role, salient themes discovered included knowing how it feels to have therapy, taking care of self, that therapists can be clients, providing a role model, learning to be one’s real self, knowing one’s boundaries and limitations, and knowing what not to do. Themes emerging related to orientation to the client role were to give clients space and to hold back from jumping in to help. Finally, the domain of listening with the third ear included separating one’s own feelings from the client’s feelings, working at a deeper level, and judging the pace of therapy. The themes discovered suggest that being in the client role allowed for personal growth that translated to the therapist role, which led to a greater awareness of how one conducts therapy with clients. The authors note that the personal growth reported and the learning of reciprocal roles is not easily attained through academic study alone. Moreover, participants believed that their personal therapy made a positive and unique contribution to how they practiced professionally.

Grimmer and Tribe (2001) conducted both group and individual interviews with counseling psychologists including seven in training and seven recently qualified (i.e., early in
their careers) from the U. K. They sought to investigate perceptions about required personal therapy during training and the relation to professional work with clients. Using a grounded theory approach for data analysis, the authors identified four core categories of experience. The first category was the reflection on being in the role of the client, which was descriptive of the empathy gained by being in the client’s position. The second category was socialization experiences which included witnessing the therapist as a model and the validation that therapy is effective. Third, support for the emerging professional, was descriptive of the way in which personal therapy allowed them to disclose freely and manage stress. Finally, the fourth category was interactions of personal and professional development. This category described being able to distinguish between one’s own issues and those of the client, and the empowerment obtained from confidently recognizing boundaries and utilizing oneself in the therapeutic role. It is important to note that personal therapy as a requirement of qualifying to practice counseling psychology did not limit learning for those without presenting problems at the outset of therapy. The categories discovered suggest that participants felt the personal therapy experience gave them a greater understanding of the therapeutic process including empathy towards the client, how to incorporate the therapist role, the validation that therapy is effective, and increased confidence in separating personal and professional boundaries.

In an attempt to explore the lasting effects of personal analysis on psychodynamic-oriented therapists in their clinical practice, Bellows (2007) interviewed 20 U.S. professionals who all had at least 5 years of psychoanalysis but were not currently in treatment. Her aim was to compare results to a model (unspecified) on personal and professional influences of psychotherapy. Data analysis included identifying and categorizing themes from each participant’s responses and then counting the number of participants that responded to a theme.
being relevant. She also ranked participants’ perceived influences (high, medium, and low) of their personal treatment on clinical work. Bellows then focused findings relevant to participants for whom personal therapy had the highest level of influence on professional work. For this group, participants reported that their treatment relationships had promoted the most psychological change, that it had enhanced their sense of professional identity, improved interpersonal relationships, and led to accepting personal imperfection in terms of understanding how difficult change is from the client’s perspective. The emergent themes from participant responses indicated that personal therapy had an impact on empathy for the client, improved clinical skills, and on the effectiveness of treatment.

From a survey about personal therapy use, Daw and Joseph (2007) collected data and analyzed responses from 48 U.K. qualified therapists on a variety of demographic, occupational, training, and supervisory information. The authors specifically wanted to explore experiences in personal therapy that respondents were asked to comment on in an open ended question at the end of the survey. Responses were given from 29 therapists and the data was analyzed via the use of interpretive phenomenological analysis. The data, that is, the individual thoughts and perceptions of participants, defined how the research question was answered. Two broad domains emerged: impact on the person and impact on the professional. Impact on the person included themes of therapist self care and personal development. Impact on the professional included themes of experiential learning and learning from being in the role of the client. Not only did participants describe personal growth and healing from their own treatment, but they discussed how they gained professional insight into the client role by increasing empathy and respect, understanding therapeutic processes at a greater level, and by recognizing the importance of boundaries between personal and professional roles.
In effort to gain further exploration of the complexity of the impact of personal therapy on therapeutic practice, Rake and Paley (2009) interviewed eight British therapists who all had personal therapy as a training requirement, were currently practicing as a therapist, and had been for at least 2 years. Semi-structured interviews were conducted as a means to gather data on the participants’ experiences. Transcripts were analyzed via interpretive phenomenological analysis and emergent themes were grouped into clusters of concepts. Master themes were then developed from the concept clusters. The first master theme described how personal therapy helped participants to learn to do therapy by watching the therapist and by experiencing being in the client role. The experience of being a client meant that they could increase their awareness, understand the process better, and inform their own work with clients. The second master theme described how personal therapy helped participants know themselves much better both personally and professionally. They reportedly felt that they were able to experience emotional distress and how to deal with it which led to less fear when working with their own clients. Finally, the third master theme related to any detrimental aspects of the personal therapy experience. Responses indicated that some aspects of the therapist were unhelpful such as the therapeutic stance, a lack of explanation in therapy, comments made by the therapist, and the unsettling nature of therapy. Some participants commented that the negative aspects of the experience helped them learn what not to do in therapy while others reflected on having to face personal issues perhaps in an untimely manner. Overall however, all participants perceived the benefits of increased self-awareness, empathy, and emotional connectedness learned from personal therapy to be a crucial experience in order to practice therapy. Despite some negative aspects stemming from experiences with individual therapists, participants indicated that therapy was a necessary feature of the training process.
Rizq and Target (2009) interviewed nine British counseling psychologists in their exploration of the meaning of personal therapy on professional practice. The authors transcribed interviews and engaged in interpretive phenomenological analysis to grasp the unique ideas and feelings expressed by participants. Ideas were then grouped together into clusters that described identified themes. Five master themes emerged: personal therapy provides an arena for intense self-experiences, personal therapy establishes self-other boundaries, personal therapy is an arena for professional learning, personal therapy is integral to training, and significance of self-reflexivity. For the purpose of their article, the authors focused on two of the master themes discovered. First, the theme of personal therapy establishes self-other boundaries was explored. Participants felt that personal therapy helped them develop a more integrated sense of self in relation to the therapist and in relationship to their clients, helping them to separate their own issues from client issues and thus, establish self-other boundaries as well as promote equality between therapist and client. Second, the theme of the significance of self-reflexivity involved participants’ experiences in searching for meaning. They described feeling as if personal therapy helped them make meaning out of life experiences and how important being self-reflective was to personal and professional development. Although discussion on the remaining themes were not presented by the authors, it is possible to conclude that findings were similar to those of other studies in terms of the importance of personal therapy as a healing environment, in the development of self-awareness, in the development of professional identity, in providing increased empathy toward clients, and learning about boundaries.

Oteiza’s (2010) study of 10 Spanish therapists interviewed about their personal therapy experiences generated themes related to both personal and professional development as well. Participants had all been in practice for at least 15 years and had a fair amount of personal
therapy in their histories ranging from a minimum of 3 years to a maximum of 10 years. The author analyzed transcript data and extracted significant statements that were organized into clusters of six themes. Some themes related to specific interview questions such as the experience of choosing a therapist and how much time should be spent in therapy; however, the remaining themes emerged from open-ended probes about the personal therapy experience influencing professional development. For example, participants indicated that personal therapy contributed to knowing oneself better, feeling better, being a better therapist in practice, and developing affectively. Although difficult to go through, participants felt that personal therapy was a helpful and enriching experience, allowing them to become more conscious of their personal issues and of their impact as therapists on others. They seemed to feel strongly that personal therapy is a unique contribution to professional development above and beyond what supervision and other growth experiences can offer. Findings from this study likewise suggest that participants believe that their personal therapy experience influences how they practice professionally.

The qualitative studies presented above offer some common insights into the personal therapy experiences of mental health practitioners and the impact on professional development. Emergent themes generally fell into two broad categories of experiencing the client role and learning about the therapist role. Engaging in personal therapy as a client helped psychotherapists become more empathic, respectful, and sensitive toward clients. They also reported that they learned from their therapists by observing and partaking in the therapeutic process. In turn, mental health providers indicated that their professional practice was enhanced as they could relate better to clients and felt more comfortable engaged in the healing process.
Although the qualitative methods provided for a more in depth exploration of psychotherapists’ personal therapy experiences, results are still limited to the specific populations studied and can only be cautiously applied to include the greater population of mental health providers. For example, sample sizes were quite small (often less than 15 participants) and even though this is sufficient for qualitative methods, the possibility exists that a different set of participants would yield differing results. Response bias may be an issue as well since psychotherapists who have had positive experiences in therapy probably would be interested in sharing their experiences. Similarly, cognitive dissonance may be present in their assessment of how helpful personal therapy was, especially if they were required to engage in it. It would be discomforting to invest time and money into something that really didn’t seem valuable. Likewise, it is possible that participants may have viewed their personal therapy as contributing to professional development when actually other influences were present. Almost all of the participants were seasoned professionals so the chances of misattributions present are possible. Finally, as with all qualitative research, interpretations are tentative and subject to interpreter bias. Researchers attempt to manage and limit what they bring into the interpretive process but the nature of qualitative analysis lends itself to researcher subjectivity. It is possible that some interpretations about the value of personal therapy and the influence on clinical practice may have been unintentionally placed on participant reports.

The first major section of this chapter presented a broad review of findings from survey research on the use of personal therapy by mental health practitioners. The overall impression as a group is that psychotherapists from the U. S. and abroad have engaged in personal therapy, typically on more than one occasion, for a variety of reasons, and found the outcomes to be beneficial to personal growth and clinical practice. The population under study represented a
variety of mental health providers all of whom were experienced professionals. The nature of survey research limits to what extent the perceptions and beliefs of these psychotherapists who have engaged in personal therapy can be explored, especially that which relates to professional practice. Therefore, the second major section of this chapter focused on qualitative research in effort to discover more in depth what mental health practitioners perceived about their personal therapy experiences and how they believed personal therapy aided in professional development. Overall, emergent themes indicated that the contribution of personal therapy to professional development included learning about the experience of being a client, observing the therapist from the role of the client, expanding empathy and personal growth, and experiencing the effectiveness of therapy. The qualitative nature of these studies allowed for the actual participant voices to be portrayed giving more depth into the exploration of their lived experiences in therapy; however, sample sizes were small and most participants were experienced professionals reflecting back on how they believed the personal therapy experience helped them become a better professional.

Although many themes emerged related to participating in personal therapy during training and how personal therapy aided in becoming a better practitioner, research is still lacking in examining the psychotherapist trainee population as to what their experiences are like and whether personal therapy aids in their professional development and clinical practice. This may be due to consistent references to a lack of evidence supporting any measurable effect of therapist personal therapy on client outcome. Thus, a gap exists between the notion that psychotherapist personal therapy leads to more effective clinical practice and the actual observation of more effective client outcome. Studies that attempted to link the effect of psychotherapist personal therapy to client outcome are outdated and often only tangentially
linked to variables in question. The next major section of this chapter presents conclusions made in numerous reviews regarding studies that attempted to measure the effects of psychotherapist personal therapy on client outcome, as well as offers a critique of the studies referenced in the reviews.

The Effects of Psychotherapist Personal Therapy on Client Outcome

Despite numerous accounts of the benefits of personal therapy by mental health professionals, research has been unable to sufficiently connect the effects of psychotherapist personal therapy experience to client outcome. Over the past few decades, researchers have reviewed several outcome studies and have found that generally, research does not support a relationship between psychotherapist personal therapy experience and client outcome. This section is divided into two subsections. The first subsection highlights some frequently referenced literature reviews regarding previous research on therapist personal therapy and the link to client outcome. The second subsection details the specific studies included in the literature reviews presented.

Literature reviews of the effects of psychotherapist personal therapy on client outcome. Throughout the vast literature on psychotherapists’ personal therapy, there is often the curiosity as to whether having one’s own psychotherapy might have an effect on one’s work with clients. The notion is that if mental health practitioners experience their own personal therapy, then their clients will benefit more so than clients of psychotherapists who have not engaged in personal therapy. In attempt to answer this question, several researchers have reviewed literature examining the effects of psychotherapist personal therapy experience on client outcome. Some frequently referenced reviews are those by Greenberg and Staller (1981), Clark (1986), Macaskill (1988), and Macran and Shapiro (1998). Within these reviews, there is overlap in the
critique of many of the outcome studies referenced. Table 1 lists the studies reviewed by each researcher and states general conclusions made regarding the studies.

The outcome studies in Table 1 with the most overlap (i.e., examined by all four reviewers listed) include Holt and Luborsky (1958), Katz et al. (1958), Derner (1960), and Garfield and Bergin (1971). Three of the reviewers cited Strupp et al. (1969) and Kernberg (1973). There are not many differences between the reviewers’ critiques across studies. Likewise, their overall conclusions regarding the study of psychotherapist personal therapy as related to client outcome are also similar. The following paragraphs highlight and discuss these conclusions before providing more detail on each of the studies listed.

Greenberg and Staller (1981) investigated literature related to the effects of personal analysis on psychotherapists. They thought that providing a rational framework of current knowledge in the field would assist psychotherapists in making sound decisions regarding personal treatment. One area explored was in the effects of psychotherapist personal therapy on client outcome. The authors stated that although there were some impressions that therapist level of experience might interact with client outcome, data linking the two variables are inconclusive. Criticisms of the literature included lack of experimental control, not separating out therapist experience from personal therapy, largely a psychodynamic perspective, and the lack of comparison with other methods for training psychotherapists. The authors concluded that more evidence is needed before solid conclusions can be drawn.

In Clark’s (1986) attempt to discover empirical research linking psychotherapist personal therapy effects and client outcome, he presented studies that controlled for the professional experience level of the clinician. He indicated that there was not enough evidence to answer the question if psychotherapists with personal therapy experience produce better client outcome.
Table 1

Overlap in Critiques by Reviewers in Psychotherapy Outcome Studies

<table>
<thead>
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<tbody>
<tr>
<td>Holt &amp; Luborsky (1958)</td>
<td>Slight trend between PT and resident abilities, not significant</td>
<td>No relationship between groups</td>
<td>Slight trend between PT and resident abilities, not significant</td>
<td>No relationship between groups</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Katz, Lorr, &amp; Rubenstein (1958)</td>
<td>No relationship between groups</td>
<td>No relationship between groups</td>
<td>No relationship between groups</td>
<td>No significant difference</td>
<td>No significant difference</td>
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<tr>
<td>Derner (1960)</td>
<td>No relationship of trainee competence and amount of PT</td>
<td>No differences between groups in patient termination</td>
<td>Trainee competence unrelated to PT experience</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>McNair, Lorr, &amp; Callahan (1963)</td>
<td>Length of PT not related to outcome</td>
<td>No differences in termination rates between groups</td>
<td>No significant difference</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>McNair, Lorr, Young, Roth, &amp; Boyd (1964)</td>
<td>No relationship between groups</td>
<td>No differences between groups in satisfaction</td>
<td>No significant difference</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Strupp, Fox, &amp; Lessler (1969)</td>
<td>Negative relationship:</td>
<td>Suggestive: No therapist PT=greater client change</td>
<td>Clients of no PT therapists showed most change</td>
<td>Negative effect: small sample limits interpretation</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Garfield &amp; Bergin (1971)</td>
<td>More PT=worse patient outcomes</td>
<td>Tentative: Therapist experience not factored out</td>
<td>Positive effect of PT on outcome; experience not controlled</td>
<td>Therapist PT=lower client premature termination rates</td>
<td>Therapist experience not factored out</td>
</tr>
<tr>
<td>Kernberg (1973)</td>
<td>Tentative:</td>
<td>Tentative:</td>
<td>Positive effect of PT on outcome; experience not controlled</td>
<td>Therapist PT=lower client premature termination rates</td>
<td>Therapist experience not factored out</td>
</tr>
<tr>
<td>Strupp (1973)</td>
<td>Negative effect:</td>
<td>No control of therapist experience</td>
<td>Therapist PT=lower client premature termination rates</td>
<td>Therapist experience not factored out</td>
<td>Therapist experience not factored out</td>
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<tr>
<td>Greenspan &amp; Kulish (1985)</td>
<td>Therapist PT=lower client premature termination rates</td>
<td>Therapist experience not factored out</td>
<td>Therapist experience not factored out</td>
<td>Therapist experience not factored out</td>
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Note. “Between groups” refers to psychotherapists with personal therapy experience versus psychotherapists with no personal therapy experience; PT = personal therapy.
Criticisms included the failure of researchers to consider motivation for treatment by psychotherapists and when the personal treatment occurred. Additionally, Clark stated that researchers tended to assume personal therapy was beneficial to client outcome before demonstrating that a relationship even existed. He advised further research is necessary in this area.

Macaskill’s (1988) aim at answering whether personal therapy in the training of psychotherapists produced an impact on client outcome also concluded that there was not enough empirical evidence to support such an idea. Specifically, his review of client outcome studies also lends to there being no difference in effects between analyzed and non-analyzed psychotherapists. He offered recommendations for future research to use more critical research designs and more systematic outcome measures. He noted the possibility of poor design obscuring real effects because of the lack of consideration for the effectiveness of personal therapy, the lack of stratification for severity of problems in the client population, and the lack of stratification in the level of therapist health. Furthermore, Macaskill proposed that more research should focus on comparing other methods besides personal therapy in the training of psychotherapists.

The review by Macran and Shapiro (1998) into the role of personal therapy for psychotherapists and the effect on client outcome included four areas of research: surveys, experimental studies, outcome studies, and process studies. The authors resorted to conclusions offered by Greenberg and Staller (1981), Clark (1986), and Macaskill (1988) listed above. Macran and Shapiro agreed that there was no evidence that either the receipt of personal therapy or length of personal therapy by psychotherapists positively related to client outcome. Although they added one additional study (Greenspan & Kulish, 1985), the authors maintained that a direct
effect of personal therapy on client outcome is inconclusive. The authors also noted problems in the research including sampling issues, the lack of formal control, confounding factors related to clients and therapists, and the use of various measures of outcome. Macran and Shapiro advocated shifting the focus from the effects of psychotherapist personal therapy on client outcome to studying the effects of psychotherapist personal therapy on the therapeutic process.

The reviews by Greenberg and Staller (1981), Clark (1986), Macaskill (1988), and Macran and Shapiro (1998) offering no conclusive evidence that psychotherapist personal therapy has an impact on client outcome were supported by Orlinsky, Norcross et al. (2005) in their exploration of what can be learned from the experience of personal therapy by psychotherapists. Orlinsky, Norcross et al. offered an additional criticism as well. Studies had failed to ask psychotherapists whether they thought they had benefitted substantially from their personal therapy experiences. The authors noted however, that they wouldn’t expect adding this criterion to result in any detection of the impact of psychotherapist personal therapy on client outcome. Moreover, they argued hypothetically that if 15% of client outcome was related to therapist factors (along with 50% client resources and 35% therapeutic relationship), that the personal therapy experience of the therapist would be one of many factors included in the therapist resources, and probably would only be a small part of the therapist’s contribution. Thus, besides the near impossibility of controlling for client factors, the variation in the factors individual therapists would be bringing to therapy would be too great to detect such a relationship. Similarly, Macran et al. (1999) noted how difficult it would be to truly test for a relationship between client outcome and psychotherapist personal therapy experience. They considered the obstacles of clinical trials where therapists are randomly assigned to receive or not receive personal therapy and clients randomly assigned to therapists, and the outcomes
assessed. They concluded that this approach would be impractical, expensive, and wrought with problems of selection, standardization, and measurement.

Research related to the effect of psychotherapist personal therapy on client outcome has been reviewed over time in effort to discover whether having one’s own personal therapy makes one a more effective therapist than someone who has not engaged in personal therapy. The more frequently cited reviews include those by Greenberg and Staller (1981), Clark (1986), Macaskill (1988), and Macran and Shapiro (1998) in which all authors generally concluded that there is not enough evidence to support a relationship between psychotherapist personal therapy and client outcome. Likewise, Orlinsky, Norcross et al. (2005) discussed how difficult it would be to detect a relationship given the large amount of variance and Macran et al. (1999) laid out the difficulties in the design of such a study. Unfortunately, the lack of older evidence supporting a relationship between psychotherapist personal therapy and client outcome has resulted in a lack of current action in exploring a relationship between psychotherapist personal therapy and client outcome. That is, researchers haven’t continued to study the possible impact of psychotherapists’ personal therapy experiences on client outcome because past research was inconclusive and future research seemed too difficult. Thus, there remains a paucity of research on the topic.

A major problem with the continued lack of research is that current thinking on the topic has relied on old conclusions based on even older studies to inform ideas about whether linking client outcome to psychotherapist personal therapy is possible or worth pursuing. Outdated studies consist of older methods for measuring client outcome and are no longer the preferred model or relevant to current practices in the field of assessment of client outcome. Yet researchers have not pursued updating knowledge in the area of psychotherapist personal therapy
and client outcome despite advancements made in how client change is measured. Additionally, the heavily cited past conclusions are based on studies not entirely relevant to the examination of client outcome as a function of psychotherapist personal therapy and perhaps, should not have previously been included as evidence in such reviews. The next subsection presents more details on the client outcome studies reviewed by authors in the preceding subsection. Further description of the client outcome studies uncovers more information regarding the purpose of the study, the motivating factors for the study, and the vague context in which client outcome was measured. The notion that perhaps these studies were not appropriate for inclusion in literature reviews exploring psychotherapist personal therapy and the effect on client outcome is illustrated.

**Client outcome studies.** In effort to inform current knowledge pertaining to the effects of therapist personal therapy on client outcome, it is helpful to not only explore literature reviews on the topic but to actually investigate studies included in reviews. The following paragraphs present brief synopses of the studies listed in Table 1 and offer rationale for whether the research is an appropriate fit for inclusion in the category of the effects of psychotherapist personal therapy on client outcome. In many cases, only findings relevant to psychotherapist personal therapy and the effect on client outcome are noted, even if the study described had additional components. Ten studies are reviewed.

**Holt and Luborsky (1958).** In the years following World War II, there was a large influx of applicants for training in psychiatry. Training institutions felt responsible to produce the best psychiatrists in the largest numbers possible. The Menniger School of Psychiatry began a 10 year research project to study the application process for psychiatric training in hopes of predicting future competence and improving methods for selection into the program. Residents
were evaluated on knowledge acquisition and skill level, and researchers aimed to identify variables that might affect progress through the program.

Out of 238 residents, 22% received psychotherapeutic help of some kind. Some sought training analysis because they had hoped to specialize in psychoanalysis whereas others needed personal analysis for the treatment of personal problems. Supervisors rated residents by attempting to identify those that received treatment and evaluating how many improved in competence during training. In comparison of supervisor ratings for those that received therapy (either training or personal) versus those that did not, there was no significant difference between groups; however, researchers noted that there appeared to be a slight trend toward better competence ratings for those who entered therapy. Holt and Luborsky stated that the groups were too small to permit conclusions and noted that it was problematic to compare groups on the assumptions that both groups had the same potential for improvement. Moreover, they added that supervisors may have been biased because of their prior established relationships with supervisees. The only point intended to be made from this segment of the study was that if residents applied for psychotherapeutic treatment, it was better for them if they received it because the group that applied for treatment and did not receive it had the lowest competence ratings.

Although supervisor ratings appeared to serve as a useful evaluation tool for many aspects in this study, the ratings are not a sound measure of client outcome. Whereas therapist competence is assumed to be related to the effectiveness of therapy, the study did not assess effectiveness in terms of outcome, which is the variable in question in relation to therapist personal therapy. The insight gained by looking into the personal therapy experiences of
psychiatric residents may have been useful for many reasons, none of which could be significantly linked to client outcome.

*Katz, Lorr, and Rubenstein (1958).* Researchers in this study had hoped to build upon previous research identifying patient attributes that related to remaining in therapy. Specifically, they had hoped to identify variables that might predict improvement for those that remained in therapy. The subjects included 232 patients from 13 nationwide Veterans Administration clinics. Subjects were randomly split into two groups of 116 patients each, and then split into 58 of those who terminated in less than 6 weeks and 58 of those who remained longer than 26 weeks. Patients completed a self-administered battery of five tests and based on tests results, an intake worker predicted if the patient would remain in treatment. After 6 months, if the patient was still in treatment, that patient’s therapist rated the extent that the patient had improved during treatment. Of the 116 patients remaining in treatment longer than 6 months, three patient variables correlated with the therapists’ rating of improvement: a study-specific configured score based on items from subscales including behavioral disturbance, anxiety, and authoritarianism; the occupational level of the patient; and the patient’s actual earnings. Three therapist variables were then correlated with their ratings of improvement: years of experience, diagnostic classification of the patient, and the presence or absence of personal therapy experience. None of the therapist variables were significantly correlated to the patients’ length of stay in treatment; however, the therapist’s years of experience was the only therapist variable significantly correlated to rating of patient improvement. Thus, the presence or absence of therapist personal therapy was not significantly correlated to the therapist rating of improvement.

Personal therapy experience as a therapist variable in the Katz et al. (1958) study was not well defined or described. It is not known from the published article how much information the
researchers collected regarding personal therapy experience, other than if subjects had it or not. Furthermore, the number of therapists included in the study was not noted. The investigation focused on identifying patient attributes that were correlated with improvement in psychotherapy for those that remained in therapy. It was not designed to assess for the effect of psychotherapist personal therapy on client outcome.

**Derner (1960).** In a written piece on an interpersonal approach to psychotherapy training, Derner describes “one small experience in an extremely minor research” (p. 133) concerning his curiosity into the personal psychotherapy of therapists in training. Each year the staff at the clinic where he worked ranked the therapists trainees in competence from best to least competent. His opinion was that the staff had good reliability although no statistical assessment was ever computed. Derner compiled a list of the top two trainees and bottom two trainees from each year over the course of a 4-year period. Then he looked into whether they had personal therapy experience. He discovered that the experience of personal therapy was evident in half of both the top and the bottom of the eight-member groups. Derner concluded that therapists with and without personal therapy can be effective and that greater amounts of effectiveness was not related to having or not having personal therapy.

This observation may have served Derner’s curiosity regarding trainees in his clinic; however, the extent to which it applies to anyone other than 16 trainees in a psychology clinic over the course of 4 years is quite minimal. Moreover, even if competence ratings by staff members were based on client outcome, this was not specified and it was not an empirical study in which relationships between variables could be statistically computed. Derner was clear that this was just a modest attempt to merely explore which trainees participated in personal therapy
in his mention of the training program requirement. It was not however, to be used as supportive evidence in whether psychotherapist personal therapy affects client outcome.

*McNair, Lorr, & Callahan (1963).* The purpose of this research was to increase the predictive accuracy of a test battery that attempted to determine who terminated and who remained in therapy and learn more about those who terminated. The effect of the therapist on termination was also investigated as well as exploring interaction effects between patient type and therapist characteristics. A sample of 282 patients from seven Veterans Administration outpatient clinics were divided into two groups of those who remained in therapy (176) and those who terminated therapy (106). Eight therapist predictor variables were tested one at a time to determine if actual duration in therapy for the two groups was related to the predictor variable tested. One therapist predictor variable included was therapist personal psychotherapy. Those with personal psychotherapy experience did not significantly differ from therapists with no personal psychotherapy experience to the extent in which they held people who stayed in therapy.

Whereas the ability to keep people in therapy may be considered client outcome, attendance is not a clear measure of the experience of the client in therapy. Too many other factors relate to termination in therapy and to use termination as a gross measure of client outcome across therapists does not allow for comparison of differences between therapists with personal therapy and those without. It was important during this time period to minimize the waste of resources on those not fit for therapy, and research served the purpose of identifying who would make the best use of therapy and who would not. In this vein researchers hoped to discover variables related to both clients and therapists, and personal therapy experience was not
found to matter in a therapist’s ability to affect clients’ attendance rates. A better measure of outcome would be the mental health status of the client.

*McNair, Lorr, Young, Roth, & Boyd (1964).* This study was conducted in effort to explore the effects of psychotherapy post treatment. After a period of 3 years, 81 male veterans from three Veterans Administration clinics were evaluated to compare results at follow up to their pre-treatment status. The authors expected scores at follow up to be related to number of months in treatment and number of sessions during treatment months. Evaluations included a research test battery and a semi-structured hour long interview by a research psychologist. The therapist sample included 40 therapists (11 psychiatrists, 15 psychologists, and 14 social workers) all with 5-6 years experience with the exception of one trainee. When looking at pre-treatment measures related to length of stay in therapy, three variables predicted how long a patient stayed in treatment: the initial self-rating, the severity of illness rating, and the amount of therapist analysis. The authors concluded in part that therapists with more personal therapy experience kept their patients longer.

In comparison to other studies of clients that remain in therapy versus terminate, there is evidence in McNair et al. (1964) that amount of personal psychotherapy correlates with how long clients stayed in therapy; however, the specific definition for amount of personal therapy was not described. It was noted that many of the therapists in the study were psychoanalytically oriented leading to the assumption that if training in psychoanalysis occurred, personal analysis did too. The lack of clarity regarding the amount of therapy variable makes it difficult to draw conclusions about the effect on the length of stay variable. Additionally, length of stay is a gross measure of client outcome which is not the most appropriate means for differentiating between
successful and unsuccessful cases. This is yet another study that does not adequately support the relationship, or lack thereof, between therapist personal therapy and client outcome.

**Strupp, Fox, & Lessler (1969).** In effort to gain a better understanding of factors in the patient-therapist relationship that account for therapeutic change, the authors compared patient outcome in a series of two studies. In the first study, 11 psychiatrists in private practice evaluated 44 long-term patients after the fact as to their change in therapy from before to after therapy occurred. Patients were mailed a questionnaire asking them to respond to their experience in therapy. The therapist sample was described as highly experienced and the patient sample as severely disturbed. The second study used clinic charts to evaluate patient progress and included 131 patients with at least 25 therapy sessions, and 79 therapists consisting of medical students. Patients in this study were also sent a questionnaire to return regarding their therapy experience. Clinic staff assessed patient progress in therapy outside of any therapist ratings of their patients. The second study sample was described as having less experienced therapists and less disturbed patients. Patients in both studies were asked to reflect on their therapy experience at least 2 years after treatment. One comparison made by Strupp et al. was the satisfaction of the therapy experience overall. The authors found no significant difference between the more experienced group and the less experienced group.

Despite the inclusion of this study in reviews of the effects of psychotherapist personal therapy on client outcome, it was not noted whether the therapist samples had personal therapy experience. Perhaps an assumption was made based on the experience level of the therapists in the first study (psychiatrists practicing psychoanalysis) and the second study (medical students) being that therapists in the first study likely had personal analysis. Even if this was true,
assessing outcome 2 years after the experience by a rating of satisfaction level is not likely to adequately reflect the impact of therapist personal therapy on client outcome.

**Garfield & Bergin (1971).** The study conducted here has been frequently cited as showing a negative effect of therapist personal therapy on client outcome. The sample included 18 therapists who were graduate students in a psychotherapy practicum, and 38 clients from the university training clinic. Personal therapy was measured in terms of hours and therapists were divided into three groups describing amount of therapy. Four therapists had no personal therapy, seven had between 80 and 175 hours of personal therapy, and seven had between 200 and 450 hours of personal therapy. Client outcome was measured by changes in the D scale and the K scale of the MMPI, and a therapist rating on a five-point scale of client disturbance at the beginning and end of treatment. Unfortunately, the sample was too small to run tests of significance. The authors noted however, that the trend described more change in clients of therapists with no personal therapy and the least amount of change in clients of therapists with the most personal therapy. They offered that perhaps the most disturbed therapists were obtaining the most therapy and so more personal therapy experience was contaminated by therapist pathology. Additionally, engaging in intensive psychoanalysis at the same time as conducting therapy with clients might result in preoccupation with one’s own problems and being less attendant to clients.

The Garfield and Bergin (1971) study is notable, but not for the reasons often cited by other researchers. Commonly cited in research is that personal therapy had a negative effect on the therapists in this study; however, this conclusion cannot be made without significant results to draw from. The study is notable because it appears to be the first to use actual client outcome measures to assess for progress in therapy. Although there are now more appropriate measures
of client outcome, this design provided an interesting look at attempting to assess amount of psychotherapist personal therapy and the effect on client outcome.

**Kernberg (1973).** It is not clear what this research report adds to the literature regarding psychotherapist personal therapy and client outcome. Kernberg issued a final report regarding conclusions made from the Psychotherapy Research Project of the Menninger Foundation. The report compares two methods of analyses used in evaluating patient outcome as a function of patient variables and type of treatment employed. Type of treatment included psychoanalysis, expressive psychotherapy, expressive-supportive psychotherapy, and supportive psychotherapy. Only one general therapist variable, skill level, was mentioned. Kernberg briefly refers to therapists with higher skill being more effective than less-skilled therapists with the administration of differing treatment types. How therapist skill is measured is not included in this report. Thus, this research does not appear to offer evidence in the debate over the effectiveness of personal therapy on client outcome.

**Strupp (1973).** Although this study has been included in some literature reviews on the effect of therapist personal therapy on client outcome (e.g., Greenberg & Staller, 1981; Clark, 1986), it does not appear to actually measure client outcome. Strupp compared therapists on the basis of personal therapy experience but actually measured their responses to client statements in an analogue study. Differences among therapist groups were found but related to levels of empathy in the process of therapy and the number of silent responses given. Whereas important findings in this study have facilitated more research on psychotherapist personal therapy and the client-therapist process during treatment, and whereas process is certainly related to outcome, client outcome was not specifically measured in this study and thus, does not fit in the discussion on psychotherapist personal therapy experience affecting client outcome.
*Greenspan & Kulish (1985).* This study examined factors in premature termination of 273 cases in an outpatient clinic. The association of 10 patient variables and nine therapist variables to premature termination was analyzed. In terms of the therapist variables tested, only two significantly correlated with premature termination: type of degree and personal therapy experience. The therapist sample included four psychiatrists (MD), five psychologists (PHD), 14 social workers (MSW), and four master’s level psychologists (MA). Based on degree type, the PHDs had the smallest premature termination rates which were significantly lower than for MSWs and MDs. PHDs also had lower rates than MAs, but not significantly. In terms of amount of personal therapy experience, there was no significant relationship to premature termination; however, the mean differences between having personal therapy and not having personal therapy on termination rates were significant. Moreover, within-group differences were computed between therapists with personal therapy and those without. In the MD group, premature termination rates were significantly lower for those with therapy versus those without. The MSW group also showed significant differences of lower premature termination rates for therapists with personal therapy experience versus those without. The therapists in the PHD and MA groups all had personal therapy so within group comparisons were not made.

Greenspan and Kulish (1985) offer insights into some therapist variables, notably the experience of personal therapy, in relation to premature termination rates. More research is needed however, that would increase the sample size of therapists, especially in terms of increasing heterogeneity of groups. Additionally, measures of client outcome that include more than just attendance rates might offer further insight into the phenomenon under study. Including this research as an example of the effect of therapist personal therapy on client
outcome is a more limited view of outcome and ignores other factors such as client mental health status and progress in therapy.

In the review of outcome studies in this section, it is evident that many do not accurately depict true measures of client outcome as a function of psychotherapist personal therapy. Studies have measured outcome in a variety of ways including supervisor ratings, therapist ratings, length of stay in therapy, client satisfaction ratings, and client file data. Although the ways in which outcome has been measured may have been the best method for the time the study was conducted, it is difficult to translate results found using older measurement methods in the application of knowledge today. Moreover, some research said to be client outcome studies in literature reviews does not seem to fit well in the discussion of whether psychotherapist personal therapy has an effect on client outcome. That is, either the link of therapist personal therapy is tangential to the study objectives or it is unclear whether psychotherapist personal therapy was actually assessed. In either case, current research that assesses for amount of therapist personal therapy and the effect on client outcome as measured by treatment progress is long overdue.

Given the limitations evident in literature reviews of psychotherapist personal therapy and the effect on client outcome, or in the original studies included in literature reviews, it is at the very least necessary to research these variables using updated research methods, outcome measurements, and analyses that might account for the small effects in the relationship between study variables. For example, therapists could be asked to describe in more detail the nature of their personal therapy experience, length of time in therapy, and whether they perceived the experience as beneficial. Client outcome can be measured via client responses on treatment progress measures and these scores can be used to examine differences in treatment rates for therapists with differing levels of personal therapy experience. The final section of this chapter
integrates the core ideas from the preceding sections and offers rationale for the current study examining the effect of psychotherapist personal therapy experience on client outcome.

**Summary and Rational for Current Study**

The foregoing literature review presents an extensive overlook of personal therapy for mental health practitioners in general, followed by research investigating the perceived benefits of personal therapy by psychotherapists, and eventually focusing inward on problems remaining in the area of finding effects on client outcome. In effort to advance knowledge regarding the impact of psychotherapist personal therapy on client outcome, some important changes must be implemented regarding how this phenomenon is studied. The remaining discussion is divided into two subsections that first provide a summary and integration of core ideas, and second, offer rationale for the current study. The rationale subsection focuses on the use of counselor trainees as a sample, and the use of newer methods for client outcome assessment and data analysis.

**Summary and integration of core ideas.** Exploring the historical context of psychotherapists in psychotherapy unveils how strongly rooted the idea of obtaining personal therapy for oneself is when pursuant of providing it to others. Freud maintained that in the training of psychoanalysis, one must also be psychoanalyzed in order to practice effectively. The notion spread to other veins of psychology training schools and can generally be found today throughout many therapy training programs. The curiosity of mental health practitioners engaging in personal therapy spawned a vast amount of research that has been collected by Geller et al. (2005) and organized into an informative volume on the practices of psychotherapists in psychotherapy. For example, current knowledge shows that mental health practitioners seek personal therapy typically more than on one occasion, for a variety of reasons, and perceive outcomes to be beneficial to personal growth and professional practice.
Specifically, the idea that personal therapy is helpful to professional development has been a widely accepted assumption. Orlinsky, Ronnestad, et al. (2005) offered similar prevalence, rationale, and outcome trends in a global exploration of how psychotherapists develop, adding that the first or second greatest influence on professional development cited by many psychotherapists is their own personal therapy. Moreover, a contemporary study by Bike et al. (2009) explored lessons learned from personal therapy experiences and found that therapist characteristics, the therapeutic relationship, being in the role of the client, and treatment effectiveness were lasting impressions from the treatment experience.

Although notable, findings presented here resulted from survey research which is difficult to generalize because data cannot be checked for accuracy and response bias is typical. In response, qualitative inquiry became a common venue for exploring the meaning of personal psychotherapy on mental health practitioners’ professional practice. Mental health practitioners described in depth how they perceived personal therapy experiences to aid them professionally. Overall, emergent themes included learning about the experience of being a client, observing the therapist from the role of the client, expanding empathy and personal growth, and witnessing the effectiveness of therapy. Using qualitative methods allowed for the actual participant voices to describe their lived experiences in personal therapy and how they believed the experience translated to better clinical practice. Additionally, qualitative studies enhanced findings from quantitative studies on psychotherapists’ experiences being clients and conclusions made from both types of studies are generally consistent with each other. The qualitative study methods presented here also have limitations such as small sample sizes and the majority of participants in professional practice being asked to think retrospectively about how personal therapy helped them become a better therapist. Whereas qualitative findings aided in providing a clearer
understanding of personal therapy and the impact on professional practice, research is still lacking in examining the psychotherapist trainee population as to how personal therapy might influence their professional development.

The lack of current research likely reflects the conclusions made by researchers who attempted to answer questions regarding the effectiveness of personal therapy on professional development, that is, whether having personal therapy experience makes one a better therapist thus translating to better client outcomes. The past few decades included research reviews that provided integrated findings from studies that in some way assessed for the effect of psychotherapist personal therapy on client outcome (Greenberg & Staller, 1981; Clark, 1986; Macaskill, 1988; and Macran & Shapiro, 1998). These reviews produced a consistently held conclusion that there was not enough evidence to make the claim that personal therapy on the part of the psychotherapist could facilitate better client outcome.

Although researchers of the original studies, as well as research review authors, generally agreed evidence was inconclusive, they also all tended to advocate for more research on the topic. Unfortunately, there seemed to be a separation over time between the ideas of inconclusive evidence and the need for further research. The generally accepted notion became that there was no relationship between psychotherapist personal therapy and client outcome, or if there was, it would be too difficult to reliably detect. A major problem with this notion is that it has been perpetuated over time despite many advances made in the assessment of client outcome. Instead, previously determined conclusions, which really should be taken in the context of the time the research was conducted, have continued to prevail in present day where they no longer fit with current practices. That is, conclusions based on older evidence supporting no relationship between psychotherapist personal therapy and client outcome have been
maintained to inform current decisions about exploring such a relationship. Furthermore, a critical look into many of the studies cited in research reviews on psychotherapist personal therapy and client outcome expose that they weren’t necessarily an appropriate prototype of the variables in question.

Above all, there continues to be a gap between the perception of psychotherapists that their personal therapy facilitates more effective clinical practice, and the actual observation of effects on client outcome. Numerous studies using both quantitative and qualitative methods in multiple research paradigms have documented the prevalence of this belief. Personal therapy for mental health practitioners has been effective in many ways, particularly in aiding professional development to the point of believing clinical effectiveness is enhanced; however, the search for evidence of the effect of personal therapy on client outcome has produced inconclusive results that have contaminated current thinking on the matter.

**Rationale for current study.** The literature regarding psychotherapists and their personal psychotherapy is in desperate need of newer insights to inform current knowledge. Reliance on past research is problematic due to two major issues. First, research in the area of psychotherapist personal therapy has mainly consisted of experienced professionals reflecting back on their personal therapy after the fact and then describing the value of the experience. Whereas findings of practicing professionals post training regarding the perceived value of personal therapy to professional development have been informative, those in training to be mental health professionals have been lacking from samples. Certainly some links from established findings can be made to what might be beneficial during the training stage; yet using a trainee population offers a clearer picture of how personal therapy might be beneficial to
trainees at the time of training, when they are initially developing professional skills and identities.

Second, research into the possible effect of psychotherapist personal therapy on client outcome is outdated, along with research reviews that claim inconclusive evidence based on past outcome studies. Much advancement has been made in outcome measurement and research needs to include the use of current and more rigorous outcome assessment, as well as newer methods of data analysis and research design. Moreover, research included in the reviews is often only tangentially linked to the question of how therapist participation in personal therapy is related to client outcome. Research needs to be designed to more appropriately assess for the effect of psychotherapist personal therapy on client outcome. For example, if therapists can describe the nature of their therapy experiences including the reasons they attended, for how long, and how it was beneficial, then the independent variable will consist of a clearer definition of psychotherapist personal therapy, particularly in terms of how it is measured. Likewise, the dependent variable will be clearly defined and measured as client progress in therapy. This examination of the relationship between the independent variable and the dependent variable will allow more direct examination than the referenced outcome studies of the past. The remainder of this subsection consists of two parts. First, the need to study a psychotherapist trainee sample is addressed. Second, the need for newer methods to discover a relationship between the psychotherapist personal therapy and client outcome variables is addressed.

**The need for trainees.** One area of research needed is the study of psychotherapist trainees and the impact of their personal therapy, especially that which relates to professional training. It is difficult to find studies exploring personal therapy use with strictly a trainee sample, and there appears to be none that examined specifically the effects of therapist trainees’
personal therapy on client outcome. It is possible that research with trainee samples may have dwindled because it is less common today for psychology training programs to include a personal therapy requirement for its students. In any case, two studies will be presented here that used survey research to inquire about personal therapy experiences with psychotherapist trainees.

Macaskill and Macaskill (1992) wanted to compare findings on psychotherapists’ use of personal therapy from U.S.-based research with psychotherapists in the U.K. They surveyed 25 U.K. psychotherapists in training about their experiences in personal therapy in terms of characteristics, attitudes, goals, and effects of therapy. Results indicated that the sample held enthusiastic attitudes toward therapy and listed primary goals in treatment of personal growth and the resolution of personal problems. The majority of participants (91%) reported purely positive outcomes of personal therapy and indicated that personal therapy during training increased self-awareness (76%), self-esteem (47%), and work competence (43%) as well as reduced symptoms (43%) and improved personal relationships (43%). The authors concluded that results were similar to U.S. findings, however the sample size was small so possible generalizations to the larger population were quite limited. Additionally, although participants endorsed positive effects of personal therapy, the categories were broad and it is unknown how the reported effect made an impact on participants’ professional training. For example, almost half of the sample indicated an increase in work competence but it is not known in what ways they felt more competent as a result of personal therapy.

Holzman, Searight, and Hughes (1996) also surveyed a national sample of U.S. clinical psychology graduate students’ use of psychotherapy. They wanted to explore the prevalence of personal therapy, the perception of personal therapy in relation to theoretical orientation, reasons for seeking treatment, and reasons for not seeking treatment. Results indicated that out of 1,018
respondents, nearly 75% endorsed being in therapy at some point in their lives with the average number of sessions totaling almost 80. Additionally, over half of respondents who endorsed personal therapy use reported being in it more than once in their lifetimes with an average of 130 sessions. Perceptions regarding the importance of personal therapy to learning to practice psychotherapy varied as a function of theoretical orientation. For example, 90% of students who identified as psychodynamic gave the importance of therapy to training the highest rating, whereas only 60% of students identifying as cognitive-behavioral endorsed that high of a rating.

Reasons for entering therapy during graduate school were personal growth (71%), desire to improve as a therapist (65%), adjustment issues (56%), and depression (38%). Students who had never been in therapy indicated having no need for it (56%) and finances (53%) as primary reasons for not seeking treatment. This study provides a clearer picture of personal therapy use among graduate students during training, particularly that trainees seek treatment largely for personal growth and wanting to improve as a therapist; however, it is not known if they believe their personal therapy was beneficial or effective, and in what ways it contributed to professional development.

Although findings from only two studies are quite limited, there is some evidence that therapist trainees have had personal therapy either before and/or during training, which seems like an opportune time to examine possible effects on client outcome. Whereas similarities likely exist between therapist trainees and the professional psychotherapist population (i.e., in terms of the prevalence, rationale, and outcome of personal therapy), studying trainees during the training period might offer more insight into the effects of their therapy use and how it applies to professional practice, thus having an impact on client outcome.
Qualitative studies exploring how psychotherapists believed their personal treatment helped them practice more effectively discovered that engaging in personal therapy provided them with the experience of being a client as well as the opportunity to learn by observing the therapist and the therapeutic process. This experience was thought to have enhanced their professional practice with their own clients based on a deeper understanding and/or appreciation for both roles in the healing process. This was an important discovery in describing how psychotherapists believed personal therapy helped them professionally. A problem is that they were practicing professionally when they participated in the studies. Therefore, when reflecting back on experiences in personal therapy, psychotherapists were no longer in the training phase to accurately portray the impact of their treatment experiences on their learning to be a therapist. In other words, time in practice, as well as other influences, as they progressed in their profession may have confounded what was truly attained and applied during the training years.

A more powerful way to examine the potential effects of therapist personal treatment on the practice of therapy with clients is to use a counselor trainee sample. The potential to capture a more meaningful connection between previous or current personal therapy experience and the impact on development seems more likely at the actual time counselors are in training. As trainees, they are at a similar level of experience in practicing therapy which is very little, if any, at the time of their first practicum. They are developing how to attend to clients so assessing for how they link what they’ve learned in personal therapy to how they want to be with clients is contained specifically to the training period. In addition to intentionally selecting trainees to study, methods for assessing client outcome and analyzing data need to be more current and appropriately designed to answer the research questions.
The need for newer methods. Research exploring possible effects of therapist personal therapy experience on client outcome has long been outdated. Conclusions regarding this phenomenon have stalled at either not having enough evidence to support a relationship or that a relationship would be too difficult to detect. Unfortunately, as methods for exploring such a relationship have evolved over time, attempts at discovering new knowledge in this area have not been updated. In order to more accurately assess for counselor personal therapy experience and the relationship to client outcome, new studies need to incorporate some critical methodological changes to the research design. First, more information should be gathered on counselors’ personal treatment history. Second, client outcome needs to be assessed by current standard outcome measures. Finally, data analysis that is capable of detecting small changes to the independent and dependent variables should be utilized. Further explanation regarding these methodological changes follows below.

Older research that attempted to link psychotherapist personal therapy experience to more effective practice typically categorized personal therapy experience by either the presence or absence of it. Sometimes participants were grouped by the number of hours in personal treatment. Unfortunately, important information related to the personal therapy experience was not included, which may have limited insight into the significance of the experience. The literature that did provide more details about the personal therapy experience (e.g., survey and qualitative research), consisted of studies not designed to examine potential effects on client outcome. Therefore, it is proposed that a new study gather more information about counselor trainees’ personal therapy experience that will explore the nature of the experience in more detail. For example, counselor trainees could respond to how many times they have been in therapy, what brought them to therapy, how many sessions they attended, for what reasons, and
in what ways they perceived it to be beneficial. Additionally, participants could respond to how they perceived each individual personal treatment experience to connect to their current training and development.

Another needed change in the study of the effect of therapist personal therapy on client outcome is to implement current measures of outcome assessment. Client outcome assessment has grown over the years into more reliable measures of treatment progress including the evaluation of clinically significant change. Historically though, treatment outcome was much more limited. Therapists providing treatment were most often the authority on client improvement and their perspective was usually sought after treatment had ended. The treating therapists’ supervisors also evaluated client outcome and sometimes clients were asked for their own opinion on treatment progress. The outcome studies presented earlier reflect this standard of measurement during that time which included ratings by supervisors, therapists, and clients, as well as the use of client file data such as attendance rates. Then the focus of client outcome shifted to specific measures developed to reflect the theoretical orientation in practice. For example, projective techniques were employed by psychoanalytic therapists to explore unconscious processes whereas cognitive-behavioral therapists would utilize inventories designed to target thought and behavior change. Outcome assessment today has evolved into measuring symptom reduction and patterns of treatment change (Lambert, 2013; 2010). Clients are able respond to statements assessing the presence of symptoms and levels of distress on a regular basis, which convert to scores that evaluate rates of change in treatment and overall progress.

Likewise, data analysis has expanded over time and includes more appropriate models designed to detect small changes in the relationship between independent and dependent
variables. Hierarchical linear modeling (HLM; Raudenbush & Bryk, 2002), is one program using advanced statistical techniques to produce growth patterns for subjects within groups of subjects across multiple levels. Studies exploring therapist effects on client outcome have used HLM to compare individual therapists in terms of their treatment effectiveness based on their clients’ outcome measurement scores. For example, Okiishi, Lambert, Nielsen, and Ogles (2003) examined if there were significant differences in the variability among individual therapists at a counseling center. They collected archival data of client outcome scores per individual therapist and used HLM to produce growth curves showing the speed of client improvement. The authors ranked therapists according to how quickly their clients improved, as well as by the total reduction in client outcome score between first and last sessions, among other factors. Speed of client improvement produced a different list than total reduction in outcome score. Of particular interest here is how HLM as a newer data analysis technique can produce significant differences in therapist variability based on client outcome assessment. This makes it more possible to compare therapists on a variety of factors in terms of what relates to improvement. In this case, amount of therapist personal therapy might account for some variation in how clients improve over time in therapy.

Given the problems listed in previous research regarding linking psychotherapist personal therapy to an impact on client outcome, it is proposed that current research be conducted to explore if the possibility of a relationship between more clearly defined variables exists. In particular, this investigation provides an updated exploration of the following questions:

1. What are counselor trainees’ experiences of personal therapy?

2. To what extent do counselor trainees perceive their personal therapy experiences to be beneficial?
3. Do counselor trainees’ clients produce larger reductions in psychological distress as a function of counselor trainee personal therapy experience?

4. Do counselor trainees’ clients produce larger reductions in psychological distress as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?

5. Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of counselor trainee personal therapy experience?

6. Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?
CHAPTER II

METHODS

The purpose of this study was to explore if counselor trainees’ personal therapy experiences are associated with client outcome. The following research questions were investigated:

1. What are counselor trainees’ experiences of personal therapy?
2. To what extent do counselor trainees perceive their personal therapy experiences to be beneficial?
3. Do counselor trainees’ clients produce larger reductions in psychological distress as a function of counselor trainee personal therapy experience?
4. Do counselor trainees’ clients produce larger reductions in psychological distress as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?
5. Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of counselor trainee personal therapy experience?
6. Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?

This chapter describes the participant sample, the instruments used, and the procedures involved in recruiting participants, collecting data, and planning for analyses. The chapter is divided into four sections beginning with describing what characteristics make up the participant
group. The second section provides information regarding the instruments used in the study. The third section details how data was collected and the last section addresses data analyses. A summary concludes the chapter.

**Participants**

The participant sample was recruited from two psychology training clinics housed in a counselor education and counseling psychology department at a large Midwestern U. S. university. The sample included graduate student counselor trainees enrolled in counseling practicum courses. Counseling practicum is the first course counselor trainees take that consists of supervised training of counseling experiences. Students have the opportunity to work with a variety of clients from differing social, cultural, economic, and racial/ethnic backgrounds who present with various concerns. The total number of participants recruited to participate in this study was 31 counselor trainees. All 31 trainees consented to participate and provided information requested in the study packet. One participant was missing information needed for data analysis so this participant was removed from the study. Thus, the final sample consisted of 30 counselor trainee participants.

Descriptive data from the counselor trainee participant sample was taken from information provided on the Counselor Information Questionnaire (CIQ). The CIQ was developed for this study and is fully described in the Instrumentation section. Participants were asked to write in how they identified themselves according to certain demographic categories so that they were not limited to choosing between predetermined labels. Participants also provided information pertaining to their development as counselors in training. Thus, the sample is described according to these two domains. The first domain describes participant demographic information including age, gender, race/ethnicity, relationship status, sexual orientation, veteran
status, and disability status. The second domain describes the training program participants are enrolled in, the number of direct service hours provided to clients that participants obtained prior to starting the practicum course, and the theoretical orientations reported as their approach to treatment. Additionally, participants reported their levels of preparedness and their levels of confidence in starting the practicum course.

**Demographic information.** Demographic characteristics of the counselor trainee sample are listed in Table 2. The reported age of participants ranged from 23 years old to 59 years old with a median age of 29 ($M = 33.00; SD = 11.04$). To provide more information regarding the frequencies of specific age ranges, participants were grouped according to the decade that their ages fell into (e.g., 20 – 29, 30 – 39, etc.). Half of the participant sample ($n = 15$) fell in the 20 – 29 age group, with reported ages ranging from 23 to 28. Seven participants fell in the 30 – 39 age group with reported ages ranging from 30 to 35. The 40 – 49 age group included five participants (16.7%) with reported ages from 41 to 49 and the 50 – 59 group included three participants (10.0%) with reported ages from 57 to 59.

Participants reported gender identities that fell into three subgroups: females, males, and gender queer/female. The female subgroup, which also included just “f” to describe gender identity, made up 63.3% of the participant sample ($n = 19$). The male subgroup, which also consisted of those reporting just “m,” made up 33.3% of the sample ($n = 10$). One participant reported gender identity as “gender queer / female.”

How participants responded to the race/ethnicity category is divided into four subgroups in Table 2: Caucasian/White, African-American/Black, Native American, and Asian/Caucasian. The Caucasian/White subgroup included those who used terms such as “Caucasian,” “cauc,” “white,” “w,” “white/non-Hispanic,” and “Irish” to describe race/ethnicity. They made up the
Table 2

Frequencies of Reported Demographic Characteristics of Counselor Trainee Participants

<table>
<thead>
<tr>
<th>Category</th>
<th>( f )</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 – 29</td>
<td>15</td>
<td>50.0%</td>
</tr>
<tr>
<td>30 – 39</td>
<td>7</td>
<td>23.3%</td>
</tr>
<tr>
<td>40 – 49</td>
<td>5</td>
<td>16.7%</td>
</tr>
<tr>
<td>50 – 59</td>
<td>3</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>63.3%</td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>33.3%</td>
</tr>
<tr>
<td>Gender queer/female</td>
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<td>3.3%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
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<td></td>
</tr>
<tr>
<td>Caucasian/White</td>
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<td>86.7%</td>
</tr>
<tr>
<td>African-American/Black</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Asian/Caucasian</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
<td>40.0%</td>
</tr>
<tr>
<td>Single</td>
<td>11</td>
<td>36.7%</td>
</tr>
<tr>
<td>In relationship</td>
<td>6</td>
<td>20.0%</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>25</td>
<td>83.3%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Gay/queer/polysexual</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Not reported</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Veteran Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>27</td>
<td>90.0%</td>
</tr>
<tr>
<td>Not reported</td>
<td>3</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Disability Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>27</td>
<td>90.0%</td>
</tr>
<tr>
<td>Legally blind</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Not reported</td>
<td>2</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

Note. \( N = 30 \)
majority of the sample (86.7%; n = 26). Two participants (6.7%) used the terms “African-American” and “black” to describe race/ethnicity and one participant reported race/ethnicity as “Native American.” One participant wrote “Asian/Caucasian” in response to race/ethnicity.

The category representing relationship status is shown in Table 2 and includes four subgroups: married, single, in relationship, and divorced. Forty percent of the sample (n = 12) reported relationship status as “married” or “m.” The single subgroup includes those who reported “single,” “single/never-married,” and “single!!!” Participants in this subgroup (n = 11) accounted for 36.7% of the sample. Twenty percent of participants (n = 6) responded to relationship status with terms such as “engaged,” “in a relationship,” and “ongoing.” One participant wrote “divorced” to describe relationship status.

Participant responses describing sexual orientation are divided into five subgroups in Table 2: heterosexual, bisexual, gay/queer/polysexual, male, and not reported. Those included in the heterosexual subgroup used terms such as “heterosexual,” “hetero,” and “straight” to describe sexual orientation. They made up the majority of the sample (83.3%) with 25 participants identifying as such. One participant reported “Bisexual” and another wrote “Gay/Queer/Polysexual” to identify sexual orientation. Two participants (6.7%) stated “Male” as their sexual orientation and one participant left the category blank.

Ninety percent of the participant sample (n = 27) reported that they were not veterans in response to the veteran status category. The none subgroup refers to those who indicated “none,” “non vet,” “non,” “no,” and “n/a.” Three participants (10.0%) did not provide a response in this category. Likewise, 90% of the participant sample (n = 27) also indicated no disability status. The none subgroup includes terms such as “none,” “non disabled,” “no,” “n,”
and “n/a.” One participant reported “legally blind” in response to disability status and two participants (6.7%) did not respond.

**Counselor trainee development information.** Characteristics that describe counselor trainee development are listed in Table 3. Participants were asked to indicate the graduate course of study they are enrolled in: Counselor Education or Counseling Psychology. The majority of participants (76.7%; n = 23) reported enrollment in Counselor Education programs. Participants reporting enrollment in Counselor Education were also grouped according to what program option they are completing. Thirteen participants (43.3%) indicated that their course of study is in Community Mental Health Counseling. Six participants (20.0%) reported studying School Counseling. Two participants (6.7%) indicated Marriage, Couple, and Family Counseling and two participants (6.7%) indicated Rehabilitation Counseling in terms of program options. No participants reported enrollment in the College Counseling program option. Seven participants (23.3%) reported being enrolled in the Counseling Psychology training program.

Participants were asked to report the number of therapy hours provided to clients, if any, that they acquired prior to the start of their counseling practicum. Table 3 shows that the majority of participants (80%; n = 24) had not provided any therapy to clients before starting the practicum course. Three participants indicated accruing therapy hours prior to practicum. One reported “50” hours, another reported “1000+” hours, and the third one listed “>3000” hours. Three participants (10%) did not provide a response in this category.

Table 3 also lists theoretical orientations as provided by participants in their own words. They were asked to report what theoretical orientations, if any, they use in their work with clients. Participants’ descriptions of their theoretical orientations are organized into eight subgroups. Subgroups contain the theoretical orientation listed alone or listed first in
Table 3

Frequencies of Reported Counselor Development Information for Counselor Trainee Participants

<table>
<thead>
<tr>
<th>Category</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor Education</td>
<td>23</td>
<td>76.7%</td>
</tr>
<tr>
<td>Clinical Mental Health Counseling</td>
<td>13</td>
<td>43.3%</td>
</tr>
<tr>
<td>School Counseling</td>
<td>6</td>
<td>20.0%</td>
</tr>
<tr>
<td>Marriage, Couple, and Family Counseling</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Rehabilitation Counseling</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>College Counseling</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Counseling Psychology</td>
<td>7</td>
<td>23.3%</td>
</tr>
<tr>
<td><strong>Therapy Hours Prior to Practicum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>24</td>
<td>80.0%</td>
</tr>
<tr>
<td>50</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>1000+</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>&gt;3000</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Not reported</td>
<td>3</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Theoretical Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive behavioral therapy(^a)</td>
<td>11</td>
<td>36.7%</td>
</tr>
<tr>
<td>Person/client–centered(^b)</td>
<td>8</td>
<td>26.7%</td>
</tr>
<tr>
<td>Adlerian(^c)</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Solution-focused therapy</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Cognitive therapy</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Constructivist</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td><strong>Preparedness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not prepared</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>A little prepared</td>
<td>12</td>
<td>40.0%</td>
</tr>
<tr>
<td>Somewhat prepared</td>
<td>13</td>
<td>43.3%</td>
</tr>
<tr>
<td>Very prepared</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Extremely prepared</td>
<td>1</td>
<td>3.3%</td>
</tr>
</tbody>
</table>
Table 3—Continued

<table>
<thead>
<tr>
<th>Category</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not confident</td>
<td>7</td>
<td>23.3%</td>
</tr>
<tr>
<td>A little confident</td>
<td>10</td>
<td>33.3%</td>
</tr>
<tr>
<td>Somewhat confident</td>
<td>12</td>
<td>40.0%</td>
</tr>
<tr>
<td>Very confident</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Extremely confident</td>
<td>1</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Note. N = 30. The Counselor Education category is shown first as the total sum of all five subgroups (i.e., program options), and then separately by subgroup.

*Includes those who listed “CBT” first, followed by one other treatment approach (e.g., “dbt,” “rebt,” and “existential”), and those who listed “CBT” first followed by two other treatment approaches (e.g., “mindfulness, solution focus” and “solution-focus, person-centered”). *Includes one who listed “person-centered” first, followed by “Rogerian, CBT, and choice theory.” *Adlerian was listed first in combination with one other treatment approach for each participant (i.e., “Rogerian” and “systemic/emotion-focused therapy”).

combination with others. The majority of participants (36.7%; n = 11) responded with “CBT” as the theoretical basis for how they work with clients. These responses make up the cognitive behavioral therapy subgroup. Of those 11 participants, six listed only “CBT” and five listed “CBT” first, followed by more theoretical approaches. For example, CBT was listed in conjunction with “DBT” by one participant, and with “Existentialism” by another participant.

Eight participants (26.7%) listed responses that make up the person/client–centered theoretical orientation subgroup. Of those eight participants, six listed “person-centered” as their sole orientation and one listed it first in conjunction with additional treatment approaches. One participant reported “client-centered.” Two participants (6.7%) described their theoretical orientation as “Adlerian” (i.e., listed first) followed by another approach. Two participants (6.7%) listed “solution-focus” as their only theoretical orientation. “Psychoanalytic” was listed as the sole orientation for one participant and “cognitive therapy” was listed as the sole orientation for another participant. One participant reported a “constructivist” approach which was followed by “solution-focused” and “client/person-centered.” Four participants (13.3%)
described not using a theoretical orientation or not having developed one yet. Information provided included “none,” “none so far,” and “not developed yet.”

Additionally, participants were asked to report both how well-prepared and how confident they felt to provide therapy to clients at the start of their practicum experience. To assess how well-prepared they felt, participants selected among five choices to describe their level of preparedness: not prepared (0), a little prepared (1), somewhat prepared (2), very prepared (3), and extremely prepared (4). Counselor trainees on average indicated feeling between a little prepared and somewhat prepared ($M = 1.60; SD = 0.86$). Frequencies of preparedness levels are listed in Table 3. The majority of participants, accounting for 83.3% of the sample, indicated feeling either a little prepared (n = 12) or somewhat prepared (n = 13). Two participants (i.e., 6.7%) reported feeling not prepared whereas two others reported feeling very prepared (i.e., 6.7%). One participant indicated feeling extremely prepared to begin therapy with clients in the practicum course.

To assess to what extent participants felt confident to provide therapy at the start of the practicum experience, they again chose among five options: not confident (0), a little confident (1), somewhat confident (2), very confident (3), and extremely confident (4). On average, counselor trainees indicated feeling between a little confident and somewhat confident ($M = 1.23; SD = 0.94$). Frequencies for each level of confidence are listed in Table 3. The majority of participants, accounting for 73.3% of the sample, indicated feeling either a little confident (n = 10) or somewhat confident (n = 12). Seven participants (23.3%) reported feeling not confident. No participants indicated feeling very confident and one participant reported feeling extremely confident to begin therapy with clients in the practicum course.
**Instruments**

The instruments used in this study included a counselor information questionnaire from counselor participants and a measure of psychological distress given to participants’ clients. Participants were asked to complete a counselor information questionnaire which requested demographic information and explored personal therapy experience. Scores from the Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 2004) are archival data obtained from the psychology training clinics where participating counselor trainees’ clients were seen. A description of both instruments follows.

**Counselor Information Questionnaire (CIQ).** The CIQ is a brief questionnaire developed for this study. It includes a section on demographic information followed by 14 questions related to any experiences that counselor trainees have had in personal therapy (see Appendix A). Demographic information requested on the CIQ includes age, gender, race/ethnicity, relationship status, sexual orientation, veteran status, disability status, and graduate course of study. Five questions follow that are related to level of experience in working with clients prior to and during the counseling practicum course. For example, counselor trainees are asked to report on the number of therapy hours provided to clients before entering the practicum course, their level of preparedness at the time the course started, and their level of confidence felt at the start of the course. They are also asked to describe the use of any theoretical orientations in their work with clients.

The remaining nine questions refer to experiences as clients in personal therapy. If participants report no history of personal therapy experience, they are instructed to skip the questions associated with these experiences. The details requested regarding each personal therapy experience are age at time of therapy, whether the therapy occurred while enrolled in a
graduate program, the level of choice in attending therapy, reasons for attending therapy, approximate number of sessions of therapy, and the level of perceived benefit of therapy to personal well-being and professional training. Participants’ perceptions of the benefits of therapy to personal well-being and professional training are gathered from responses to a list of potential benefits of therapy.

Perceived benefit to personal well-being is divided into six components. Participants provide a rating corresponding to how helpful they perceive the personal therapy experience to be to each component listed. The components listed as potential benefits to personal well-being were selected based on previous research identifying how therapists perceived therapy to be helpful to personal well-being. The six components that make up the benefit to personal well-being construct are as follows: (a) lessening the severity of presenting symptoms, (b) offering emotional relief, (c) improving mood/outlook, (d) improving self-esteem/confidence, (e) increasing insight/self-awareness, and (f) improving interpersonal relationships. The following 0 to 4 point scale is used to rate each component: not helpful (0), a little helpful (1), somewhat helpful (2), very helpful (3), and extremely helpful (4). Item values are added together to yield a total score reflective of perceived benefit to personal well-being. Benefit to personal well-being scores range from 0 to 24 points with higher scores indicating the degree to which the personal therapy experience was perceived to be helpful to personal well-being.

Perceived benefit to professional training is divided into seven components. Participants again provide a rating corresponding to how helpful they perceive the personal therapy experience to be to each component listed. The components listed as potential benefits to professional training were selected by reviewing research identifying how therapists perceived therapy to be helpful to professional training. The seven components that make up the benefits
to professional training construct are as follows: (a) preparing for clinical work, (b) understanding clients’ clinical concerns, (c) increasing empathy towards clients, (d) learning/incorporating the role of the therapist, (e) navigating the client-counselor relationship, (f) trusting the therapeutic process, and (g) believing in the effectiveness of therapy. Each component is rated according to the following 0 to 4 point scale: not helpful (0), a little helpful (1), somewhat helpful (2), very helpful (3), and extremely helpful (4). Item values are added together to yield a total score reflective of perceived benefit to professional training. Benefit to professional training scores range from 0 to 28 points with higher scores indicating the degree to which the personal therapy experience was perceived to be helpful to professional training.

Participants are asked to provide specific details for each personal therapy experience. The same set of questions regarding details of the therapy experience is listed three times so that participants may provide information for each separate therapeutic experience should they have more than one experience participating in therapy. Each “experience” is called an “occasion” or “episode,” referring to a distinct time period that participants sought out therapy, attended, and concluded (i.e., unless they are still attending currently). Participants begin with the most recent experience and move backward to the first experience, that is, if there is more than one occasion/episode to report on. If participants had additional occasions where they participated in personal therapy, space is provided to report on further experiences beyond the three listed using the same format for responding to the previous three experiences.

Finally, participants are asked to provide an overall impression of how beneficial their personal therapy experience(s) were as a whole, taken together if more than one, to their personal well-being and professional training in general. The following 0 to 4 point rating scale is provided: the experience was extremely beneficial (4), the experience was very beneficial (3), the
experience was somewhat beneficial (2), the experience was a little beneficial (1), and the experience was not beneficial (0). In contrast, they are also asked to provide an overall impression of how harmful their personal therapy experience(s) were as a whole, taken together if more than one, to their personal well-being and professional training in general. Ratings are given according to the same 0 to 4 point scale: the experience was extremely harmful (4), the experience was very harmful (3), the experience was somewhat harmful (2), the experience was a little harmful (1), and the experience was not harmful (0).

**Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 2004).** The OQ-45.2 is a 45-item self-report questionnaire designed to monitor client progress on a weekly basis over the course of therapy. It measures the subjective experience of a person in terms of how that person functions in the world (Lambert et al., 2004). Items fall into three domains descriptive of symptoms of distress, problems in interpersonal relations, and problems in social role performance (see Appendix B). For example, items assessing symptoms of distress include statements such as *I tire quickly, I feel irritated, I like myself* (reverse scored), and *I feel blue*. Items describing problems in interpersonal relations include *I get along well with others* (reverse scored), *I have frequent arguments*, and *I am satisfied with my relationships with others* (reverse scored), whereas items related to problems in social role performance include *I feel stressed at work/school, I find my work/school satisfying* (reverse scored), and *I enjoy my spare time* (reverse scored). Items are scored using a five-point Likert scale with a range of 0 to 4 assigned to responses including *never, rarely, sometimes, frequently, and almost always*. Items are summed to provide a total score as well as three domain or subscale scores. Total scores range from 0 to 180 with higher scores indicating more frequent symptoms and thus, more
psychological distress. A score of 63 is the cut-off point between nonclinical and clinical populations. OQ-45.2 total scores were used for the purposes of this study.

Lambert et al. (2004) assessed reliability with both university student and clinical patient samples. The student sample included test-retest reliability (.84) for the OQ-45.2 total score, and scores remained fairly stable over time. Weekly test-retest correlation coefficients for the student sample at the third, fourth, and fifth week administrations were .86, .82, and .77, respectively. Internal consistency for total score for both student and patient populations was .93.

The OQ-45.2 has demonstrated strong construct validity in two main areas. The first area is in the overall measurement of psychological distress. The OQ-45.2 total score correlates significantly with other instruments intended to measure psychological distress. For example, Lambert et al. (2004) reported correlation coefficients from an initial data set of university students using domain scores and total score of the OQ-45.2 with a variety of similar measures. Instruments such as the Symptom Checklist 90 R (SCL-90-R; Derogatis, 1977), Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Taylor Manifest Anxiety Scale (TMAS; Taylor, 1953), and SF 36 Medical Outcome Questionnaire (Ware, Snow, Kasinski, & Gandek, 1994) had correlation coefficients of .78, .80, .86, and .81 respectively, with the OQ-45.2 total score. Additionally, Umphress, Lambert, Smart, Barlow, and Clouse (1997) compared the OQ-45.2 to the SCL-90-R, the Social Adjustment Scale (SAS; Weissman & Bothwell, 1976), and the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988) with patient populations from a college counseling center, an outpatient clinic, and an inpatient hospital. Correlation coefficients for the OQ-45.2 total score were .78 (SCL-90-R), .79 (SAS), and .66 (IIP) for the counseling center; .84 (SCL-90-R), .71 (SAS), and .74 (IIP) for the outpatient clinic; and .88 (SCL-90-R), .81 (SAS), and .81 (IIP) for
the inpatient sample. The results suggest that the OQ-45.2 has high to moderately high concurrent validity with total scores and that it provides a valid index of mental health.

The second component of strong construct validity for the OQ-45.2 is evident in how the instrument reflects change in psychological distress. OQ-45.2 items, subscales, and total score were analyzed for sensitivity to change over time for treated (patient data) and control (student data) populations (Vermeersch, Lambert, & Burlingame, 2000). Results indicated significant differences for the total score, subscale scores, and 37 of 45 OQ-45.2 items for the treatment group versus the control group. In other words, those receiving treatment had scores that decreased over time and those not receiving treatment had scores that remained stable. In an archival study comparing another treatment group of counseling center clients with a control sample of undergraduate students, Vermeersch et al. (2004) found that 34 of 45 OQ-45.2 items differed significantly in that scores decreased over time for the treatment group versus the control group, and those treated improved more quickly than those not treated. The treatment group also differed significantly from those not treated on the three subscale scores and total score. Furthermore, the OQ-45.2 has been shown to detect differences in levels of psychopathology for patient and non-patient samples as well as predict with 84% accuracy membership in non-patient and patient samples (Lambert et al., 2004). Overall, the OQ-45.2 is an appropriate measure to monitor client progress during treatment.

**Procedures**

Once approval was granted to conduct this study (see Appendix C), the investigator obtained permission from the directors of the psychology training clinics that were designated for recruitment. The psychology training clinics where recruitment took place are located within a Midwestern public university. Counselor trainees worked within the training clinics one night
per week for the course of a semester. Practicum sections typically include five or six counselors-in-training who are supervised by licensed therapists. Practicum courses consist of seeing clients in therapy, participating in supervision, observing peers, keeping records, and didactic instruction.

The recruitment and subsequent data collection period took place over the course of one semester. There were seven possible practicum courses in session for that semester in which participants could be recruited (i.e., four courses in one location and three courses in the other location). Instructors of practicum courses were contacted and asked if the investigator could visit during class time to invite counselor trainees to participate in this study. In one location, all four practicum instructors allowed the investigator to visit their respective practicum classes to recruit participants. In the other location, two instructors agreed to the investigator’s recruitment visit. The remaining third instructor denied permission. Thus, six out of seven possible practicum groups were invited to participate in the current study.

Recruitment occurred at two time points during the one semester. Some counselor trainee practicum groups were recruited at the midpoint of the semester and other groups were recruited near the end of the semester. The recruitment period was intentionally designed to invite some participants earlier in the semester and others later in the semester. The rationale was to obtain a sample that differed in when participants were exposed to the study in case awareness of the purpose of the study might have influenced how they conducted therapy. There was a total of 19 counselor trainees in one location and 12 counselor trainees in the other location invited to participate in the study. In total, 31 counselor trainees were recruited for participation in the current study during the semester period. Every counselor trainee invited to
participate from each practicum course accepted the invitation to participate. Thus, 100% of 
participants recruited for the study agreed to participate in the study.

During the recruitment visit, instructors were asked to not be present at the time 
counselor trainees were invited to participate. Their absence was intended to eliminate potential 
pressure on students from witnessing who chose to participate. All students were given a packet 
at the point of invitation and instructed on how to accept or decline participation. The 
investigator stated to potential participants that the study aimed to learn more about how 
therapist factors relate to counseling outcomes, provided information regarding the participation 
process, and explained the methods used to protect privacy (see Appendix D). After graduate 
student counselor trainees were invited to participate in the study, they were instructed to review 
the consent form attached to the study packet. The informed consent document included the 
purpose, procedures, risks, benefits, and contact information pertaining to this study (see 
Appendix E). Students were then encouraged to ask the investigator any questions they had. 
The investigator left the room after addressing questions and/or concerns with the intention of 
giving students privacy to decide whether to participate without feeling pressure by the 
investigator’s presence. Again, all 31 counselor trainees recruited for the study provided consent 
to participate and completed the study packet following review of the informed consent 
document.

As an incentive to participate, counselor trainees were offered a few different options to 
choose from including café and restaurant gift cards, and prepaid parking passes. All incentive 
options had the same value and the variety was provided to appeal to participants in multiple 
settings. Once participants completed the CIQ, they separated the informed consent forms from 
the CIQ and deposited them separately into designated locked file boxes in the possession of the
investigator. Before releasing the CIQs into the locked file box, participants were asked to provide their names on an index card with the code number that was listed on their respective CIQ. This list of names and code numbers were then deposited into a third locked file box that was stored separately from all other research materials. The intent of this coding scheme was to store participant names separately from their CIQs. Participants were thanked for their participation and given the incentive of their choice, which signified the completion of their requirements of participation.

All data collected in this study were coded in effort to protect the privacy and confidentiality of the participants. The following coding system was implemented so that participants’ names would not be connected to their responses. First, CIQs were numerically coded and attached to informed consent forms. The consent forms did not include a numerical code and were stored separately from other research materials. After signing consent forms, participants were instructed to detach consent forms from the rest of the study packet (i.e. the CIQ). Next, they completed the CIQs and brought them with the detached consent forms to deposit individually into separate secure locked file boxes. Participants signed their names on individual index cards containing the numerical code on their respective CIQs. Index cards were placed into a third secure locked file box kept in the possession of the investigator. Consent form and CIQ file boxes were also stored independently with the investigator. Participant names did not appear on any of the CIQs. Index cards with participant names and codes were used by the investigator to create a master list of participating counselor trainees for the purpose of retrieving archived client OQ-45.2 scores. Locked file boxes were not linked from one to another.
Archival data needed for this study consisted of scores from the OQ-45.2, a brief assessment of psychological symptoms routinely collected via the clinics where counselor trainees were enrolled. When clients initially present for therapy at one of the clinics, they complete an informational packet regarding the process and procedures of obtaining counseling at the clinics. Within this packet is a statement of professional intent that they must sign if they wish to pursue counseling at the clinics (see Appendix F). This statement informs clients that their information on file may be accessed for the purposes of research. Only weekly OQ-45.2 scores were needed for this study from client files that were assigned to participating counselor trainees. The researcher met with designated staff personnel in both locations to obtain archived OQ-45.2 scores from clients that have received therapy by participants of the study.

Client OQ-45.2 scores were input by the researcher using the following process. Participants were listed with their corresponding numerical code on a password-protected document. Under each participant name and code, spaces for clients were listed by the letters “A, B, C, D, etc.” Each “letter” represented one client and corresponded to a list of successive scores. Clients’ scores were recorded onto the document if there were at least three OQ-45.2 scores and the scores did not result from couple’s or family therapy. If a particular counselor trainee participant did not have a client with at least three scores, then clients with two scores were accepted. There were six clients with only two OQ-45.2 scores included. Once scores were input into the document, the names of the participants were permanently deleted from the document. Only the respective numerical codes and client OQ-45.2 scores remained before the password-protected document could be taken from either location.
Analysis

Research questions related to the effects of counselor trainee personal therapy experience on client outcome and the effects of counselor trainee perception of benefit of personal therapy experience on client outcome were addressed with the use of multilevel modeling (MLM) statistical analyses. MLM is an extension of regression analyses where one or more independent variables may be used to predict a dependent variable on multiple levels within a nested data structure (Garson, 2013; Kahn, 2011, 2013; Nezlek, 2012; Raudenbush & Bryk, 2002). Data are nested when observations can be subdivided into a smaller number of groups, typically from a naturalistic setting. Observations at one level of analysis are grouped within another level of analyses, which can then be grouped within yet another level depending on the design. Research questions sought to identify both change over time within individuals and variation in degree and rate of change between individuals. Specifically, the rate at which clients change was tracked over time and that rate was then analyzed to discover whether variables that are associated with clients’ therapists have an effect on client progress in therapy. MLM is beneficial for the purposes of this study because the analytic procedures offer improved estimation of effects within individual units, improved hypotheses formulation and testing of cross-level effects, and the partitioning of error variance onto the appropriate level to which it is associated (Raudenbush & Bryk, 2002). Additional details concerning the analysis process are provided below. The first subsection addresses issues related to decisions made regarding the type of MLM chosen to analyze this data set. The second subsection presents an overview of the variables included in the analyses for the present study.

**MLM design.** MLM can be used to represent the change process in longitudinal data. Change is modeled within individuals at one level and between individuals at another level
(Singer & Willett, 2003). When individual trajectories of change are analyzed over time with respect to patterns within individuals as well as differences between individuals, it is termed growth curve modeling. With regards to psychotherapy outcome research, Kahn and Schneider (2013) assert that growth curve modeling is a preferable form of analyses because of its ability to model complex patterns of change indicative of client progress throughout the therapy process. In this study, client change was tracked as a function of counselor trainee variables to determine elements within trainees that affect their clients’ outcome. The data structure included two hierarchical levels where the first level was nested within the second level to predict client outcome. The first level included time as the predictor variable and the second level included counselor trainee variables. Thus, client progress in therapy was predicted by time in therapy at level 1, which was nested within counselor trainee variables at level 2.

The MLM analyses conducted on the current data set was performed via Hierarchical Linear Modeling 7 (HLM 7; Raudenbush, Bryk, Cheong, Congdon, & du Toit, 2011). HLM 7 was designed to analyze multilevel data structures where data points on one level exist in subgroups on another level. HLM 7 also formulates models of individual change over time and can detect small effects in relationships within each level and across each level by adding variables individually to compare reductions in unexplained outcome variance. HLM 7 can account for cases in which data are missing at certain time points and where time intervals are uneven. Thus, HLM 7 was selected as the ideal program to model client change trajectories and to test hypotheses in determining model fit.

A two-level nested design to model the study data was selected to examine the effects of counselor trainee experiences with personal therapy on levels of client psychological distress. The two-level structure consisted of the time predictor variable measured on level 1 and
counselor trainee predictor variables measured on level 2. The level 1 variable of time was used to predict client averages of psychological distress. On level 2, client averages of psychological distress and rates of change were predicted by client variables; however, there were no client variables created given that counselor trainees, and not clients, were the participants of the study. Therefore, counselor trainee predictor variables on level 2 were input to become client predictor variables. Thus, clients varied on whether their counselor had engaged in personal therapy or not, as well as on whether their counselors perceived their own personal therapy to be beneficial to personal well-being and professional training. The structure consisted of time on level 1 nested within clients on level 2. An overview of the variables is described next.

**Overview of variables.** The variables examined for inclusion in building the model to fit the present data included one outcome variable, one predictor variable on level 1 (scaled in two different ways), and eight predictor variables on level 2. The outcome variable (i.e., OQSCR) is symptoms of psychological distress which was measured by scores on the OQ-45.2. Distress symptoms were measured at each session as routine procedure while obtaining therapy at the training clinics. At level 1, the predictor variable (i.e., SESSION) is time as measured in sessions. Sessions typically occurred on a weekly basis and were paired with distress level scores taken immediately prior to each session. Scaling time with the SESSION variable provides information about differences in client status at the beginning of treatment. The time variable on level 1 is also scaled so that the last session could be modeled with a second MLM analyses (i.e., RSESSION). Rescaling time with the RSESSION variable provides information about differences in client status at the end of treatment.

There were 8 predictor variables examined at level 2 which are divided into three groups (i.e., Set 1, Set 2, and Set 3). Set 1 represents the clinical range variable and includes one
variable measuring level of client distress at intake. Set 2 represents personal therapy variables and includes three variables measuring whether or not counselor trainees had experiences in their own personal therapy. Set 3 represents perceived benefit variables and includes four variables concerning the perceived benefits of personal therapy to personal well-being and professional training. Similar variables can be grouped initially for exploratory purposes to determine which variables provide a stronger fit during model development (Raudenbush & Bryk, 2002). Those that provide a better representation of the data can be included for further analyses in the model-building process.

The first level 2 predictor variable is SC0CL in Set 1 (i.e., the clinical range variable). SC0CL is defined as whether a client’s initial distress level score taken before the first session with a counselor trainee was considered to be in the clinical range per the OQ-45.2 measure. Consistent with normative information for the OQ-45.2 (Lambert et al., 2004), scores above 63 were coded as “1” to indicate that the score was in the clinical range whereas scores of 63 and below were coded as “0” (i.e. not in the clinical range).

The second group of three variables on level 2 that make up Set 2 described counselor trainees’ experience in their own personal therapy (i.e., personal therapy variables). Personal therapy experience was assessed as ever having engaged in it (PERSTX), having engaged in it during their graduate training (PTGRPRG), and being currently engaged in it during practicum (PTCRT). These three variables were coded as “1” which represented having had the experience and “0” for not having had the experience.

Finally, the third group of four variables on level 2 making up Set 3 described to what extent the counselor trainees believed that their personal therapy experience was beneficial to their personal well-being and professional training (i.e., perceived benefit variables). Two
variables referred to the most recent (or only) experience in personal therapy and two variables referred to the most beneficial therapy experiences for counselor trainees. The two variables based on the most recent (or only) experience in personal therapy summarize the extent participants believed it was beneficial to their personal well-being (PTBNPER) and professional training (PTBNPRO). These variables were measured by counselor trainees’ total scores pertaining to ratings given in response to perception of a series of specific potential benefits to personal well-being and perception of a series of specific potential benefits to professional training on the CIQ. The two other variables based on the most beneficial experiences were derived from the CIQ responses pertaining to the personal therapy experience that was rated to yield the highest personal benefit (PERMAX) and highest professional benefit (PROMAX) scores for counselor trainees. Personal therapy experiences were not split to take the highest number from one experience and the highest number of another experience. Rather, for cases in which the highest scores for personal benefit and highest scores for professional benefit occurred on different occasions, the sum of benefit scores was calculated per occasion to determine the highest rated experience. Individual personal and professional benefit scores were then used from that experience to create the PERMAX and PROMAX variables. For example, one participant reported three episodes of personal therapy. The consecutive scores moving backward from the most recent episode to the least recent (or oldest) episode for perceived benefit of personal therapy to personal well-being and perceived benefit of personal therapy to professional training are as follows: (1) 18 and 18, (2) 17 and 21, and (3) 11 and 7. Thus, the predictor variables measuring the most recent scores were PTBNPER = 18 and PTBNPRO = 18. The second most recent episode rated had a lower personal benefit score (17) and a higher professional benefit score (21) compared to all episodes. To decide what set of values to use for
the PERMAX and PROMAX variables, the scores were summed and the totals compared (i.e. 18 + 18 = 36; 17 + 21 = 38; and 11 + 7 = 18). Because the second most recent episode of personal therapy was rated higher in level of perceived benefit overall (38) compared to the others (36 and 18), the values from the second most recent episode were used to represent the maximum benefit variables (i.e., PERMAX = 17; PROMAX = 21).

Summary

This chapter provided information regarding who participated in the study and how the research was conducted. There were 30 graduate student counselor trainees who participated in the study. They were described in terms of demographic characteristics (e.g., age, gender, race/ethnicity, etc.) and training characteristics (e.g., graduate program, previous experience, theoretical orientation, etc.). Participant information was gathered via the Counselor Information Questionnaire (CIQ) which was used to obtain demographic information and to assess personal therapy experience. Scores from the OQ-45.2, obtained for all clients of participants, served as the outcome variable for this study. An overview of multilevel modeling (MLM) provided the basis for data analyses and variables were constructed and defined. The next chapter presents results.
CHAPTER III

RESULTS

The purpose of this investigation was to examine if counselor trainees’ participation in their own personal therapy experiences were associated with their clients’ outcome in therapy. The study sought to identify if trainees with a history of personal therapy might influence how much their clients changed over the course of therapy by evaluating the following outcome variables: the overall reduction in psychological distress and the speed with which client distress symptoms decreased. This was accomplished by the use growth curve modeling, a form of multilevel modeling that explores individual change trajectories both within and between participants. Research questions were as follows:

1. What are counselor trainees’ experiences of personal therapy?
2. To what extent do counselor trainees perceive their personal therapy experiences to be beneficial?
3. Do counselor trainees’ clients produce larger reductions in psychological distress as a function of counselor trainee personal therapy experience?
4. Do counselor trainees’ clients produce larger reductions in psychological distress as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?
5. Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of counselor trainee personal therapy experience?
6. Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?

Results reported in this chapter comprise three main sections. The first section describes and reports findings from preliminary analyses that explore the nature of the data and the assumptions tested. The second section provides findings from descriptive statistics regarding participant experiences of personal therapy and the distribution of variables among the final sample. The third section presents growth curve analyses, including discussion of variables tested, model comparisons, and the specification of an optimal model to represent the study data.

**Preliminary Analyses**

Prior to beginning to build multilevel models to fit the data, preliminary analyses were conducted to explore the data for missing information, give insight into general patterns, investigate cases that don’t follow the general patterns, and test assumptions. The preliminary analyses section is composed of three subsections. The first subsection details exploration of the raw data for missing information. The second subsection depicts the investigation into general patterns and trends in client change trajectories. The third subsection describes how assumptions were tested and the conclusions generated.

**Exploration of raw data.** Data preparation began with examining participant questionnaires. All 31 counselor trainees recruited were given a study packet and instructed on how to accept or decline participation. Every counselor trainee consented to the study and provided data on the Counselor Information Questionnaire (CIQ); however, two CIQs were identified as missing data. Reasons to explain the missing data are unknown. One participant did not respond to the subset of questions rating how beneficial personal therapy had been to the
individual’s professional training. Because data from these questions were necessary for analyses, this participant’s CIQ data were not used. The other participant with missing data did not respond to two final questions at the end of the CIQ asking for overall ratings of how beneficial and how harmful personal therapy had been to the individual’s personal well-being and professional training. Because these final questions asking for an average rating across reported personal therapy experiences were not used in the analyses, this participant’s data was retained. Thus, the final sample included 30 of 31 possible participants.

**Investigation of patterns and trends in client change trajectories.** Data were entered into an Excel spreadsheet using a univariate format. This format is structured vertically so that each measurement for each participant is listed per row of data, producing a growth record for each participant. The advantage of this format is the inclusion of an explicit time variable that can accommodate research designs with unequal measurement occasions (Singer & Willett, 2003). Once data were reviewed for accuracy, the data set was transferred into the HLM 7 statistical software program (Raudenbush et al., 2011) to create empirical growth plots of client change trajectories. Client change trajectories were plotted individually and displayed on graphs according to each participating counselor trainee. Trainees varied in the number of clients they had (e.g. between one and three), which resulted in a total of 47 clients across all counselor trainees. All 30 of the counselor trainees’ graphs can be viewed in Appendix G.

Client data were smoothed across time so that change trajectories could be compared between clients and across counselor trainees. This allowed for visual assessment of potential trends and functional forms of growth curve trajectories. Client change trajectories were compared with one another in terms of elevation and shape, generally revealing a downward pattern of change over time (i.e., a reduction in client scores of psychological distress). As
sessions increased for the majority of clients (n = 28), distress scores decreased; however, 18 clients had higher distress scores at the end of therapy than they did when they started therapy, and one client indicated no change. Similarly, 25 clients dropped in distress scores after their first session whereas 22 clients rose in distress levels. One client showed no change between the first and second session. The shape of client change trajectories often fluctuated between higher and lower levels of distress over time, depending on length of time in treatment. These variations are typical though, when examining client-reported levels of psychological distress over therapy sessions (Lambert et al., 2004).

Client change trajectories were further explored by inspecting ordinary least squares (OLS) regression equations for each client. Examination of OLS-estimated intercepts and slopes aid in gathering information about client data in general and in identifying possible outlying cases. Across all 47 client cases included in the data, the average OLS-estimated coefficient for the initial intercept is 64.09 (SD = 23.26). The estimated intercept represents the average level of distress for clients at initial status, or the beginning of therapy. The average OLS-estimated coefficient for the slope is -0.49 (SD = 8.00). The estimated slope represents the average change in levels of distress from one session to the next. OLS-estimated intercepts and slopes for each client can be seen in Appendix H. Overall, there is considerable variation among the estimated intercepts and slopes. There are 25 estimated intercepts above the clinical cutoff score of 63; twenty-two initial intercepts fall below in the non-clinical range. Likewise, estimated slopes vary with respect to both the amount and direction of change. Levels of psychological distress drop quickly for some clients whereas others decrease more slowly over the course of therapy. Similar variation in rates of change exist for increases in levels of psychological distress too. That is, some clients have large increases whereas others slowly rise over time.
Using these initial OLS-estimated regression results, there were two cases that appeared to deviate considerably from the rest of the group and thus, could be possible outliers in the data set. The first case (i.e., client #1442) showed the largest estimated initial intercept (114.00) and largest rate of change (-36.00) as far as reduction in psychological distress. The second case (i.e., client #2151) had one of the smallest estimated initial intercepts (27.33) and the largest rate of change (32.00) as far as increase in psychological distress. Further investigation of these two cases revealed low numbers in total sessions attended. Client #1442 attended 2 sessions and client #2151 attended 3 sessions. Whereas these cases might seem uncommon, Lambert et al. (2004) note that across several studies, clients “show not only great variability from one another in their responses to therapy, but also show wide fluctuations in their subjective estimates of the intensity of their symptoms over the course of treatment” (p. 31-32). Additionally, it is not known why either client did not return to therapy; however, in terms of therapist predictors central to the study (i.e., experience in one’s own personal therapy), client #1442’s therapist did report experience in personal therapy whereas client #2151’s did not report personal therapy experience. Together these two examples represent the phenomenon under study (i.e., the potential impact of therapist personal therapy experience on client outcome). Therefore, these cases were retained for inclusion in the full set of preliminary analyses.

Client change trajectories were also explored by plotting linear models of OLS-estimated regression equations on observed data. This was primarily to gather information about functional form and to view exploratory estimates of each trajectory. OLS regression is valuable for exploring change trajectories that make up the rate of change over time on the first level in MLM because the analysis provides unbiased estimates of intercepts and slopes (Singer & Willet, 2003). Moreover, a linear change model used for everyone in the sample makes it easier
to compare client change trajectories across the sample. Raudenbush and Bryk (2002) advise that when the number of observations per individual are few, linear individual growth models provide good approximations for more complex processes that can’t be modeled due to the lower number of observations. Based on the examination of within person regression models described below, a linear trend was identified as the most appropriate simple representation of the change trajectories with just the use of estimated intercepts and slopes.

Appendix I includes individual graphs of within-person regression models for each client in the data set. Outcome, as measured by levels of psychological distress (i.e., OQSCR), was regressed on time (i.e., SESSION), to produce fitted lines on client empirical growth plots. Observed data points were compared with OLS-fitted regression lines to explore how closely client trajectories resembled linear predictions. Client growth plots contain a reference line on the y axis (y = 63) to distinguish between clinical and nonclinical levels of psychological distress. The quality of fit is also presented with individual $R^2$ statistics on each plot. Linear change appears likely on some growth plots where the differences between observed and fitted values are slim. Other plots may also be considered linear if deviations from the fitted line are due to random error. For plots where observed data points appear more scattered away from the fitted trajectory, another functional form (e.g., curvilinear) may be more appropriate. Given the variation in client number of sessions and that some plots have only a few observed data points, it is difficult to determine if a higher order growth model would explain additional variance. Thus, a linear change model is selected as a useful functional form for the current data set.

As helpful as OLS linear regression models are for exploring change trajectories, the assumptions that the errors are independent with normal distribution and constant variance are not likely to hold up within the multilevel repeated measures design. Problems with
autocorrelation and heteroscedasticity arise due to the effect of unexplained variance in residuals correlating across occasions from the same participant being measured on multiple occasions (Singer & Willett, 2003). Thus, error variance can differ over time within the same person, resulting in outcome accuracy fluctuating across measurements. Multilevel modeling analyses account for some of these issues by the various methods used for parameter estimation. Regardless, assumptions are more complex with multiple levels of nested data because of the number of components to consider in meeting them. Singer and Willett offer strategies for testing assumptions in multilevel growth models pertaining to functional form, normality, and homoscedasticity at each level. Their recommendations were followed in the evaluation of the tenability of assumptions at each level for models considered in the final specification process and are discussed next.

**Tenability of assumptions.** To test the assumption that a linear form was reasonable, outcome versus predictor plots were inspected at each level. At level 1, empirical growth plots were created for each client to depict psychological distress (OQSCR) against time in therapy (SESSION). OLS-estimated individual change trajectories were added to the growth plots to evaluate how closely observation data coincided with fit lines (see Appendix I). As noted earlier, linear change appears reasonable for many of the individual trajectories and deviations from fit lines could be due to measurement error. Many trajectories also contain only a few points of observation which makes it difficult to conclude that linearity is not present. Thus, the linearity assumption is met on level 1.

On level 2, linearity was examined by plotting OLS estimates of individual growth parameters (i.e., the intercept and slope) against level 2 predictor variables (see Appendix J). Given that the SC0CL and PERSTX predictor variables are dichotomous, there was no linearity
assumption for either parameter. There are four predictor variables intended to measure
counselor trainees’ perceived benefit of personal therapy: PTBNPER, PTBNPRO, PERMAX,
and PROMAX. Two predictor variables (PTBNPER and PERMAX) represent benefit to
personal well-being whereas as the other two (PTBNPRO and PROMAX) represent benefit to
professional training. Plots of OLS-estimated intercepts against each perceived benefit of
personal therapy variable all indicated that a linear form was acceptable to assume for the study
data. When the OLS-estimated slopes were plotted against each perceived benefit of personal
therapy variable, linearity emerged as an appropriate form. Therefore, the linearity assumption is
also met on level 2.

Normal distribution of error variance was checked by visual inspection of normal
probability plots for each raw residual (see Appendix K). At level 1, a plot of the residuals
against their associated normal scores showed that the points formed a line, indicating that the
assumption of normality appeared to be met; however, one extreme outlier existed. To provide
further insight, standardized level 1 residuals were plotted against the level 1 predictor. At least
95% of cases fell within ± 2 standard deviations of their center. The standardized level 1
residuals were also plotted according to their identification number. This revealed that a majority
of cases fell within ± 2 standard deviations of their center, with a few between ± 2 and ± 3
standard deviations. Given that only one extreme case fell beyond these markers (i.e., #2151), it
was concluded that the distribution of error variance on level 1 was assumed to be normal.

On level 2, a normal probability plot of raw residuals descriptive of the intercept term
depicted the formation of a line, indicative of a normal distribution. The intercept residual
values appeared to meet the normality assumption. When level 2 residuals pertaining to the
slope term were plotted, the distribution of values formed a line; however, the line intersected the
45-degree angle above what is expected with a normal distribution. Standardized level 2 residuals were then plotted against level 2 predictor variables for further evaluation. For all level 2 predictors (i.e., SC0CL, PERSTX, PTBNPER, PTBNPRO, PERMAX, and PROMAX), all but two cases fell within ± 2 standard deviations of their center. The two cases outside of this range fell between ± 2 and ± 3 standard deviations. Therefore, the distribution of error variance on level 2 was also assumed to be normal.

In addition to examining normal probability plots, the output from HLM 7 analyses provides some insight into meeting the normality assumption by inspecting the standard errors of the fixed effects. Parameter estimation via the use of maximum likelihood procedures are deemed more robust against moderate departures from normality (Garson, 2013; Raudenbush & Bryk, 2002; Raudenbush et. al., 2011). For example, if the normality assumption is violated, the standard errors used in significance testing of fixed effects may be biased. The HLM 7 program also reports robust standard errors to somewhat correct for possible biases (Kahn & Schneider, 2013), which can then be compared to the typical standard errors to identify a potential violation of normality. Kahn and Schneider advise that if the standard errors differ greatly in size, an important assumption about the distribution might have been violated and further investigation is necessary. Output from present data analyses of both sets of standard errors were nearly equal. Thus, the assumption of normality was determined to be met.

The assumption of homoscedasticity was evaluated by plotting raw residuals against predictor variables at both levels and visually inspecting the variability for each value of the predictor variable (see Appendix L). On level 1, a plot of the residuals versus SESSION showed approximate equal range for each session; however, given that clients varied in the number of sessions attended, most data points were clustered within the first few sessions of treatment.
Thus, there were more observations to vary early in treatment versus later in treatment when fewer observations were distributed. This could have indicated heteroscedasticity in that range but with such a small number of clients staying in treatment beyond seven sessions, there was not enough information to confirm a lack of homoscedasticity of residual variance on level 1.

On level 2, residuals of the intercept term and of the slope term were plotted individually against each level 2 predictor (i.e., SC0CL, PERSTX, PTBNPER, PTBNPRO, PERMAX, and PROMAX). Residuals for the intercept term appeared to vary equally for most values of each predictor; however, one potential issue is that the number of cases might have been too small to sufficiently conclude that the homoscedasticity assumption was not met. Plots of the residuals of the slope term indicate a similar conclusion. Most values of each predictor approximately show an even distribution of error variance, with the exception of the two cases (i.e., #1442 and #2151) that were first noted as potential outliers when examining OLS estimates of intercepts and slopes. Because observations vary on each value of predictor variables, some values show more clearly an even distribution of variance whereas others don’t have enough cases to identify trends. Thus, there was insufficient evidence of heteroscedasticity to raise concerns about the violation of the assumption of homoscedasticity. The decision was to retain the outlying cases for further analyses.

**Descriptive Statistics**

This section presents findings from descriptive statistics regarding participant experiences of personal therapy and the distribution of variables used in the study. Results providing information about personal therapy experiences by counselor trainees in the study are presented first, followed by results describing the distribution of variables. This section is
composed of two subsections. The first subsection presents descriptive findings from counselor trainee participants. The second subsection describes the distribution of variables.

**Counselor trainee findings.** Counselor trainee participants were asked to provide information regarding if they ever attended their own personal therapy as clients. Twenty five participants (83.3%) reported that they had been clients in personal therapy at some point in their lives. Five participants (16.7%) reported having never been a client in personal therapy. For those that indicated that they had participated as a client in their own personal therapy, they were asked to provide some general details about their experiences. Details requested were based on prior research findings regarding mental health practitioners in personal therapy. Table 4 lists categories of information gathered from participants reporting a history of personal therapy. Categories include when the personal therapy occurred, the number of different time periods sought out for personal therapy, and the number of sessions per time period. Participants also reported to what extent the pursuit of treatment was voluntary, the timing of treatment relative to graduate training, and the reasons for seeking treatment.

Counselor trainee participants who reported experience attending personal therapy identified whether the experience occurred in the past, present, or both past and present. The majority of participants (n = 17; 68.0%) reported that they had attended their own personal therapy in the past but were not currently participating in personal therapy. Seven participants indicated that they attended their own personal therapy in the past and were currently attending personal therapy (28.0%). One participant reported no past experience in personal therapy, but did indicate current participation in personal therapy.
Table 4

*Personal Therapy (PT) Experiences of Counselor Trainee Participants*

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<tr>
<td>Past and present</td>
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<td>Past but not present</td>
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<td>3</td>
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Table 4—Continued

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<tr>
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<td>5.7%</td>
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<td>3.8%</td>
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<td>0.0%</td>
</tr>
<tr>
<td>School and/or work problems</td>
<td>4</td>
<td>7.5%</td>
</tr>
<tr>
<td>Personal growth group experience</td>
<td>6</td>
<td>11.3%</td>
</tr>
<tr>
<td>Mandated</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td>Other( ^b )</td>
<td>5</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

Note: \( N = 25 \). The categories including Session Total, Pursuit of Treatment, Time of Treatment, and Reasons are referring to participants’ most recent reported personal therapy experience.

\( ^a \) Participants were asked to select the reason(s) that led them to seek personal therapy. Several participants (\( n = 15 \)) identified more than one reason for seeking treatment so frequencies listed are computed from the total number of reasons indicated (\( N = 53 \)). \( ^b \) Other includes the following reasons added by participants: infertility, stress management, weight concerns, eating disorder, and insomnia.

To provide more details about personal therapy experience, participants responded to a series of questions and/or statements per experience (i.e., therapy “episode” or “occasion”). Each treatment time period was listed separately moving chronologically away from the most current experience. Table 4 displays how many therapy episodes or occasions participants reported attending throughout their lives. The majority of participants who reported personal therapy experience did not report treatment for more than one distinct episode (\( n = 14; 56.0\% \)). Six participants (24.0%) indicated that they sought out treatment at two separate times in their lives. Three participants (12.0%) provided information for three separate occasions of personal therapy. If participants had additional experiences where they attended personal therapy beyond
three separate occasions, they listed those experiences in the space provided following the same format used in earlier descriptions. Because the total number of episodes is unknown for the two participants that listed additional personal therapy experiences, their sub group in this category is considered “3+.” Thus, 8.0% of those reporting personal therapy experience provided information beyond three separate episodes.

The remaining categories in Table 4 refer to counselor trainees’ most recent personal therapy experience. For 14 participants, their most recent experience was their only experience in personal therapy. This means that “most recent” varies as to how long ago the experience occurred. For example, the most recent episode in personal therapy reported for these 14 participants ranged from occurring 11 years ago to currently attending. That is, eight of the 14 participants reported current participation in therapy so their most recent experience was still occurring at the time of data collection. Regardless, frequencies are listed for the total number of sessions attended, how voluntarily the decision to seek treatment was, if the time of treatment occurred while enrolled in graduate school, and the reasons they attended therapy. Appendix M includes frequency information regarding additional experiences reported in personal therapy by counselor trainee participants beyond the most recent episode. Table M1 lists frequencies for 11 participants who provided information regarding a second most recent episode of personal therapy and Table M2 refers to 5 participants who provided information regarding a third most recent episode. Two participants also provided statements regarding additional episodes beyond three but are not included here.

For 25 counselor trainee participants who reported a history of personal therapy experience, the average number of sessions attended during their most recent episode of treatment is 22 \((M = 22.16; SD = 33.29)\). The range of total sessions is 119. The median and
mode of sessions attended are both 6. Frequencies are displayed in Table 4 to reflect the breakdown of total sessions in the sample. For the most recent episode of personal therapy treatment, 14 participants (56.0%) reported session totals that fell between 1 and 6. Four participants (16.0%) indicated that their most recent personal therapy experience totaled sessions falling between 8 and 14. Two participants (8.0%) reported session totals of 20 and 24, respectively. Two other participants (8.0%) reported session totals of 42 and 50, respectively. Three participants (12.0%) indicated the largest total number of sessions regarding their most recent experience in therapy at 96, 96, and 120, respectively.

Counselor trainees were asked to what extent their most recent pursuit of personal therapy was voluntary. That is, trainees reported whether they chose to pursue treatment autonomously, via the encouragement of others, as part of a requirement (e.g., school/work-related, premarital counseling), or if treatment was involuntary. The majority of participants (n = 19; 76.0%) indicated that they sought out their most recent personal therapy experience on their own. Three participants (12.0%) reported that they were encouraged by others to seek out their most recent personal therapy experience and three participants (12.0%) reported that their most recent experience in personal therapy was part of a requirement. No participants reported involuntary treatment.

Participants were also asked to provide information regarding the timing of their most recent experience in personal therapy relevant to their enrollment in their graduate training programs. Fourteen participants (56.0%) reported that they were in graduate school at the time of their most recent personal therapy experience and 11 participants (44.0%) indicated that their most recent experience in personal therapy occurred prior to becoming graduate students.
Counselor trainees indicated from a list of common concerns what precipitated seeking their most recent personal therapy experience. Table 4 shows the list of 14 concerns under the “Reasons” category, with the last subgroup being Other. Participants could choose as many reasons as needed to depict what led them to seeking treatment. Five participants added to the list to denote their reasons for treatment, creating the Other subgroup. The total number of reasons checked off by 25 participants was 53. Therefore, frequencies displayed under the “Reasons” category in Table 4 were computed according to the number of times a particular reason was selected.

As shown in Table 4, Relationship concerns was selected the most among participants as their reasons for seeking treatment (18.9%). Anxiety was the next most frequently marked reason (15.1%), followed by Depression and Personal growth group experience both at 11.3%. Participants added reasons (9.4%) that created the Other subgroup. Reasons written in by participants included infertility, stress management, weight concerns, eating disorder, and insomnia. Reasons marked less frequently are as follows: school and/or work problems (7.5%), grief counseling (5.7%), fluctuating moods (5.7%), couple’s therapy (3.8%), anger (3.8%), substance abuse (3.8%), premarital counseling (1.9%), and mandated (1.9%). Although one participant indicated “mandated” as one of the reasons for seeking therapy, this is in contrast to no participants reporting that their pursuit of treatment was “involuntary/mandated.”

For each personal therapy experience reported by counselor trainees, participants were asked to indicate how helpful they perceived the experience to be to both their personal well-being and professional training. Recall that benefit to personal well-being included six components that participants could rate individually, producing a total benefit score reflective of the perception of total benefit to personal well-being. Likewise, participants could rate seven
components regarding how helpful personal therapy was to their preparation for professional training, also producing a score reflective of the perception of total benefit to professional training. Table 5 displays means, standard deviations, modes, and frequencies for total benefit scores, as well as the components that make up each score.

Table 5

Means, Standard Deviations, Modes, and Frequencies of Perceived Benefit Scores to Personal Well-Being and Professional Training for Counselor Trainees’ Most Recent Experience in Personal Therapy

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Mean</th>
<th>SD</th>
<th>Mode</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Well-Being</strong></td>
<td>15.08</td>
<td>6.47</td>
<td>18.00</td>
<td>4</td>
<td>16.0%</td>
</tr>
<tr>
<td>Lessening of symptoms</td>
<td>2.44</td>
<td>1.22</td>
<td>3.00</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>Emotional relief</td>
<td>2.52</td>
<td>1.12</td>
<td>3.00</td>
<td>13</td>
<td>51.0%</td>
</tr>
<tr>
<td>Mood/outlook</td>
<td>2.48</td>
<td>1.23</td>
<td>3.00</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>Self-esteem/confidence</td>
<td>2.48</td>
<td>1.29</td>
<td>3.00</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>Insight/self-awareness</td>
<td>2.76</td>
<td>1.30</td>
<td>3.00</td>
<td>10</td>
<td>40.0%</td>
</tr>
<tr>
<td>Relationships</td>
<td>2.40</td>
<td>1.26</td>
<td>3.00</td>
<td>11</td>
<td>44.0%</td>
</tr>
<tr>
<td><strong>Professional Training</strong></td>
<td>17.72</td>
<td>6.73</td>
<td>16.00</td>
<td>4</td>
<td>16.0%</td>
</tr>
<tr>
<td>Prepare clinical work</td>
<td>2.00</td>
<td>1.26</td>
<td>3.00*</td>
<td>8</td>
<td>32.0%</td>
</tr>
<tr>
<td>Understanding concerns</td>
<td>2.28</td>
<td>1.10</td>
<td>2.00</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>Increased empathy</td>
<td>2.64</td>
<td>1.06</td>
<td>3.00</td>
<td>11</td>
<td>44.0%</td>
</tr>
<tr>
<td>Learn therapist role</td>
<td>2.76</td>
<td>1.09</td>
<td>3.00</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>Navigate relationship</td>
<td>2.44</td>
<td>1.16</td>
<td>3.00**</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>Trusting process</td>
<td>2.72</td>
<td>1.31</td>
<td>3.00</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>Belief in therapy</td>
<td>2.88</td>
<td>1.09</td>
<td>3.00</td>
<td>10</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

*Note.* N = 25. Response scales ranged from 0 to 4 points. Both categories and subgroups had minimum ratings of 0 and maximum ratings of 4.

*Benefit to personal well-being is rated according to six components: Lessening the severity of presenting symptoms, offering emotional relief, improving mood/outlook, improving self-esteem/confidence, increasing insight/self-awareness, and improving interpersonal relationships. *Benefit to professional training is rated according to seven components: Preparing for clinical work, understanding clients’ clinical concerns, increasing empathy towards clients, learning/incorporating the role of the therapist, navigating the client-counselor relationship, trusting the therapeutic process, and believing in the effectiveness of therapy. *Preparation for clinical work also had a mode of 2.00 (n = 8; 32.0%). **Navigating the client-counselor relationship also had a mode of 2.00 (n = 9; 36.0%).
The benefit to personal well-being total score ranged from 0 to 24, with higher scores indicating a stronger perception of how helpful personal therapy was to personal well-being ($M = 15.08; SD = 6.47$). The most frequent score was 18 ($n = 4; 16.0\%$). Among the components included as potential benefits to personal well-being, individual scores ranged from 0 to 4 (i.e., not helpful to extremely helpful). Table 5 shows the most frequent rating for each component was 3 (i.e., very helpful). The component that included the most “3” ratings was in reference to the perception that personal therapy offered emotional relief ($n = 13; 51.0\%$). Participants also rated “3” more often for components regarding improving interpersonal relationships ($n = 11; 44.0\%$) and increasing insight/self-awareness ($n = 10; 40\%$). The highest average rating among all components regarding potential benefits to personal well-being was the perception of benefit to increasing insight/self-awareness ($M = 2.76; SD = 1.30$); the lowest average rating was regarding the perception of benefit to lessening the severity of presenting symptoms ($M = 2.44; SD = 1.22$). All components included averages between 2 and 3, indicating that each potential benefit was rated somewhat helpful to very helpful to personal well-being.

The benefit to professional training total score ranged from 0 to 28, with higher scores indicating a stronger perception of how helpful personal therapy was to professional training ($M = 17.72; SD = 6.73$). The most frequent score was 16 ($n = 4; 16.0\%$). Among the components included as potential benefits to professional training, individual scores ranged from 0 to 4 (i.e., not helpful to extremely helpful). Table 5 shows that the most frequent rating for four of seven components was 3 (i.e., very helpful). Two other components were also most frequently rated 3, but these components also had an equal number of “2” ratings (i.e., somewhat helpful). One component was most frequently rated 2. The component that included the most “3” ratings was in reference to the perception that personal therapy helped with increasing empathy toward
clients (n = 11; 44.0%). Participants also rated “3” more often for the component regarding believing in the effectiveness of therapy (n = 10; 40.0%). Likewise, this component also had the highest average rating among all components regarding the perception of benefit to professional training ($M = 2.88; SD = 1.09$); the lowest average rating was regarding the perception of benefit to preparing for clinical work. ($M = 2.00; SD = 1.26$). All components included averages between 2 and 3, indicating that each potential benefit was rated *somewhat helpful* to *very helpful* to professional training.

**Distribution of variables.** Variables used in the multilevel model-building process are listed in Table 6 to show the distribution across level 1, and in Table 7 to show the distribution across level 2. Level 1 consists of an outcome variable (OQSCR) and a predictor variable that is scaled to measure time in two different ways (SESSION and RSESSION). Descriptive information of level 1 variables include the total number of data points, minimum values, maximum values, means, and standard deviations. Table 6 displays these results. Additionally, frequency information is provided for the level 1 predictor variable SESSION, which is included in Table 7. On level 2, there are three sets of predictor variables: *clinical range* (SC0CL), *personal therapy* (PERSTX, PTCRT, and PTGRPRG), and *perceived benefit* (PTBNPER, PTBNPRO, PERMAX, and PROMAX). Frequency information is provided for each variable in each set in Table 7. Level 1 variables will be presented first, followed by discussion of level 2 variables.

In this study, the dependent or outcome variable on level 1 is represented as OQSCR, which is a measure of psychological distress obtained from the OQ-45.2. Clients routinely complete this measure before each counseling session at the two training clinics where the study took place. Table 6 lists the total number of observations collected for the OQSCR outcome
variable (N = 290). Scores range from 7 to 114 with a mean score of 60.19 and standard
development of 21.99. Recall that scores can range from 0 to 180 with elevated scores indicating
the endorsement of more symptoms of psychological distress. A score of 63 is the cut-off point
between nonclinical and clinical populations. The mean score of 60.19 is just below the clinical
cut-off point of 63 indicating an average score consistent with non-clinical populations.

Table 6

*Descriptive Information for the Distribution of Level 1 Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
</table>
| *Level 1*
| Outcome | OQSCR | 290 | 7.00 | 114.00 | 60.19 | 21.99 |
| Predictors | SESSION | 290 | 0.00 | 11.00 | 3.31 | 2.72 |
|          | RSESSION | 290 | -11.00 | 0.00 | -3.31 | 2.72 |

*Note.* OQSCR = OQ-45.2 scores; SESSION = Sessions of therapy beginning with 0; RSESSION = Sessions of therapy rescaled to end at 0.

Level 1 also contains a predictor variable that is scaled to measure time in two different
ways. It is essentially the same variable that represents time in therapy. It can be scaled in
multiple ways to give insight at different points when building the multilevel model. Table 6
lists the time predictor variable scaled as both SESSION and RSESSION. Both ways of scaling
this variable pertain to time in therapy as measured by the number of sessions attended by each
client; however, when clients attended their first individual session, it was coded as “0” to
correspond to the initial level of psychological distress measured just prior to the first therapy
session. Additionally, it was not an initial distress score measured at intake when clients first
presented for therapy with an intake counselor; rather, only distress scores measured in the time
period clients were meeting with counselor trainees in this study were used. Sessions beyond
“0” were scaled to increase numerically by one for each session attended (i.e., 1, 2, 3, etc.).
distribution of the SESSION variable (i.e., time points associated with the OQ-45.2 measurements) ranged from 0 to 11 \( (M = 3.31; SD = 2.72) \). Alternatively, time in therapy is also scaled as RSESSION, which is simply the reverse of SESSION. Time scaled by RSESSION tracks the number of sessions preceding termination where “0” represents the last measure of psychological distress while in treatment with a particular counselor trainee. Counting sessions in which the end of treatment is Session 0 allows for a shift in focus from the beginning of treatment to the end of treatment. The change trajectory using RSESSION focuses on ending status. Thus, the RSESSION variable ranged from -11 to 0 \( (M = -3.31; SD = 2.72) \).

Because the SESSION variable was scaled to represent the time points that clients were given the OQ-45.2 assessment, means and standard deviations did not portray a clear distribution of total sessions of therapy by clients of participating counselor trainees. For example, the minimum number of total sessions attended by trainees’ clients was 2; the maximum attended was 12 \( (M = 6.17; SD = 3.02) \). The median and mode number of sessions attended by clients were both 6. Table 7 lists frequencies of the total number of sessions attended by clients. The majority of clients attended 6 sessions of therapy with counselor trainee participants \( (n = 8; 17.0\%) \), followed by 3 sessions attended \( (n = 7; 14.9\%) \) and 2 sessions attended \( (n = 6; 12.8\%) \). Over half of clients attending therapy with counselor trainee participants attended between 2 and 6 sessions \( (57.4\%) \).

Table 7 also lists frequencies for the clinical range and personal therapy Level 2 predictor variables. The clinical range predictor (SC0CL) refers to the number of clients who had initial OQ-45.2 scores (i.e., measured at Session 0) in the clinical range. Approximately half of clients attending therapy with participating counselor trainees presented with psychological
distress levels in the clinical range (n = 24; 51.1%), compared to those not indicating distress
scores in the clinical range at initial assessment (n = 23; 48.9%).

Table 7

*Frequencies for Total Sessions Attended by Clients of Counselor Trainee Participants and for
the Clinical Range and Personal Therapy Level 2 Predictor Variables*

<table>
<thead>
<tr>
<th>Category</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Session Totals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>12.8%</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>14.9%</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>6.4%</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>6.4%</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>17.0%</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>10.6%</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>8.5%</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
<td>6.4%</td>
</tr>
<tr>
<td>11</td>
<td>5</td>
<td>10.6%</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Level 2 Predictors

*Clinical Range*

<table>
<thead>
<tr>
<th>SC0CL</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>23</td>
<td>48.9%</td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>51.1%</td>
</tr>
</tbody>
</table>

*Personal Therapy*

<table>
<thead>
<tr>
<th>PERSTX</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>10</td>
<td>21.3%</td>
</tr>
<tr>
<td>Yes</td>
<td>37</td>
<td>78.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PTCRT(^a)</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>22</td>
<td>59.5%</td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>40.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PTGRPRG(^a)</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>16</td>
<td>43.2%</td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>56.8%</td>
</tr>
</tbody>
</table>

*Note.* N = 47 unless otherwise noted. Client Session Totals = The number of sessions of therapy attended by clients of participating counselor trainees; SC0CL = Initial OQ-45.2 score in clinical or nonclinical range; PERSTX = Counselor trainee personal therapy experience; PTCRT = Counselor trainee currently in personal therapy; PTGRPRG = Counselor trainee personal therapy experience during graduate program.

\(^a\)n = 37
The *personal therapy* predictor variables on level 2 refer to personal therapy experiences of counselor trainee participants. Table 7 shows that the majority of clients (n = 37; 78.7%) attended therapy with a counselor trainee participant who indicated having had experience in personal therapy (PERSTX); ten clients (21.3%) met with counselors who indicated no personal therapy experience. Out of 37 clients who met with counselor trainee participants who had reported personal therapy experience, 15 clients (40.5%) met with counselor trainees who reported that they currently were in therapy (PTCRT). Twenty-one clients (56.8%) met with counselor trainees who reported personal therapy experience that occurred during their graduate programs (PTGRPRG); sixteen clients met with counselor trainees who had experience in personal therapy, but not that occurred during graduate school (43.2%).

The *perceived benefit* predictor variables on level 2 refer to the level of perceived benefit of personal therapy to personal well-being and professional training. In Table 5, descriptive statistics regarding only the 25 counselor trainee participants who reported levels of perceived benefit of personal therapy experience were reported; however, to run analyses in HLM 7, client data from all 30 counselor trainees was needed. In order to include all data from 47 clients in the analyses, clients working with counselors without personal therapy experience also had to have scores for *perceived benefit* predictor variables. Because counselors who did not report personal therapy experience also did not indicate level of perceived benefit to personal well-being and professional training, they were given scores of 0 for the *perceived benefit* predictor variables. This resulted in the *perceived benefit* predictor variables reflecting lower values when computing statistics by HLM 7. Descriptive information for the perceived benefit *predictor variables* as computed by HLM 7 are presented next.
The perceived benefit predictor variables on level 2 are PTBNPER, PTBNPRO, PERMAX, and PROMAX. The variables PTBNPER and PTBNPRO represent levels of perceived benefit of personal therapy experience to personal well-being (PTBNPER) and professional training (PTBNPRO). PTBNPER ranged from 0.00 to 24.00 points. Recall that higher values indicate a higher perception of benefit of personal therapy to personal well-being. PTBNPRO ranged from 0.00 to 28.00 points. Higher values are also indicative of higher perception of benefit of personal therapy, but to professional training. The means and standard deviations were calculated based on data from all 47 clients, even though not all clients were in treatment with a counselor trainee who reported personal therapy experience, and subsequently rated the benefits. Means and standard deviations calculated from full client data are as follows: PTBNPER ($M = 11.89, SD = 8.48$); PTBNPRO ($M = 13.62, SD = 9.52$).

The PERMAX and PROMAX perceived benefit predictor variables on level 2 represent the highest ratings of perceived level of benefit of all personal therapy experiences (i.e., if more than one episode was reported) to personal well-being (PERMAX) and professional training (PROMAX). The PERMAX variable ranged from 0.00 to 24.00 points with higher values indicating a higher perception of benefit to personal well-being. The PROMAX variable ranged from 0.00 to 28.00 points with higher values indicative of higher perception of benefit to professional training. Again, the means and standard deviations were calculated based on data from all 47 clients and include those who were in treatment with a counselor trainee who did not report personal therapy experience, hence providing no perceived level of benefit rating. Means and standard deviations include the following: PERMAX ($M = 13.49, SD = 8.08$); PROMAX ($M = 14.15, SD = 9.62$).
Models Tested and Model Specification Process

The third section of the results chapter describes the model-building process by explaining how variables are tested for inclusion and how an optimal model is specified in fitting the study data. This section is divided into two subsections. The first subsection will summarize the process of building a multilevel model and report on the specific variables tested for inclusion in determining an optimal model to explain the study data. The second subsection will describe additional findings that address research questions regarding overall change, compare results with the removal of outliers, and report findings from post hoc analyses.

**MLM process and variables tested.** The process of building a multilevel growth model with HLM 7 (Raudenbush et al., 2011) to fit the current data began with selecting a method for parameter estimation. The HLM program uses iterative procedures through a maximum likelihood approach to obtain consistent and efficient estimates; this is especially necessary when data are unbalanced as in the present data set (Raudenbush & Bryk, 2002). Decisions regarding parameter estimation vary according to several components, notably the strategies considered for testing hypotheses. Full maximum likelihood was selected as the most appropriate estimation method for the current data set because it allows for ease in comparison of all components between models during hypothesis testing. Once the estimation method was determined, the model-building process began.

Growth curve models are made up of outcome and predictor variables, as well as fixed effects and variance components. The goal is to produce a model where only necessary predictor variables are included (Singer & Willett, 2003). Each new model should advance the fit from the model prior to it in a substantive way. Two models are initially constructed to examine if there is potentially predictable outcome variation and if so, where it is located. First, the unconditional
means model provides some indication of the distribution of outcome variance and at what level analyses are most useful. Second, the unconditional growth model adds a time predictor to show the impact of rate of change on outcome variance. The purpose is to partition out and quantify outcome variation across clients without regard to time (the unconditional means model), and then across both clients and time (the unconditional growth model). As detailed below, results of these initial models for the present data set point to outcome variation to explore both within clients on the first level and between clients on the second level. These models also determine the baselines for comparison as model-building proceeds.

Once baselines are established via the unconditional means and unconditional growth models, predictor variables are added to assess the impact on outcome variance. The goal of model building is to explain as much of the outcome variance as possible. At level 1, the purpose of adding predictor variables is to further explain within-person variance. At level 2, the purpose of adding predictor variables is to further explain between-person variance. Level 2 predictor variables are examined for the extent to which they explain additional variance between clients in both initial status (i.e., intercept) and rate of change (i.e., slope). The analysis proceeds by adding one variable at a time in a forward-building process until there are no other alternatives to extend the model meaningfully. Predictor variables that result in a significantly better fit when added to the model are retained whereas those that do not significantly advance the model are removed.

The remainder of this subsection of the MLM results section will be divided into six parts that provide detailed explanation of the process of testing variables in working towards the specification of an optimal model in the current study. The first part describes the unconditional means and unconditional growth models (i.e., Models A and B). Model A, the unconditional
means model, partitions outcome variance on both levels and is the comparison model for Model B, the unconditional growth model, when the time predictor is added. Model B reveals the amount of outcome variance attributable to time and becomes the comparison model for subsequent models in testing level 2 predictor variables, when evaluating their impact on outcome variance. The second part addresses conditional growth models when the clinical range level 2 predictor variable (SC0CL) is added in Model C, and when the personal therapy level 2 predictor variables (PERSTX and PTGRPRG) are added in Models D1 and D2. Models D1 and D2 both illustrate the association between counselor trainee personal therapy and client outcome. Specifically, Model D1 represents the presence of ever having personal therapy and the relationship to client outcome, and Model D2 represents the presence of having personal therapy during graduate training and the relationship to client outcome. The third part explains the impact on Model D1 when the perceived benefit level 2 predictor variables (PERMAX and PROMAX) are added to create Models E1 and F1. Likewise, the fourth part explains the impact on Model D2 when the perceived benefit level 2 predictor variables (PERMAX and PROMAX) are added to create Models E2 and F2. The fifth part explores more parsimonious alternatives to Models D1 and D2 by removing the intercept components predicted by personal therapy variables in Models G1 and G2. Model G1 is essentially Model D1, but without predicting an association between counselor trainees ever having personal therapy experience and client initial status. Model G2 mimics Model D2, but without predicting an association between counselor trainees engaging in personal therapy during graduate training and client initial status. Finally, the sixth part summarizes decisions made throughout the model specification process and provides interpretation to the findings.
Two tables are provided for reference as the model-building process is described. The first table (see Appendix N) lists the definition of each model tested according to its level 1 and level 2 sub models, and then as one combined “mixed” model. This is especially helpful initially to understand the basic structure and components involved in the multilevel model as predictor variables are added. The second reference table is Table 8 which displays results from HLM 7 analyses for systematic comparison during the model building process. There are eight models listed horizontally (Model A – Model G2) across the top. Components that make up each model are listed vertically beginning with fixed effects and followed by variance components. Statistics for hypotheses testing are listed below variance components. This table illustrates the process of testing predictor variables as they are added and removed from the analyses, identifying those variables that were most effective in explaining outcome variation. Tests on the fixed effects helps determine variables for retention whereas tests on the variance components examines if there is additional outcome variation to predict.

**Models A and B.** The first model fit was the unconditional means model (Model A). This model does not contain any predictor variables at any level but rather, is used to estimate variance components existing at each level. Parameters estimated are the overall intercept ($\beta_{00}$), the within-person error variance ($e$), and the between-person error variance ($r_0$). The intercept ($\beta_{00}$) represents the grand mean of the outcome variable (OQSCR), and is the fixed effect for Model A. This is the average of all OQ-45.2 scores from every session across all clients and it represents how much clients varied in psychological distress without regard to time or other predictors. Table 8 shows that the grand mean of psychological distress (OQSCR) is 61.84 ($p < .001$). The meaning of significance for the intercept indicates that the grand mean of distress is
different than 0. Recall that scores above 63 are considered in the clinical range for psychological distress, so overall clients averaged levels of distress just below the clinical cutoff.

The random effects in Model A are the within-person ($e$) and the between-person ($r_0$) error variances. These variance components identify how much outcome variation resides at each level. If both within- and between-person effects are significantly different from 0, the indication is that there is further variance to be explained by predictors, and model-building is warranted. Table 8 lists the amount of variation at level 1, the within-client level, which is 84.12 ($p < .001$). The amount of variation existing at level 2, the between-client level, is 406.43 ($p < .001$). These figures are significantly different from 0 and indicate that average levels of psychological distress varied both within clients across sessions and between clients in comparison to one another.

To show the relative magnitude of the variance components, the interclass correlation coefficient (ICC) is computed as an indicator of the need for MLM. ICC values lie between 0 and 1 and show how much of the total variation exists at level 2 between clients. Values closer to 1 indicate larger variance on level 2. The ICC statistic was computed for Model A by dividing the level 2 variance component by the total variance [i.e., (406.43) / (406.43 + 84.12) = .83]. The ICC indicates that roughly 83% of the total variation is occurring between clients on level 2 (versus approximately 17% within clients on level 1). Again, ICC values closer to 1 describe larger variance on level 2, which here suggests that there is significant variation to be explained by additional predictors on level 2. Thus, MLM was deemed appropriate and needed.

One other number listed under Model A in Table 8 is the deviance statistic (2263.44). Preferable for its “superior statistical properties (p. 116),” the deviance statistic is used to compare the likelihood of fit between two models and allows for hypotheses testing about
differences in fit for two competing models (Singer & Willett, 2003). Moreover, it is a statistic that indicates how much a model deviates from the data so higher deviance values represent a worse model fit (Kahn & Schneider, 2013). In Model A, the deviance statistic provides the baseline for comparison with Model B, the unconditional growth model. As modeling progresses, more predictors are added and models become more complex. The retention of predictor variables in the model is evaluated based on the significance of the particular effect in the model as well as how greatly the evolving model reduces the deviance statistic in comparison to the preceding model. The difference in deviance values between models is evaluated via likelihood ratio tests, which are the primary method used to test significance in moving forward toward determining an optimal model to describe data in this study.

Model B in Table 8 illustrates the unconditional growth model which depicts change over time. In this model, the time predictor variable (SESSION) is added at level 1 to estimate the average linear change trajectory across all clients. There are no other predictors in this model. The fixed effects are the average intercept ($\beta_{00}$) and the average slope ($\beta_{10}$) for the entire data set. The intercept is the average initial distress across clients on level 2 and the slope is the average pattern of change across clients on level 2. When SESSION is added to level 1, regression lines are created separately for each client to estimate differences in variation in intercepts and slopes. The fixed effect for the intercept in Model B indicates that the average level of psychological distress for clients at initial status is 64.60 ($p < .001$). The fixed effect for the slope in Model B indicates that distress levels decrease over time by an average by -0.95 ($p = .043$) per session. Thus, with no other predictor variables than time (SESSION), the unconditional growth model predicts average client psychological distress scores just above the clinical cutoff, and that time in therapy alone is predicted to reduce distress by nearly 1 point per treatment session (as
measured by the OQ-45.2). Hypothesis testing of fixed effects shows that the average level of distress and rate of change are significantly different from 0, indicative of the necessity of both parameters to describe the mean growth trajectory (Raudenbush & Bryk, 2002).

The random effects in Model B include within-client variance on level 1 ($e$) and between-client variances on level 2. Between-client variances on level 2 include error associated with differences in initial status ($r_0$) and error associated with differences in slope ($r_1$). The intercept and slope are specified to vary across clients on level 2 because clients are expected to differ in their overall level of distress (i.e., the intercept) and in the rate that they change (i.e., the slope). The amount of variation in parameters across level 2 are represented by the random component of the intercept (i.e., among initial distress levels), and the random component of the slope (i.e., among patterns of change in treatment). Small random components suggest accuracy in the fixed estimates of the intercept and slope for each client; large random components suggest large differences in clients across intercepts and slopes (Kahn & Schneider, 2013). The error variance on level 1 is 57.08, a decrease from 84.12 in Model A. On level 2, error variances are 440.24 ($p < .001$) for the intercept component and 5.40 ($p < .001$) for the slope component. Results indicate that clients varied significantly in their initial levels of psychological distress and in the rates at which they experienced change in treatment. Moreover, there was still more variance to be explained with additional predictor variables.

One way to measure the proportion of outcome variation explained by the addition of predictors (i.e., the size of an effect) is to compute a statistic similar to the $R^2$ statistic in multiple regression; however, there are no accompanying significance tests to conduct these analyses so cautious interpretation is advised (Kahn & Schneider, 2013). Due to the challenges that emerge when total outcome variation is partitioned into several components as is the case in MLM,
Singer and Willett (2003) present “pseudo-$R^2$ statistics” (p. 102) as helpful data analytic tools to be used carefully when assessing how much outcome variation might be explained by the multilevel model predictors. As predictors are added during the model-building process, the reduction in outcome variation is the proportion of variance explained in the random effects. Using pseudo-$R^2$ is advantageous because it is easy to compute and provides an understandable measure of effect size (Kwok et al., 2008). Table 8 also includes the pseudo-$R^2$ statistic as a criterion for model comparison. The difference between the total parameter variance (estimated from the unconditional model) and the residual parameter variance (based on the fitted model) is divided by the total parameter variance. Returning to the within-client variance on level 1 in Model B, this value (57.08) is subtracted from the within-client variance in Model A (84.12) and divided by total within-client variation (i.e., 84.12 in Model A). The result is that 32% of the within-client variation in psychological distress could be systematically explained by time in therapy [i.e., $R_e^2 = (84.12 - 57.08) / 84.12 = 0.32$]. Thus, the reduction of error variance on level 1 from the unconditional means model to the unconditional growth model illustrated the effect of adding time as a predictor.

Table 8 shows how time in therapy as the sole level 1 predictor variable continues to explain between 32% and 34% of within-client variation in psychological distress in all subsequent models. The level 2 error variance in initial status ($R_0^2$) in Model B however, is not compared to that of Model A because the introduction of the time predictor changes the interpretation of the level 2 variance components (Singer & Willett, 2003). That is, the focus shifted from main effects to interaction effects rendering the comparison of these values not conceptually equivalent. Instead, Model B becomes the comparison model for evaluating future models with predictors added to level 2.
Thus far, Model B indicates that time in therapy (SESSION) accounts for approximately 32% of variation in psychological distress within clients. There is also a significant amount of variance in initial distress levels and rates of change between clients to be explored by testing more predictor variables. Models are compared in terms of how well they fit the data with the use of the likelihood ratio test. The likelihood ratio test compares the deviance statistic of one model to another to evaluate improvement in fit. Model B was compared to Model A via the likelihood ratio test and deviance statistics are listed in Table 8. Deviance in Model B (2217.20) is lower than deviance in Model A (2263.44) and this reduction is statistically significant ($\chi^2 = 46.24; p < .001$), indicating that the unconditional growth model (Model B) is a better fit than the unconditional means model (Model A). Given that there is more variance yet to be explained, level 2 predictor variables are tested in the remaining models before eventually determining the best model to represent the study data.

Before moving forward in explaining the results of fitting additional models with level 2 predictor variables, it is important to note how the meaning of the time variable can be scaled to reflect different points of the growth trajectory. Recall that research questions ask about the effects of counselor trainee personal therapy experience on client outcome regarding an overall effect (i.e., from the beginning to the end of therapy) and on the rate of change (i.e., reduction of psychological distress across sessions). Analyses were conducted to address both types of questions; however, such analyses require that the time variable on level 1 be scaled in two different ways. Time in therapy was scaled both as SESSION (ranging from 0 to 11) and RSESSION (ranging from -11 to 0). When the time predictor SESSION is used, the first observation starting at 0 produces an intercept that represents the average level of psychological distress across all clients as measured just prior to the first session. The first observation
provides a meaningful comparison point across clients because it captures clients at a similar point in therapy, prior to meeting their new therapist for the first time. Likewise, the slope is the average growth rate in the beginning of treatment, also meaningful going forward as Session 0 represents the start of therapy.

To address the impact of counselor trainee predictor variables on client psychological distress overall, the time predictor RSESSION is used. The intercept shifts to represent the end of treatment where level of distress was measured just prior to each client’s last session. The slope also shifts to show growth rates at the end of therapy. RSESSION facilitates comparison between initial and ending status. One challenge with the use of the time variable rescaled in RSESSION is the variation in client total sessions. Because the data are unbalanced, there is more variability in the meaning of Session 0 for RSESSION. When time in therapy counts forward to where Session 0 represents the final observation in treatment, the length of treatment and total number of sessions across clients differs. That is, although clients all end at Session 0, for some clients Session 0 reflects more treatment with their therapists (e.g., 7 sessions) whereas for others, Session 0 reflects less treatment with their therapists (e.g., 3 sessions). Likewise, rates of change at the end of treatment may vary more in part due to differences in total sessions.

Results for the remainder of models in this subsection will be presented as analyzed with the time variable SESSION so that changes in psychological distress between are compared to distress levels at the beginning of therapy. Interpretation of the values of the intercept become limited as level 2 predictor variables are tested from Set 2 (personal therapy) and Set 3 (perceived benefit). Given that sets 2 and 3 represent potential effects of counselor trainees on clients, logically it is not possible for these variables to have influenced distress levels prior to the start of therapy. In some respects, the more meaningful hypothesis testing occurs with the
level 2 slope, where variables pertaining to clients’ therapists are tested for association with client rate of change. After analyses are performed using the SESSION time variable, RSESSION will be substituted into the obtained optimal model to address levels of psychological distress at the end of treatment. This shift makes the potential effects of level 2 variables on the intercept meaningful.

To review, Models A and B were constructed to provide insight on how much outcome variation resided at each level and to evaluate the impact of adding the time predictor variable. Model A (the unconditional means model) did not include any predictor variables. Its purpose was to estimate the amount of outcome variance within clients (on level 1) versus the amount of outcome variance between clients (on level 2). Model A indicated that the majority of variance in outcome (83%) existed primarily between clients on level 2. This means that there is considerable variation between clients and that further testing of level 2 predictor variables will help determine the impact on the distribution of that variance. Model B (the unconditional growth model) introduced the time predictor variable and compared the change in outcome variation from that of Model A. Its purpose was to estimate how much variance was accounted for by time in therapy. Model B provided evidence that time in therapy accounted for changes in client psychological distress. The next part illustrates conditional growth models with the introduction of level 2 predictor variables. Variance components in conditional growth models (Models C, D1, and D2; E1 and E2; F1 and F2; and G1 and G2) are compared to the variance in the unconditional growth model (Model B) to estimate the size of the effect of the variable tested. The clinical range level 2 predictor variable (SC0CL) is added in Model C, and the personal therapy level 2 predictor variables (PERSTX and PTGRPRG) are added in Models D1 and D2.
Table 8  
Results of Model Testing with Level 1 and Level 2 Predictor Variables

<table>
<thead>
<tr>
<th>Category</th>
<th>Parameter</th>
<th>Model A</th>
<th>Model B</th>
<th>Model C</th>
<th>Model D1</th>
<th>Model D2</th>
<th>Model E1</th>
<th>Model F1</th>
<th>Model G1</th>
<th>Model G2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Effects</td>
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<td></td>
</tr>
<tr>
<td>Initial Status, $\pi_0$</td>
<td>Intercept</td>
<td>$\beta_{00}$</td>
<td>61.84***</td>
<td>64.60***</td>
<td>46.80***</td>
<td>39.78***</td>
<td>43.26***</td>
<td>39.74***</td>
<td>40.00***</td>
<td>46.65***</td>
</tr>
<tr>
<td></td>
<td>SC0CL</td>
<td>$\beta_{01}$</td>
<td>34.72***</td>
<td>35.92***</td>
<td>35.26***</td>
<td>35.95***</td>
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<td>34.64***</td>
<td>34.77***</td>
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<tr>
<td></td>
<td>PERSTX</td>
<td>$\beta_{02}$</td>
<td>7.83</td>
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<td>-1.74</td>
<td>2.98</td>
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<tr>
<td></td>
<td>PTGRPRG</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PERMAX</td>
<td>$\beta_{03}$</td>
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<td></td>
<td>0.27</td>
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<tr>
<td>Rate of Change, $\pi_{1i}$</td>
<td>Intercept</td>
<td>$\beta_{10}$</td>
<td>-0.95*</td>
<td>-0.18</td>
<td>3.15*</td>
<td>1.12</td>
<td>3.19*</td>
<td>3.15*</td>
<td>2.63*</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>SC0CL</td>
<td>$\beta_{11}$</td>
<td>-1.45</td>
<td>-1.95*</td>
<td>-1.73*</td>
<td>-2.00*</td>
<td>-1.95*</td>
<td>-1.84*</td>
<td>-1.65</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PERSTX</td>
<td>$\beta_{12}$</td>
<td>-3.63**</td>
<td></td>
<td></td>
<td>-2.09</td>
<td>-2.80</td>
<td>-3.09**</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>PTGRPRG</td>
<td></td>
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<tr>
<td></td>
<td>PERMAX</td>
<td>$\beta_{13}$</td>
<td></td>
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<td>-2.24*</td>
<td>-0.09</td>
<td></td>
<td></td>
<td>-1.81*</td>
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<tr>
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<td></td>
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<td>Variance Components</td>
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<td></td>
</tr>
<tr>
<td>Level 1</td>
<td>Within-person</td>
<td>$e$</td>
<td>84.12</td>
<td>57.08</td>
<td>57.07</td>
<td>55.49</td>
<td>56.42</td>
<td>55.79</td>
<td>55.62</td>
<td>55.86</td>
</tr>
<tr>
<td></td>
<td>In initial status</td>
<td>$r_0$</td>
<td>406.43***</td>
<td>440.24***</td>
<td>138.68***</td>
<td>128.15***</td>
<td>128.89***</td>
<td>118.70***</td>
<td>124.89***</td>
<td>137.68***</td>
</tr>
<tr>
<td></td>
<td>In rate of change</td>
<td>$r_1$</td>
<td>5.40***</td>
<td>4.94***</td>
<td>4.23***</td>
<td>4.14***</td>
<td>3.85***</td>
<td>4.07***</td>
<td>4.02***</td>
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<tr>
<td></td>
<td>Covariance</td>
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<td>-1.00</td>
<td>-2.81</td>
<td>0.79</td>
<td>-0.21</td>
<td>-1.54</td>
<td>-3.23</td>
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<tr>
<td></td>
<td>Correlation</td>
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<td>-0.22</td>
<td>-0.04</td>
<td>-0.12</td>
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<td>-0.01</td>
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<td>-0.14</td>
</tr>
<tr>
<td>Size of Effect (Pseudo-$R^2$) and Goodness of Fit</td>
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<td>0.32</td>
<td>0.32</td>
<td>0.34</td>
<td>0.33</td>
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<tr>
<td></td>
<td>$R_{0}^2$</td>
<td>0.69</td>
<td>0.71</td>
<td>0.71</td>
<td>0.71</td>
<td>0.73</td>
<td>0.72</td>
<td>0.69</td>
<td>0.68</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$R_{1}^2$</td>
<td>0.09</td>
<td>0.22</td>
<td>0.23</td>
<td>0.23</td>
<td>0.29</td>
<td>0.25</td>
<td>0.25</td>
<td>0.26</td>
<td></td>
</tr>
<tr>
<td>Deviance</td>
<td></td>
<td>2263.44</td>
<td>2217.20***</td>
<td>2167.80***</td>
<td>2157.72***</td>
<td>2159.88*</td>
<td>2154.51</td>
<td>2156.67</td>
<td>2160.57</td>
<td>2163.03</td>
</tr>
</tbody>
</table>

Note. Parameter definitions are as follows: $\beta_{00}$ = Average initial distress score when all predictors are 0; $\beta_{01}, \beta_{02}, \beta_{03}$ = Average value added to initial distress score when stated predictors are present; $\beta_{10}$ = Average change in distress per session when predictors are 0; $\beta_{11}, \beta_{12}, \beta_{13}$ = Average value added to rate of change when stated predictors are present; $e$ = Error variance within clients on level 1; $r_0$ = Error variance in the intercept between clients on level 2; $r_1$ = Error variance in the slope term between clients on level 2. Size of effect definitions are as follows: $R_0^2$ = Proportion of variance explained within clients on level 1; $R_1^2$ = Proportion of variance explained in the intercept between clients on level 2; $R_{ij}^2$ = Proportion of variance explained in the slope between clients on level 2.

*p < .05. **p < .01. ***p < .001.
Models C, D1, and D2. There are three sets of predictor variables tested on level 2. The first is from the clinical range set (SC0CL) and indicates whether clients’ initial levels of psychological distress were considered to be in the clinical range or not. Model C in Table 8 lists results from analyses with the SC0CL predictor variable. Four fixed effects and three variance components are estimated. The intercept now represents the average level of psychological distress at the beginning of treatment when all predictors equal 0. Model C estimates that for clients entering therapy with levels of psychological distress below the clinical cutoff score (SC0CL = 0), the intercept is 46.80 ($p < .001$). For clients entering therapy with levels of psychological distress above the clinical cutoff (SC0CL = 1), 34.72 ($p < .001$) is added to the intercept. Thus, clients above the clinical cutoff for levels of reported psychological distress averaged a score of 81.52 on the OQ-45.2 (i.e., 46.80 + 34.72 = 81.52). Fixed effects for the slope predicts rates of change of -0.18 ($p = .780$) per session for clients starting treatment with nonclinical levels of psychological distress, and -1.45 ($p = .109$) per session for clients starting treatment with clinical levels of psychological distress. These rates were not significantly different from 0 indicating that the degree to which psychological distress reached clinical levels at the beginning of treatment were not estimated to be significantly associated with rates of change over treatment.

Examination of the variance components in Model C offered additional information as to the value of the SC0CL predictor variable. Recall that the within-client variance component will stay approximately the same across models ($R_w^2 = .32$) because no additional level 1 predictors are being added. The SC0CL predictor on level 2 however, did account for a significant reduction of error variance between clients in regards to both initial status (138.68; $p < .001$) and rate of change (4.94; $p < .001$). The proportion of variance explained in initial status ($R_o^2$) with
the addition of the SC0CL predictor variable is 69% [i.e., \((440.24 - 138.68) / 440.24 = 0.69\)].

The proportion of variance explained in the rate of change \((R^2)\) with the addition of the SC0CL predictor variable is 9% [i.e., \((5.40 - 4.94) / 5.40 = 0.09\)]. Thus, the size of the effect of having clinical levels of psychological distress at the beginning of treatment accounts for much of the error variance in the intercept, and a small portion of the error variance in the slope.

Additionally, results indicate that there continues to be significant variation between clients regarding levels of psychological distress and patterns of change. In assessing model fit, the deviance value declined from 2217.20 in Model B to 2167.80 in Model C. The likelihood ratio test confirmed that Model C was shown to be a better fit than Model B \(\left(\chi^2 = 49.40; p < .001\right)\).

Given that the fixed effects in Model C for the intercept were significant yet the fixed effects for the slope were not, a decision needs to be made regarding retention of the SC0CL variable in the model. Significance in the intercept indicates that initial levels of client psychological distress, whether those levels were above the clinical cutoff score or not, were nonzero. Patterns of change however, were not significantly different from 0 regardless of initial levels of psychological distress. Additionally, variance components suggest that there is still significant variation between clients in initial status and rate of change. Moreover, a likelihood ratio test significantly identified Model C as a better fit than previous models. Considering statistical evidence in combination with theory and research, the SC0CL predictor variable was retained in the model. Research associated with the OQ-45.2 measure points to the rationale of the development of the marker between functional and nonfunctional populations. Because the purpose of this study is to examine the effects of predictors on client change, knowing whether clients reported psychological distress of clinical proportions when entering treatment is necessary to consider. In addition, the SC0CL variable could be removed in subsequent models.
if those models indicate that there is no meaningful differences in initial status or rate of change for clients who entered counseling in the clinical versus the nonclinical range. Thus, SC0CL was retained for further evaluation in subsequent models.

Models D1 and D2 extend Model C by adding the *personal therapy* set of level 2 predictor variables, which are representative of personal therapy experience by clients’ respective counselor trainees. Recall that personal therapy experience is assessed by whether counselor trainees reported ever having engaged in it (PERSTX), having engaged in it during their graduate program (PTGRPRG), or being engaged in it during practicum (PTCRT). Each personal therapy experience variable was evaluated individually in sub-models and compared to determine whether it strengthened the fit beyond that observed in Model C. The goal of this part of multilevel modeling was to discover which method of representing personal therapy experiences provided the best fit for model advancement in terms of statistical significance and conceptual explanation.

Before designating which *personal therapy* variables would be tested in Models D1 and D2, all personal therapy predictor variables (i.e., PERSTX, PTGRPRG, and PTCRT) were tested individually and compared as far as optimal fit beyond Model C. All three variables were evaluated by their impact on significant reductions in deviance and significant fixed effects. PERSTX, PTGRPRG, and PTCRT were all significant in reducing deviance and yielding significant fixed effects; however, PTCRT did not show significant effects on rates of change. The effect on rate of change is of particular interest with this set of analyses because the potential importance of counselor trainee predictor variables are limited when initial status represents distress prior to therapy. That is, counselor trainee personal therapy experience cannot be associated with client levels of psychological distress before ever meeting them. Thus, fixed
effects on the intercepts for the *personal therapy* variables were not expected to be significant and were not for the PERSTX and PTGRPRG predictor variables. PTCRT however, did result in significant effects for the intercept. This meant that clients seen by counselor trainees who reported that they were currently engaged in personal therapy during practicum were significantly different from clients seen by counselor trainees who did not report current personal therapy use. These results, which are not presented in Table 8, are explained below.

The PTCRT predictor variable resulted in significant fixed effects for the intercept for clients who began therapy in both the nonclinical and clinical ranges of psychological distress. This meant that clients who entered therapy with levels of psychological distress below the clinical range and who were seen by counselor trainees denying the current use of personal therapy, were estimated to score approximately 42.56 ($p < .001$) points on the OQ-45.2; clients with levels of psychological distress within the clinical range entered therapy scoring approximately 78.14 points on the OQ-45.2 [i.e., $45.26 + 35.58 (p < .001) = 78.14$]. Significance here represents that initial scores, whether below or above the clinical cutoff, were different from 0. In contrast, the addition of the PTCRT predictor variable should not result in a significant value because clients at this point had not met their counselors and thus, could not have distress levels associated with their counselors’ use of current personal therapy. Yet results indicated that clients who met with counselor trainees reporting the current use of personal therapy did have higher initial scores on the OQ-45.2 by approximately 13.41 ($p < .001$) points. For example, clients entering therapy with nonclinical levels of psychological distress and who met with counselor trainees who reported the current use of personal therapy, were estimated to score 55.97 on the OQ-45.2 [i.e., $45.26 + 13.41 (p < .001) = 55.97$]. Clients presenting with clinical levels of psychological distress who met with counselor trainees currently in personal therapy
scored approximately 94.25 on the OQ-45.2 [i.e., 45.26 + 35.58 + 13.41 = 94.25]. Although it is not possible for client initial psychological distress to be associated with counselor personal therapy use, the results indicate that clients meeting with counselor trainees currently participating in personal therapy had significantly higher levels of psychological distress. Moreover, fixed effects for the slope were not significant \((p = .153)\), indicating that rates of change for these clients were not different from 0 and that clients seeing counselors currently in personal therapy did not significantly change over the course of treatment. Given that results from the addition of the PTCRT predictor variable indicated significant differences in psychological distress at initial status and not in rate of change, PTCRT was deemed problematic and was not retained in the model for further analyses.

As detailed in Table 8 and described further below, the addition of the other personal therapy predictor variables (PERSTX and PTGRPRG) did not yield significant fixed effects for the intercept but did result in significance in slope values. The impact of these predictor variables on rates of change indicates that something important is occurring and thus, further analyses with these variables are warranted. Thus, PERSTX and PTGRPRG predictor variables are retained for subsequent model testing. There are two “D” models tested: Model D1 and Model D2. Model D1 includes the PERSTX predictor variable and Model D2 includes the PTGRPRG predictor variable.

Table 8 displays the results of testing both the PERSTX predictor variable (Model D1) and the PTGRPRG predictor variable (Model D2). In Model D1, the PERSTX variable is added to Model C to evaluate if clients having a counselor who had ever engaged in personal therapy is associated with client rates of change. There are six fixed effects and three variance components. The three fixed effects pertaining to the initial intercept are not as meaningful
beyond estimating nonclinical (39.78; \( p < .001 \)) and clinical (35.92; \( p < .001 \)) averages of psychological distress at initial status. The effect of the PERSTX variable on initial intercept (7.83; \( p = .093 \)) is not relevant to distress levels prior to beginning therapy. Of more interest are the three fixed effects pertaining to the rate of change. Model D1 predicts that the average rate of change for clients when all other predictors are equal to 0 is 3.15 (\( p = .013 \)). This means that these clients would be projected to increase in psychological distress as measured by the OQ-45.2 by approximately 3 points per session (i.e., if entering therapy below the clinical cutoff with a counselor trainee reporting no history of personal therapy experience). For clients entering treatment above the clinical cutoff score with a counselor trainee reporting no history of personal experience, the differential is (-1.95; \( p = .028 \)). They are projected to still increase in distress points, but by a smaller number [i.e., (3.15) + (-1.95) = 1.20]. Clients beginning treatment below the clinical cutoff but who met with counselor trainees who had reported a history of personal therapy experience are predicted to experience a reduction in psychological distress (-3.63; \( p = .003 \)). For these clients though, the predicted rate of change over treatment is to decrease psychological distress by approximately one-half of a point on the OQ-45.2 per session [3.15 + (-3.63) = -0.48]. The largest rate of change in terms of reduction in psychological distress is predicted for clients who enter therapy within the clinical range of psychological distress and meet with a counselor trainee who has reported experience in personal therapy. Their predicted rate of change is -2.43 points per session [3.15 + (-1.95) + (-3.63) = -2.43]. Thus, for the current data, reduction of psychological distress is associated with starting therapy in the clinical range of distress and working with counselor trainees who have experience in their own personal therapy.
In examining variance components, effects are still significant for initial status and the rate of change between clients with the addition of the PERSTX predictor variable. As expected, the proportion of variance explained within-clients remains stable around 32 – 34% because no additional level 1 predictors have been added. Also expected is a small reduction, if any, of error variance related to client initial status. This is because the inclusion of the PERSTX predictor variable cannot explain variance at initial status before treatment began. The variance component pertaining to initial status is 128.15 ($p < .001$), which is slightly reduced from 138.68 in Model C. This results in Model D1 explaining 71% of the estimated variance between clients in initial status, which is quite similar to the percentage explained in Model C (69%). The variance component for the rate of change is 4.23 ($p < .001$), lower than the component in Model C (4.94). This reduction accounts for 22% of the proportion of variance explained in the rate of change when the PERSTX predictor variable is included in Model D1. Thus, the personal therapy experience of the counselor trainee accounted for approximately 13% of the slope variance explained between clients. The deviance statistic in Model D1 (2157.72) also reduced significantly ($\chi^2 = 10.08; p = .007$) from Model C (2167.80). Model D1 indicates a better fit of the study data than previous models and thus, both level 2 predictor variables (SC0CL and PERSTX) are retained for further analyses. Before moving forward and introducing variables from the third set of level 2 predictors, the PTGRPRG variable (i.e., regarding counselor trainees reporting the occurrence of personal therapy experience while in their graduate programs) is examined in Model D2.

When assessing the personal therapy set of level 2 variables about the experiences of personal therapy by counselor trainees, the PTGRPRG predictor variable also resulted in significant effects that warranted further examination. The PTGRPRG predictor variable is
tested in Model D2 and follows the same process in testing as Model D1. Model D2 is building upon Model C to examine how the addition of the PTGRPRG predictor variable extends the model. Table 8 displays six fixed effects and three variance components. Similar to Model D1, the three fixed effects in Model D2 that pertain to initial status are not as meaningful beyond estimating nonclinical (43.26; \( p < .001 \)) and clinical (35.26; \( p < .001 \)) averages of psychological distress. The effect of the PTGRPRG variable on initial status (6.59; \( p = .078 \)) is also not relevant to distress levels prior to beginning therapy; however, the three fixed effects pertaining to the slope project faster rates of change. Model D2 predicts that the average rate of change for clients when all other predictors are equal to 0 is 1.12 (\( p = .164 \)). The lack of significance indicates that this rate of change (1.12) is indistinguishable from 0. In other words, when all predictors are equal to 0, clients would not be predicted to change over time from their initial levels of psychological distress because the rate of 1.12 is assumed to be 0. For clients entering treatment above the clinical cutoff score, but with counselor trainees reporting no history of personal experience during their graduate programs, the rate of change is predicted to be -1.73 (\( p = .047 \)). The projected decrease in distress scores on the OQ-45.2 is nearly 2 points per session. Clients beginning treatment below the clinical cutoff score but who met with counselor trainees who had reported a history of personal therapy experience occurring during graduate training are predicted to reduce levels of psychological distress by -2.24 (\( p = .011 \)) points per session. Furthermore, clients in this study are predicted to reduce psychological distress the fastest if they entered therapy within the clinical range of psychological distress and met with counselor trainees who had reported experience in personal therapy occurring during the time they were in their graduate programs. Their predicted rate of change is -3.97 points per session \([(-1.73) + (-2.24) = -3.97]\), or on average about 4 points per week in treatment. Thus, Model D2 indicates
that a reduction of psychological distress is associated with starting therapy in the clinical range of distress and working with counselor trainees who reported receiving their own personal therapy at the time they were enrolled in their graduate programs.

One caution in interpreting the fixed effects in Model D2 is in how the PTGRPRG predictor variable was created. Recall that when counselor trainees reported on the CIQ that they had personal therapy experience, they were asked to indicate if it occurred during their graduate training programs. The values of the PTGRPRG variable refer to the presence (1) or absence (0) of when therapy occurred (as related to the timing of graduate school), not if they ever received therapy. Therefore, clients’ counselors who had not reported personal therapy during graduate school could have still received personal therapy at some point. Thus, the PTGRPRG variable doesn’t separate clients’ counselors into groups defined by whether they had therapy or not, just whether the therapy reported occurred during their graduate programs. Counselors who did not report any personal therapy experience were also included in the “0” group (i.e., therapy not in graduate school). The coding of the PTGRPRG predictor variable presents some issues moving forward in the model-building process when decisions are made regarding the better-fitting model. This will be addressed later when predictor variables are tested from Set 3 to expand on Model D2.

In examining variance components in Model D2, effects are significant both between clients in initial status and rate of change with the addition of the PTGRPRG predictor variable. Again, the proportion of variance explained within-clients is stable between 32% and 34% and will remain so unless there were additional predictors on level 1 to test. As similar to variance explained in Model D1, adding the PTGRPRG variable in Model D2 doesn’t further explain outcome variance between clients in initial status given that therapist personal therapy,
regardless of when it occurred, cannot have an impact on clients prior to treatment. The variance in initial status in Model D2 (128.89; \( p < .001 \)) explained approximately the same proportion of variance in initial status between clients (71%) as in Model D1 when compared to Model C (69%). The variance component for the rate of change is also explained further in Model D2 (4.14; \( p < .001 \)). Compared to Model C, this reduction accounts for 23% of the proportion of variance explained in the rate of change, similar to 22% explained in Model D1 when the PERSTX predictor was tested. Thus, personal therapy experience occurring during graduate school as reported by counselor trainees accounted for approximately 14% of the variance explained in rate of change between clients. Likewise, the deviance statistic in Model D2 (2159.88); also reduced significantly (\( \chi^2 = 7.92; \ p = .019 \)) from Model C (2167.80) indicating a better fit than previous models tested (i.e., with the exception of Model D1). Further exploration of Model D2 with additional level 2 predictors from Set 3 will be addressed following the examination of these predictors in Models E1 and F1.

This part described the model-building process when Model B was extended to include the clinical score predictor variable in Model C, and when Model C was extended to include the personal therapy predictor variables in Models D1 and D2. In Model C, the addition of the clinical score predictor variable (SC0CL) resulted in the reduction of error variance for both the initial status and rate of change components. There was also a significant reduction in deviance from Model B to Model C, indicating that Model C provided a better representation of the study data than Model B. This resulted in the retention of the clinical score predictor variable (SC0CL) in the model. The personal therapy predictor variables tested in Models D1 (PERSTX) and D2 (PTGRPRG) also resulted in significant fixed effects in initial status and rate of change. Model D1 predicted that change in client psychological distress is associated with counselor
trainees who reported experience in personal therapy (PERSTX). Model D2 predicted that change in distress is associated with counselor trainees who reported personal therapy experience during their graduate training programs (PTGRPRG). Moreover, Models D1 and D2 revealed reductions in error variance in each model for both initial status and rate of change, as well as in significant reductions of deviance. That is, Models D1 and D2 were shown to be better representations of the study data than previous models. Comparing Models D1 and D2 to one another did not indicate that one model provided a better fit than the other. Because both personal therapy predictor variables offered substantive information regarding the personal therapy of counselor trainees, both predictors (PERSTX and PTGRPRG) were retained for further testing. The next part assesses Models E1 and F1 as extensions of Model D1 by introducing perceived benefit predictor variables, followed by exploring Models E2 and F2 as extensions of Model D2 with perceived benefit predictor variables.

**Models E1 and F1.** The third set of level 2 predictors (i.e., perceived benefit variables) pertain to therapist perception of benefits of personal therapy. These predictors are first added to extend Model D1. Table 8 shows the definition of Model D1 which contains the SC0CL and PERSTX predictors. Models E1 and F1 assess predictor variables representative of how beneficial counselor trainees perceived their personal therapy to be to their personal well-being (i.e., PTBNPER and PERMAX) and professional training (i.e., PTBNPRO and PROMAX). The perceived benefit predictor variables were measured via the CIQ responses in reference to both their most recent personal therapy experience (PTBNPER and PTBNPRO) and the experience they rated the highest (PERMAX and PROMAX). These two subsets of predictor variables were tested to discover which method of representing the perceived personal and professional benefits of counselor trainee personal therapy experiences provided the better fit for model advancement.
Statistical significance, the proportion of variance explained, and conceptual explanation facilitated decision-making to retain or eliminate these predictor variables. None of the perceived benefit predictor variables tested (PTBNPER, PTBNPRO, PERMAX, and PROMAX) resulted in a significant reduction of deviance; however, PERMAX and PROMAX are included in Table 8 for illustration purposes. The variables representing the highest-rated benefit scores were chosen because theoretically, the perception of benefit of a particular personal therapy experience need not occur during the most recent experience to have an effect on the counselor trainee. Model E1 focuses on the addition of the predictor variable representing highest personal benefit (PERMAX) and Model F1 focuses on the addition of the predictor variable representing highest professional benefit (PROMAX).

Models E1 and F1 both have eight fixed effects and three variance components. Similar to previous models, psychological distress at the beginning of therapy is significantly different from 0 for clients below and above the clinical cutoff score (i.e., as predicted by the SC0CL variable). In Model E1, clients below the clinical cutoff are projected to enter therapy with a distress score of 39.74 on the OQ-45.2 ($p < .001$). Clients above the clinical cutoff score are projected to enter therapy with a distress score of 75.69 on the OQ-45.2 [$39.74 + (35.95; p < .001) = 75.69$]. In Model F1, clients with nonclinical levels of psychological distress are projected to enter therapy with an OQ-45.2 score of 40.00 ($p < .001$); those with clinical levels of distress are projected to enter therapy with a score of 75.60 [$40.00 + (35.60; p < .001) = 75.60$]. The PERSTX predictor variable does not predict initial status in Model E1 (-1.74; $p = .813$) or Model F1 (2.98; $p = .675$) which is expected given that counselor trainee personal therapy experience could not have had an impact on initial levels of client psychological distress. Likewise, PERMAX tested in Model E1 (0.56; $p = .109$) and PROMAX tested in Model F1
(0.27; \textit{p} = .376) do not have an effect on client psychological distress levels prior to treatment. Neither \textit{perceived benefit} variable was expected to yield significant effects at initial status.

The fixed effects pertaining to growth rates in Model E1 and Model F1 are significant for clients who entered therapy with psychological distress in both the nonclinical and clinical ranges. In Model E1, the growth rate is predicted to be 3.19 (\textit{p} = .010) when all other predictor variables are 0. This means that clients entering therapy below the clinical cutoff are projected to increase in distress points as measured by the OQ-45.2 by approximately 3 points per session. If they are above the clinical cutoff at the start of therapy, the projected rate is closer to increasing by 1 point per session [i.e., 3.19 + (-2.00; \textit{p} = .022) = 1.19].

Similarly in Model F1, the predicted growth rate for clients entering therapy below the clinical cutoff is 3.15 (\textit{p} = .012) OQ-45.2 points for each session attended. If they enter therapy above the clinical cutoff, they are projected to increase in distress at a lower rate [i.e., 3.15 + (-1.95; \textit{p} = .027) = 1.20]. The effect of the PERSTX predictor variable on client growth rate is not significant in either Model E1 (-2.09; \textit{p} = .251) or Model F1 (-2.80; \textit{p} = .098). Likewise the perceived benefit variables included in both models are non-significant. In Model E1, the impact of the PERMAX predictor variable on client growth rates is indistinguishable from 0 (-0.09; \textit{p} = .285). In Model F1, the impact of the PROMAX predictor variable on client growth rates is also indistinguishable from 0 (-0.04; \textit{p} = .502).

Variance components for Models E1 and F1 continue to show that significant variance exists between clients in both initial status and rate of change with the inclusion of the perceived benefit predictors. The proportion of variance explained within clients continues to be stable at approximately 34% in Models E1 and F1. On level 2, the variance in initial status in Model E1 (118.70; \textit{p} < .001) and Model F1 (124.89; \textit{p} < .001) indicates that clients do vary significantly in
psychological distress at the start of therapy; however, the *personal therapy* and *perceived benefit* predictor variables when included are not expected to explain more variance in initial status because these predictors do not have an effect prior to therapy. Thus, the variance in initial status explained in Models E1 and F1 remain approximately stable at 73% and 72%, respectively.

Variance in the rate of change indicates clients still vary significantly from one another in their growth rates over the course of therapy. In Model E1, the addition of the PERMAX predictor variable (in combination with SC0CL and PERSTX) reduces variance to 3.85 ($p < .001$), resulting in 29% of variance explained in client growth rates. In Model F1, the addition of the PROMAX predictor variable (in combination with SC0CL and PERSTX) reduces variance to 4.07 ($p < .001$), resulting in 25% of variance explained in client growth rates. Recall in Model D1 (the comparison model for Models E1 and F1) that the proportion in variance explained pertaining to the slope was 22%. With the addition of variables representing the maximum perceived benefit of personal therapy to personal well-being (Model E1) or professional training (Model F1), the proportion explained increased seven and three percentage points, respectively.

Although Models E1 and F1 did result in more variance being explained between clients in rates of change, it was not enough overall to significantly reduce deviance to the point of providing a better fitting model. Table 8 lists deviance as 2154.51 in Model E1 and 2156.67 in Model F1. The insignificant results of the likelihood ratio tests on the difference in deviance for both Models E1 ($\chi^2 = 3.21; p = .199$) and F1 ($\chi^2 = 1.06; p > .500$), in comparison to deviance from Model D1, suggest that there are no differences in fit between models. That is, Model D1 and Model E1, and Model D1 and Model F1, are presumed not to differ in fit for the current study data. Recall that in MLM, working toward finding an optimal model fit using the least
amount of terms is preferable. Therefore, neither predictor variable added in Model E1 (PERMAX) nor Model F1 (PROMAX) was retained.

In sum, Models E1 and F1 were tested to extend Model D1 with the addition of the third set of predictor variables (i.e., perceived benefit variables). Counselor trainees’ perceptions of potential benefits of personal therapy were examined according to aspects found to be beneficial to personal well-being (PTBNPER and PERMAX) and aspects found to be beneficial to professional training (PTBNPRO and PROMAX). Perceived benefit variables were examined according to trainees’ most recent experience in personal therapy (PTBNPER and PTBNPRO) and alternatively, according to trainees’ highest-rated experience in personal therapy (PERMAX and PROMAX). None of the perceived benefit predictor variables significantly extended Model D1. Models E1 and F1 were included to illustrate the process of testing the PERMAX (Model E1) and PROMAX (Model F1) predictor variables. Although Models E1 and F1 included significant fixed effects and resulted in reductions of error variance for initial status and rate of change components, neither model reduced deviance to the point of producing a significantly better-fitting model. Thus, counselor trainees’ perceptions of benefit from participation in personal therapy (at any point in time) was not shown to be meaningfully associated with changes in client psychological distress.

Models E2 and F2. Models E2 and F2 explore the combination of the perceived benefit level 2 predictor variables when added to the SC0CL and PTGRPRG predictor variables retained in Model D2. This set of analyses parallels how Models E1 and F1 were evaluated, but expands Model D2 with the use of PTGRPRG predictor variable as representative of counselor trainee personal therapy experience. Perceived benefit predictor variables assess for the effect of how beneficial counselor trainees perceived their personal therapy to be to their personal well-being
and professional training. Benefit to personal well-being (PTBNPER) and professional training (PTBNPRO) regarding the most recent experience were tested first and compared to the addition of the highest-rated benefit predictors (PERMAX and PROMAX) in Model D2. Again, none of the benefit variables in Set 3 extended the model further by explaining additional variance. Consequently, perceived benefit predictor variables were not retained and were not considered further.

One issue that emerged during the model-building process is regarding how to represent perception of benefit of personal therapy that occurred during graduate training. For example, the highest-rated perceived benefit scores were chosen because they are believed to best represent the theoretical idea of the effect explored. That is, whether or not trainees reaped the benefits of professional therapy during their actual graduate programs, they still carry notions regarding those benefits. Alternatively, asking counselor trainees if their personal therapy experience occurred during graduate training is connected theoretically to concepts regarding applying what is learned about therapy in graduate school while also participating in it as a client. Thus, it might make more sense to assess how beneficial trainees viewed their personal therapy at the time of their graduate training. Because these questions would likely need to be addressed in the methods prior to data collection, conclusions regarding the impact of perception of benefits of personal therapy experience during graduate training are ineffective. Moreover, both choices of benefit predictors and the rationale behind using one over the other complicates, rather than clarifies, interpretation of the perception of benefit of personal therapy.

Model D2, which predicts associations between counselor trainee personal therapy during graduate training and client rates of change in psychological distress, could not be extended further in subsequent models. Models E2 and F2 were an attempt to extend Model D2 by
examining the addition of *perceived benefit* predictor variables to the model. None of the *perceived benefit* predictor variables significantly extended Model D2. Furthermore, the issue of including *perceived benefit* variables relevant to the most recent personal therapy experience (PTBNPER and PTBNPRO) versus the highest-rated personal therapy experience (PERMAX and PROMAX) presented some challenges regarding how best to represent benefits of personal therapy while in a graduate program. Given that there are no further predictor variables to include in the analyses, alternatives to Model D1 and Model D2 are examined in Models G1 and G2.

*Models G1 and G2.* Before determining the choice of an optimal model to describe the study data from Models D1 and D2, alternatives are explored in Models G1 and G2. Raudenbush and Bryk (2002) assert that the model specification process be guided by both empirical and theoretical considerations. Model specification involves determining the best fit with the use of only necessary components. Because the models evaluated above are coded to represent time at the beginning therapy, predicting the intercept at level 2 becomes challenging once *personal therapy and perceived benefit* predictor variables are included. Therefore, in searching for an optimal and parsimonious model, Models G1 and G2 are developed and tested in response to empirical and theoretical rationale.

Models G1 and G2 explore the impact of removing seemingly unnecessary components from the respective preceding models. Recall that in Models D1 and D2 that the *personal therapy* predictor variables (PERSTX and PTGRPRG) are tested for effects on both the intercept and the slope components on level 2. These components represent the average levels of psychological distress (i.e., the intercept) and rate of change (i.e., the slope) at the start of therapy. Level 2 predictor variables are tested one at a time, yet entered simultaneously in both
level 2 sub models (i.e., one for the intercept component and one for the slope component). Because the intercept component in these models represents initial levels of client distress, *personal therapy* and *perceived benefit* predictor variables that are descriptive of clients’ counselors cannot logically predict initial status given that clients had not met their respective counselors yet. Not surprisingly, the resulting fixed effects for PERSTX in Model D1 and PTGRPRG in Model D2 were not significant. It makes little sense to include these terms that cannot have an impact on client initial status. Therefore, Models D1 and D2 have been modified to remove PERSTX and PTGRPRG from the analyses in predicting the intercept.

Table 8 displays the results from analyses in Models G1 and G2. Model G1, now compared to Model D1, has five fixed effects. The intercept term is only predicted by the SC0CL variable which separates clients into clinical and nonclinical populations. The average level of psychological distress for clients entering therapy below the clinical cutoff score is 46.65 ($p < .001$). If clients present for therapy above the clinical cutoff score, their distress levels rise to 81.28 points on the OQ-45.2 [i.e., $46.65 + 34.64 (p < .001) = 81.29$]. The slope term in Model G1 is predicted by SC0CL and PERSTX variables. Results show that the rate of change is 2.63 ($p = .030$) when both predictors are 0. This means that clients entering therapy below the clinical cutoff score and who meet with counselor trainees who denied having personal therapy experience are projected to increase in distress levels by approximately 2 to 3 points each session. For clients entering therapy above the clinical cutoff score, but who meet with trainees who denied having personal therapy experience, the rate of change is predicted to be 0.79, or approximately 1 point increase per session [i.e., $2.63 + (-1.84; p = .035) = 0.79$]. When clients enter therapy below the clinical cutoff score and meet with counselor trainees who reported personal therapy experience, the rate of change is predicted to be -0.46, or approximately one-
half of a point reduction per session [i.e., $2.63 + (-3.09; p = .007) = -0.46$]. If clients enter therapy above the clinical cutoff and meet with trainees who reported personal therapy experience, the predicted rate of change is -2.30. These clients would be projected to reduce psychological distress by approximately 2 points per session [i.e., $2.63 + (-1.84) + (-3.09) = -2.30$].

The variance components also shift in Model G1 with the removal of the PERSTX variable from predicting initial status. First, as in earlier models, error variance within clients (55.86) does not change given that no new level 1 predictor variables have been added. The proportion of variance explained within clients remains approximately 34%. Variance components for the intercept (137.68; $p < .001$) and the slope (4.02; $p < .001$) show that there are significant differences in client distress at initial status and in their rates of change. The proportion of variance explained between clients in the intercept in Model G1 (69%) returns to that of Model C, where only the SC0CL predictor variable is included. With the combination of SC0CL and PERSTX predictor variables, the proportion of variance explained in the slope is now 25%, an increase from only 9% in Model C and 22% in Model D1. Comparison of the deviance statistics in Model G1 (2160.57) to Model D1 (2157.72), however, did not indicate a significantly better fit ($\chi^2 = 2.85; p = .087$).

Model G2, now compared to Model D2, also has five fixed effects (see Table 8). The intercept term again is only predicted by the SC0CL variable (i.e., separating clients into clinical and nonclinical populations). The average level of psychological distress for clients entering therapy below the clinical cutoff score is 46.75 ($p < .001$). Clients presenting for therapy above the clinical cutoff score show average distress levels at 81.52 points on the OQ=45.2 [i.e., 46.75 + 34.77 ($p < .001$) = 81.52]. The slope term in Model G2 is predicted by SC0CL and PTGRPRG
variables. Results show that the rate of change is 0.85 ($p = .274$) when both predictors are 0. Because the rate is not significant, it is not considered to be different from 0. Thus, clients are predicted to maintain initial levels of distress over the course of therapy if they begin below the clinical cutoff score and meet with counselor trainees who denied having personal therapy experience at the time of graduate training. For clients entering therapy above the clinical cutoff score, but who meet with trainees who denied having personal therapy experience during graduate school, the rate of change is predicted to be -1.65 ($p = .055$); however, this rate just misses reaching significance. The indication is that the SC0CL predictor variable is also not different from 0, meaning that clients are not predicted to show significant change over time regardless of where distress levels are at initial status. Statistical significance is shown for the predicted growth rate when clients meet with counselor trainees who reported having personal therapy experience occurring during their graduate training programs (-1.81; $p = .029$). These clients are predicted to reduce levels of psychological distress by almost 2 points on the OQ-45.2 per session.

The variance components in Model G2 show similar results to Model G1 as far as variance explained within clients and significant variation between clients. Again, error variance within clients (56.73) does not change given that no new level 1 predictor variables have been added. The proportion of variance explained within clients (33%) remains stable. Variance components for the intercept (138.97; $p < .001$) and the slope (3.99; $p < .001$) show that there are significant differences in client distress at initial status and in rates of change in this model. The proportion of variance explained between clients in the intercept (68%) shifts to resemble that of Model C, where only the SC0CL predictor variable is included. With the combination of SC0CL and PTGRPRG predictor variables in Model G2, the proportion of variance explained in the
slope is now 26%, an increase from only 9% in Model C and 23% in Model D2. Comparison of the deviance statistics in Model G2 (2163.03) to Model D2 (2159.88), however, did not indicate a significantly better fit ($\chi^2 = 3.15; p = .072$).

Models G1 and G2 improve upon Models D1 and D2 by removing the intercept component indicative of initial status that is represented by personal therapy predictor variables. Theoretically, because counselor trainee personal therapy experience cannot logically be associated with initial status, it is not necessary to include this component in either Model D1 or Model D2. Models G1 and G2 revealed similar findings to Models D1 and D2 and thus, offer more parsimonious options in considering decisions regarding the specification of an optimal model. Model comparisons of D1 to G1, and D2 to G2, did not result in significantly better fit; however, the indication is that Models G1 and G2 do not fit the data worse than Models D1 and D2. Given that Models G1 and G2 removed unnecessary components, they describe the study data better than there D1 and D2 counterparts.

**Specification of an optimal model.** Table 8 displays the progression of advancing each model by adding one predictor variable at a time. Initially, Models A and B were constructed to give an estimation of the distribution of variance across both levels and of the rate of change in distress scores over time. Time in therapy was a significant level 1 predictor explaining approximately 32% of outcome variance within clients. No other level 1 predictor variables were examined so time in therapy remained stable across each model.

Once the level 1 model was specified, predictor variables were tested on level 2 and evaluated for statistical significance and proportion of variance explained. Model C introduced the *clinical range* predictor variable regarding the cutoff between clinical and nonclinical levels of psychological distress. Although the growth rate pertaining to this predictor was not
significant in Model C, the variance components were significant and deviance significantly reduced overall in comparison to Model B. The *clinical range* predictor variable was retained in the model and showed significance in combination with other predictor variables in subsequent models. Model D1 tested the first *personal therapy* predictor variable regarding the personal therapy experience overall of counselor trainees. All fixed effects were significant for rate of change, which was of greater interest than initial status due to counselor personal therapy experience incapable of having an effect on distress levels prior to therapy. Results indicated significant variation between clients in psychological distress at the beginning of therapy and in individual growth rates. The *clinical range* predictor and the first *personal therapy* predictor combined explained 71% of error variance between clients in initial status and 22% of error variance in rate of change. Additional level 2 *perceived benefit* predictor variables were added regarding counselor trainee perceived benefit of personal therapy to personal well-being and to professional training. Neither set of *perceived benefit* predictors (i.e., regarding the most recent experience or the highest rated experience) significantly extended the model to explain more variance.

Concurrently, the second *personal therapy* predictor variable regarding having had personal therapy during graduate training also produced significant fixed effects for rate of change in Model D2. Again, these effects were of greater interest than those pertaining to initial status because counselor personal therapy experience cannot predict initial levels of distress. Moreover, there was a larger reduction in psychological distress rates in Model D2 for clients working with counselor trainees who had personal therapy experience during their graduate training versus in Model D1 with clients of trainees who reported ever having personal therapy experience. The proportion of variance explained was also similar to that of Model D1 and
deviance reduced significantly in comparison to Model C. Unfortunately, questions emerged regarding which pair of perceived benefit predictor variables to use with PTGRPRG in Model D2. The highest-rated benefit variable was developed in response to the notion that perceptions of therapy as beneficial could have occurred after any personal therapy experience versus the most recent experience; however, the rationale for identifying if personal therapy occurred during graduate training had specific implications for that particular therapy experience. Thus, further analyses extending Model D2 were deemed futile to examine.

Model D1 and Model D2 are more optimal in describing the study data than preceding models; however, they appear to have misleading and perhaps, unnecessary terms. According to Raudenbush and Bryk (2002), one set of predictor variables may be applied to the intercept and a different set applied to the slope; however, they advise extra caution when interpreting the results. The authors add that not every predictor variable in any of the level 2 equations should be used in all level 2 equations. Rather, they advise that whenever a predictor is included in one of the level 2 equations but not included in the other level 2 equations, that the predictor is in fact determined to be non-significant before removing it. Thus, Models G1 and G2 were developed by modifying Models D1 and D2 to test the removal of the personal therapy predictor variables on the intercept.

Likelihood ratio tests comparing deviance statistics in Model G1 to Model D1 and in Model G2 to Model D2 did not result in a significantly better fit of either Model G1 or Model G2 in comparison to the respective preceding models; however, the non-significant findings indicate that there is no difference between the two models compared. Thus, either model (G1 or G2) could be specified as optimal. Singer and Willett (2003) recommend comparing deviance statistics across consecutive models to evaluate the impact of each new term. They advise not
adopting a more complex specification if it does not fit any better than a simpler one. Both Models D1 and D2 have an unnecessary term that when removed, does not worsen the fit in the alternative reduced models (G1 and G2). Therefore, both Model G1 and Model G2 are optimal and parsimonious models to describe the data. Ideally, one model would be specified as the optimal model yet both provide meaningful interpretations. Deviance statistics were compared in a likelihood ratio test and results indicated no significant differences between Model G1 and G2 ($p > .500$). Because neither model fits the data better than the other, both could be selected as optimal, each presenting a unique interpretation of the data. Model G1 addresses differences between clients’ counselors who reported personal therapy experience versus clients’ counselors who did not. Model G2 addresses differences between clients’ counselors who reported having personal therapy during their graduate programs versus clients’ counselors who either had personal therapy before graduate training or not at all. Although Model G2 presented some issues in interpretation, it provides additional insight into concepts presented and for future research. Given that research questions ask specifically about differences regarding personal therapy experience overall (versus when the experience occurred), Model G1 is specified as an optimal for this study.

In sum, Model G1 describes the study data by illustrating that client rate of change in psychological distress is a function of counselor trainee personal therapy experience. Model G1 focuses on the beginning of therapy when clients first start meeting with their respective counselor trainees so initial levels of psychological distress are not predicted by counselor trainee variables. Instead, average initial levels of client psychological distress are predicted as a function of either beginning treatment with or without clinical levels of distress. The rates in which clients change in distress however, are predicted by both the presence of clinical levels of
psychological distress and the presence or absence of counselor trainee personal therapy experience. Clients who entered therapy either below or above the threshold of clinical levels of psychological distress were projected to increase in distress over time unless they met with counselor trainees who reported experience in personal therapy. That is, when clients met with counselor trainees who reported personal therapy experience, their levels of psychological distress decreased over time. Distress over time was predicted to decrease for both clients who entered therapy with clinical levels of distress and those entering therapy without clinical levels of distress, as long as they worked with counselor trainees who indicated personal therapy experience. Essentially, Model G1 depicts how clients change over time as a function of initial levels of psychological distress and counselor trainee personal therapy experience.

**Additional findings.** This subsection presents additional information found relevant to questions of overall change in therapy, the impact of outliers in the data, and post hoc analyses performed. There are three parts. First, research questions not yet addressed that pertain to change overall are addressed. Second, outliers from the data are removed and the optimal model specified is tested again to evaluate the potential impact. Third, post hoc analyses are reported regarding questions that arose during the data analyses process.

**Overall change in psychological distress.** Earlier in the chapter it was noted how using variations in the scaling of time in growth curve analyses can provide information at different points along the growth trajectory. Analyses with time scaled by the SESSION variable allowed results to produce information on client initial status and rate of change; however, the impact of level 2 counselor trainee *personal therapy* and *perceived benefit* predictor variables on client overall change could not be explored due to intercept values pertaining to levels of psychological distress prior to treatment. Variables representing therapist experiences would not be expected to
influence clients before treatment began. Therefore, to examine the impact of level 2 counselor
trainee predictor variables on client psychological distress overall, analyses were performed
using the rescaled RSESSION time predictor. Specifically, RSESSION was used to provide
information regarding total client change by shifting the focus of the intercept to represent the
end of treatment.

Analyses were conducted using Model G1, the model specified as an optimal model to
describe the data in the current study. Recall that Model G1 used the SESSION variable on level
1 which was scaled beginning with 0 and increasing in increments of 1. This means that results
represented client psychological distress and rate of change at the beginning of treatment.
Variables were then added on level 2 to predict both the intercept and the slope, and to examine
reductions in unexplained variance. The SC0CL was included to predict differences in the
intercept variable and in rates of change. The PERSTX variable was included to predict
differences in rates of change only. This decision was based on the impossibility of the PERSTX
variable being associated with initial levels of distress before client and counselor trainee started
working together. To examine differences at the end of treatment, the time variable (SESSION)
was rescaled so that Session 0 represented the last session of treatment (i.e., RSESSION).
Rescaling a variable does not have an effect on model fit overall; rather, it alters some of the
meanings of the parameter estimates (Kahn & Schneider, 2013). In the current analysis,
rescaling the time variable shifts parameter estimates to the end of treatment.

Following the same process of analyses used in building Model G1, the RSESSION
variable was entered on level 1 to produce averages of client psychological distress at the end of
treatment. This model will be called Model G1-R to differentiate from Model G1, which used
SESSION as the time variable. On level 2, the SC0CL and PERSTX variables were included to
predict both the intercept and slope at the end of treatment. Previously, the PERSTX variable was removed from predicting the intercept when it represented initial status. Now that the intercept represents ending status, the PERSTX predictor variable was included given that it is possible for this variable to produce an effect after clients and counselor trainees had been working together. Results from Model G1-R indicate that at the end of treatment, the average level of psychological distress for clients who started therapy below the clinical cutoff is 50.16 \( (p < .001) \). The average level of distress at the end of treatment for clients who began above the clinical cutoff is 78.89 [i.e., \( 50.16 + 28.73 \ (p < .001) = 78.89 \) ]. The PERSTX predictor variable in Model G1-R was not significantly associated with a reduction in psychological distress at the end of treatment \( (-6.36; \ p = .286) \). Thus, it is a value not considered different from 0.

Compared to Model G1, average distress scores on the OQ-45.2 at the beginning of treatment were predicted to be 46.65 \( (p < .001) \) for the nonclinical client population and 81.29 for the clinical client population [i.e., \( 46.65 + 34.64 \ (p < .001) = 81.29 \) ]. The change in distress scores is estimated to increase slightly over the course of therapy for clients who started below the clinical cutoff (i.e., from 46.65 to 50.16). For clients who started therapy above the clinical cutoff, the change in distress scores by the end of treatment slightly decreases (from 81.29 to 78.89). Of interest in Model G1-R is the intercept term as it provides information on average distress at the end of treatment and thus, can be compared to average distress at the start of treatment and address questions regarding total change. Unfortunately, the variation in meaning of Session 0 at the end of therapy is greater due to client differences in total number of sessions. The last session in Model G1-R indicates more treatment for some clients and less for others.

To further investigate research questions related to overall change, OQ-45.2 scores from the last session of therapy were subtracted from scores at initial status to capture total change in
levels of psychological distress. This value represents the difference in number of OQ-45.2 points between first and last sessions. The PERSTX variable included two groups: clients who met with counselor trainees who had reported personal therapy experience ($M = -9.08$, $SD = 14.55$) and clients who met with trainees who reported no personal therapy experience ($M = 7.40$, $SD = 26.60$). Client group means were compared and results indicated significant differences between group means [$t(45) = 2.622, p = .012$]. On average, clients working with counselor trainees who reported personal therapy experience reduced overall levels of psychological distress by approximately 9 points between the beginning and end of therapy. For those working with trainees who denied personal therapy experience, overall levels of psychological distress increased an average of approximately 7 points by the end of therapy.

Client overall change in psychological distress was analyzed by multilevel modeling techniques and comparisons of group means. First, the model selected as optimal was rescaled to focus on the end of treatment where counselor trainee personal therapy could be tested for associations with client distress levels. Because significant differences in distress levels at the end of treatment were not found as a function of counselor trainee personal therapy experience using multilevel modeling, group means were compared using analysis of variance. When overall change in psychological distress was compared between clients who met with counselor trainees indicating personal therapy experience and clients who met with counselor trainees denying personal therapy experience, significant differences were found. Overall distress reduction was greater for clients who met with counselor trainees indicating experience in personal therapy than for clients who met with counselor trainees indicating no experience in personal therapy.
**Model G1 with outliers removed.** During the data exploration process, preliminary analyses identified two potential outlying observations. The first case (#1442) showed the largest estimated initial intercept (114.00) and largest reduction of psychological distress in rate of change (-36.00). The second case (#2151) had one of the smallest estimated initial intercepts (27.33) and the largest increase of psychological distress in rate of change (32.00). These two cases happened to have low session totals in common. Client #1442 attended 2 sessions and client #2151 attended 3 sessions. To examine the impact of these two outliers, the cases were removed from the data and analyses performed with Model G1 provided results for comparison.

Results from Model G1 analyzed with outliers removed indicated a change in significance for the fixed effects of the slope. Fixed effects for the intercept are still significant indicating that estimates of client distress at the start of therapy are significantly different from 0 both below (46.76; \( p < .001 \)) and above the clinical cutoff \([46.76 + (33.85; \ p < .001) = 80.61\]). The outlying observations did not change the significance of the intercept estimates. Fixed effects for the slope are no longer significant with outliers removed. The rate of change when all predictors are 0 is now 1.08 \( (p = .491) \). For clients who began therapy above the clinical cutoff score, the differential is -1.16 \( (p = .162) \). The differential for clients meeting with counselor trainees who endorsed personal therapy experience is -1.82 \( (p = .196) \). The lack of significance indicates these rates are not different from 0. Thus, Model G1 with outliers removed predicts that clients will not significantly change in distress levels over the course of therapy from distress at initial status. Furthermore, although variance components are significant in this version of the model \( (p < .001) \), comparison of the deviance statistic (2076.38) to that of the preceding model did not reach significance \( (\chi^2 = 3.03; \ p = .078) \). Regardless, Model G1 with or without outliers removed still optimally provides the best representation of the data in this study.
**Post hoc analyses.** During the analysis process, two questions emerged that prompted investigation beyond that which was initially specified. The first question asked if there were differences in the total number of sessions attended by clients who met with counselor trainees who reported personal therapy experience versus clients who met with counselor trainees who reported no personal therapy experience. The second question asked if there were differences in overall change in psychological distress by clients who met with counselors who reported personal therapy experience in graduate school versus clients who met with counselors who did not report personal therapy experience while in graduate school. Results follow below.

The first question examined differences in total sessions attended by clients with respect to the personal therapy experience of their respective counselor trainees. Mean differences were compared between clients who met with counselor trainees who reported personal therapy experience and clients who met with counselor trainees who reported no personal therapy experience. Clients who met with counselor trainees who reported having personal therapy experience attended an average of 6 to 7 sessions overall ($M = 6.46, SD = 3.08$). Clients who met with counselor trainees who did not report any experience in personal therapy attended an average of 5 sessions overall ($M = 5.10, SD = 2.69$). The mean difference was not significant [$t(45) = -1.270, p = .405$]. Thus, session totals do not appear to be associated with counselor trainee personal therapy experience.

Although Model G1 has been specified as an optimal model to describe the data in the current study, Model G2 also provided good fit. Model G1 included the PERSTX predictor variable representing personal therapy overall by counselor trainees. Model G2 included the PTGRPRG predictor variable representing personal therapy experience by counselor trainees while enrolled in their graduate programs. Model G1 was specified as optimal over Model G2
because Model G1 was more straightforward in answering research questions than Model G2. Model G2 presented some challenges in describing the study data because of how the PTGRPRG predictor variable was coded; however, questions still emerged regarding overall client change. Clients were grouped by the presence or absence of their counselor trainees’ personal therapy experience occurring in graduate school. This meant that counselor trainees who had personal therapy experience prior to graduate school and not at all were combined into one group. The PTGRPRG variable would be better represented by three groups instead of two in evaluating client total session differences among trainees. Thus, three groups were created and a one-way ANOVA was performed to compare group differences.

Client overall distress reduction means and standard deviations for each group in the PTGRPRG predictor variable are as follows: counselor trainee personal therapy experience during graduate training \((M = -12.95, SD = 14.34)\), counselor trainee personal therapy experience prior to graduate school, but not in graduate school \((M = -4.00, SD = 13.62)\), and counselor trainees with no reported personal therapy experience \((M = 7.40, SD = 26.60)\). The omnibus test of the main effect of overall distress reduction was statistically significant between groups \([F (2, 44) = 4.753, p = .014]\). Tukey’s test was performed to identify which groups were significantly different. Clients who met with counselor trainees who indicated no personal therapy experience differed in overall change in distress in comparison to clients who met with counselor trainees who reported personal therapy experience occurring during graduate training \((p = .011)\). Differences were not significant between client means in overall change in distress between those who had counselors with personal therapy experience during graduate school and those who had counselors with personal therapy experience prior to graduate school \((p = .276)\). Likewise, client means in overall change in distress were not significantly different between
those who had counselors with personal therapy experience prior to graduate school and those who had counselors reporting no history of personal therapy experience ($p = .244$).

**Summary**

The present study sought to discover if there is an association between counselor trainees’ participation in their own personal therapy experiences and their clients’ outcome. Multilevel modeling was used to analyze how counselor trainees with a history of personal therapy might potentially influence how their clients change over the course of therapy as far as the overall reduction in psychological distress and the speed with which distress symptoms decreased. Individual change trajectories were investigated both within and between clients to explore the impact of counselor trainee participant variables and to identify an optimal model representative of the study data.

Preliminary analyses helped facilitate decision-making regarding the structure of the data and identify trends present. Assumptions regarding linearity, normality, and homoscedasticity were tested and found to be reasonable in the current data. Descriptive statistics provided information about counselor trainee participant experiences of personal therapy and the degree to which personal therapy was perceived to be beneficial to personal well-being and professional training. For example, the majority of counselor trainees reported that they have engaged in their own personal therapy and have perceived the experience to be beneficial to personal well-being and professional training. Most trainees listed one occasion of personal therapy which most often was sought out on their own accord. Relationship concerns and anxiety were the most frequently cited reasons for attending therapy. A little more than half of trainees who reported personal therapy experience indicated that they attended therapy while enrolled in their graduate
programs and approximately one-third of those reporting experience in personal therapy indicated that they were currently in treatment at the time of their practicum course.

The model-building process involved testing variables on each level in effort to create an optimal model to explain the study data. On level 1, time was introduced as a predictor of client psychological distress. Generally, levels of distress decreased as time in therapy (i.e., the number of sessions attended) increased. On level 2, variables tested included an indicator of initial levels of clinical psychological distress, personal therapy experience of counselor trainees, and the level of perceived benefit gained from these experiences. Predictor variables that significantly reduced unexplained variance in the model were retained for further analysis and comparisons of models tested led to the selection of an optimal model to describe the data. The optimal model estimates that client psychological distress is associated with time in therapy, initial levels of clinical distress, and the reported personal therapy experience of the counselor trainee. Specifically, psychological distress was shown to reduce the quickest when clients entered therapy with clinical levels of distress and met with counselor trainees who reported experience in their own personal therapy. Additional findings suggested that the overall change in levels of client psychological distress from the beginning to the end of treatment was not associated with counselor trainee personal therapy experience when analyzed via modeling techniques; however, when client group means were compared between clients of counselor trainees indicating personal therapy experience and clients of counselor trainees denying personal therapy experience, clients of trainees reporting personal therapy were found to have greater overall distress reduction than clients of trainees denying personal therapy. Variables testing the benefits of personal therapy experience to personal well-being and professional training were not found to significantly influence the rate at which clients changed or the overall
outcome of therapy. The next chapter provides further interpretation of these findings as well as suggestions for future research in this area.
CHAPTER IV

DISCUSSION

The purpose of this investigation was to discover if counselor trainees’ participation in their own personal therapy might be associated with how their clients fare in treatment. Specifically, client growth trajectories were examined for differences in both the overall reduction in psychological distress and the speed in which distress symptoms decreased, based on counselor trainee experiences in personal therapy. Growth curve modeling was used to identify individual client change trajectories and evaluate effects both within and between clients and compare them as a function of counselor trainee personal therapy experience. Change trajectories were also examined for differences based on how helpful counselor trainees perceived their own personal therapy to be to personal well-being and professional training. The following questions are addressed by the current study:

1. What are counselor trainees’ experiences of personal therapy?
2. To what extent do counselor trainees perceive their personal therapy experiences to be beneficial?
3. Do counselor trainees’ clients produce larger reductions in psychological distress as a function of counselor trainee personal therapy experience?
4. Do counselor trainees’ clients produce larger reductions in psychological distress as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?
5. Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of counselor trainee personal therapy experience?

6. Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?

This chapter is composed of three sections. The first section is organized thematically by three categories of research findings divided into subsections: personal therapy findings, perceived benefit findings, and supplemental findings. Summaries and interpretations of findings are included for each subsection including relevance to the existing literature on personal therapy for mental health practitioners. The second section addresses limitations of the current study regarding issues related to design, measurement, and statistical analyses. The third section presents implications of current findings and provides suggestions for future research.

**Summaries and Interpretations of Research Findings**

This section summarizes and offers interpretations for research findings which are organized into three subsections. The first subsection presents findings related to the personal therapy experiences of counselor trainees. For example, a large percentage of trainees reported participation in personal therapy with over half of them indicating that their personal therapy experiences took place during enrollment in their graduate programs. Engaging in personal therapy was also associated with faster rates of change for clients who met with counselor trainees reporting personal therapy experience; however, overall reduction in psychological distress revealed mixed findings. The second subsection presents findings regarding counselor trainees’ perceptions of benefit of personal therapy. On average, trainees rated their personal therapy experiences *somewhat helpful* to *very helpful* in response to various components
describing personal well-being and professional training. Although deemed helpful, counselor trainees’ perceptions of benefit were not significantly associated with the rate at which their clients changed or the overall reduction in distress from the beginning to end of therapy. The third subsection reports findings from supplemental analyses such as removing potential outlier data and running the optimal multilevel model analysis again, testing group means of client session totals based on counselor trainee personal therapy experience, and addressing an unexpected finding regarding clients of counselor trainees reporting current participation in personal therapy. More specifically, this subsection explores mixed results after the removal of outlier data, the lack of significance between trainee personal therapy and client session totals, and the discovery of higher initial levels of psychological distress in clients of counselor trainees reporting current personal therapy use.

**Personal therapy findings.** This subsection provides summaries and interpretations of research findings regarding counselor trainees’ personal therapy experiences. Findings describe the experiences counselor trainees have had in personal therapy, the potential impact of personal therapy experience on total client outcome, and the relationship between personal therapy experience and client rate of change.

**Counselor trainees and personal therapy experience.** The first research question asked “What are counselor trainees’ experiences of personal therapy?” There were 30 counselor trainees who participated in this study and 25 of them (83.3%) reported that they have been in personal therapy (PT). Of the 25 trainees that reported PT experience, eight trainees indicated that they currently were participating in personal therapy. A little over half of those reporting PT experience indicated that they had only participated for one time period (i.e., “episode” or “occasion”). The remainder ranged between two and three episodes with two trainees providing
information for more than three episodes. Referring to their most recent episode, the majority of counselor trainees indicated attending 6 or less sessions; however, a few participants reported session totals around 100 with the remainder falling between 8 and 50. Most participants indicated that they sought out their most recent treatment episode on their own. Almost half of counselor trainee participants reported that their most recent episode of therapy occurred prior to enrollment in graduate training whereas a little more than half indicated that their most recent episode was during graduate training. The top reason noted for seeking the most recent episode of therapy was relationship concerns, followed by anxiety, depression, and personal growth group experience.

Findings from the current study are consistent with previous research. Although literature on personal therapy use among psychotherapists is still lacking in reference to the trainee population, one study did find that 75% of trainees reported personal therapy use at least once and that over half of them had more than one experience in therapy (Holzman et al., 1996). Additionally, similar rates of prevalence in past research were found among broader samples of mental health practitioners. For example, Norcross and Guy (2005) reported approximately 75% of respondents across several studies had attended personal therapy. Bike, et al. (2009) reported that 84% of their sample of mental health practitioners indicated having been to personal therapy on at least one occasion. They also noted that the average number of times therapy had been sought was 2.8 and that 61% of respondents endorsed attending therapy prior to their career. More recently, a large-scale study including a sample of nearly 4000 mental health practitioners from six English-speaking countries found that 87% of the sample attended personal therapy at least once, with half of them attending more than on one occasion (Orlinsky, Schofield,
Schroder, & Kazantzis, 2011). Furthermore, 1 in 4 respondents were reportedly currently in therapy.

Reasons for attending therapy in the present study were similar to previous findings. Whereas trainees in this study indicated most recently attending personal therapy for relationship concerns, anxiety, depression, and personal growth group experience, Holzman, et al. (1996) reported that their trainee sample indicated attending therapy for personal growth, adjustment, and depression. More broadly, reasons for attending therapy by mental health practitioners have included the following: depression, couple conflict, and anxiety (Norcross & Conner, 2005); and relationships, depression, self-understanding, and anxiety (Bike et al., 2009).

The participant group in this study represents a unique population of counselors in training. They are students seeking Master’s level degrees who were recruited from the first practice course in their training. They reported very little experience, if any, in providing therapy to clients. Given that half of the sample reported their ages to be in their 20s, many of them are also at the start of their careers. Despite the appearance of such a novice group, most of them have participated in therapy as a client. Orlinsky et al. (2011) found that their sample, when grouped by age in decades, included 73% of therapists in their 20s reporting past and/or current use of personal therapy.

It seems as if for the current sample of counselor trainees, that the actual therapy process and experience as a whole exists as a real reference point for most of them. Whereas many of those reporting PT experience indicated attending on one occasion for approximately 6 sessions or less, they may still possess intricacies of the process (e.g., vulnerability, trust, intimacy, etc.) that others who have not been in therapy might struggle to grasp initially. Likewise, almost all participants who reported PT experience indicated that they sought out treatment on their own.
As consumers of their own mental health services, this group also seems to possess autonomy and knowledge of what help-seeking behavior entails. Furthermore, over half of those reporting PT experience indicated that it occurred during their graduate training, which may suggest a more salient awareness of the treatment process. Finally, their most frequently reported reasons for attending personal therapy (with the exception of personal growth group experience) are common concerns of the client population assigned to work with them. Therefore, participants who reported experience in personal therapy bring several unique facets with them in their new roles as counselors in training.

Participant information was obtained from the Counselor Information Questionnaire, a self-report and confidentially coded survey. Data provided could not be checked for accuracy and had to be taken as presented. It was not possible to clarify information if needed or ask follow-up questions. Additionally, no participants asked questions of the investigator regarding what the meaning of CIQ items as they completed the questionnaire. This means that how items were interpreted by participants and how responses were interpreted by the investigator were limited by each person’s subjective experience. Although the majority of participants provided information regarding PT experience, five participants indicated no experience in personal therapy. It is possible that some of them may have attended personal therapy before but chose not to report it. It is also possible that some reported having had personal therapy but perhaps did not; however, that seems less likely given that stigma associated with mental health treatment still exists. Participants all received the same choice of incentive regardless of what they reported on the questionnaire so it could have been tempting, and subsequently more likely, to indicate no PT experience and bypass providing details when they actually had PT experience.
Given that so many still chose to report details, participant information provided is taken as valid.

_Counselor trainees’ personal therapy and client overall change._ The third research question asked “Do counselor trainees’ clients produce larger reductions in psychological distress as a function of counselor trainee personal therapy experience?” The relationship between the PT experience of counselor trainees and client outcome as far as the total reduction of distress from the beginning of treatment to the end had mixed results. Model testing with HLM 7 did not indicate that counselor trainee PT experience was associated with reductions in client psychological distress at the end of treatment; however, mean comparisons of client groups in overall distress reduction suggested significant group differences between clients of PT-experienced trainees and clients of trainees reporting no PT experience. Both findings are considered further below.

_Model-based findings suggesting no relationship._ When models were analyzed with a shift in focus to the end of therapy, averages of ending status were not shown to be associated with counselor trainee personal therapy experience. Counselor trainee PT experience was measured according to when the experience occurred (i.e., if trainees had ever been to personal therapy, if they had been to personal therapy during their graduate programs, and if they currently were participating in personal therapy). Regardless of how PT experience was represented, relationships between PT experience and client ending status were still not detected. Additionally, client initial levels of psychological distress were categorized as being either above or below a clinical cutoff point. Counselor trainee PT experience was also shown not to relate to client distress at the end of therapy regardless of where client initial levels fell (i.e., in the clinical or nonclinical range). Conversely, HLM 7 estimates of nonclinical levels of client distress at the
beginning of treatment were predicted in models to rise slightly by the end of treatment. Estimates of clinical levels of client distress at the beginning of treatment were predicted in models to fall slightly by the end of treatment.

Findings that indicate no association between counselor trainee personal therapy and overall reductions in client psychological distress may be interpreted as accurately representing the absence of a relationship between the variables or alternatively, missing the presence of a relationship because it but was too small to detect. When analyses shifted to reflect the end of treatment rather than the beginning, the meaning of distress scores varied due to the uneven number of treatment sessions. Depending on the session number, some clients had met more times with their respective counselors whereas others met only a few times. The potential effect of counselor trainee personal therapy on overall reductions in distress may not have had enough time to develop or was simply too difficult to identify with the varied time points representing ending status in therapy.

*Mean group comparisons suggesting significant differences.* When additional analyses (i.e., *t*-test) were performed on client group differences, total reduction in psychological distress was found to be greater for clients of counselors who reported PT experience than clients of counselors who denied PT experience. Clients working with PT-experienced counselor trainees decreased in total distress scores over the course of treatment whereas clients working with trainees who did not report PT experience showed an increase in distress scores over the course of treatment. Analyses of group differences (i.e., ANOVA) were also found in the total reduction of psychological distress between clients who met with counselor trainees who reported having had personal therapy during their graduate training, clients of counselor trainees who had PT experience prior to graduate training, and clients of counselor trainees who denied
PT experience. Distress reduction was the largest for clients working with counselors who reported that their PT experience occurred during their graduate programs. No group differences were found in the total reduction of distress between clients of counselors who reported PT experience prior to graduate training and clients of counselors who denied PT experience.

Findings that indicate the presence of group differences in mean distress reduction totals suggest the possibility that counselors who reported PT experience may have had additional skills beyond that of counselor trainees denying PT experience. Differences were first shown to exist between clients who met with PT-experienced counselor trainees versus clients who met with counselor trainees reporting no PT experience. Clients of PT-experienced trainees averaged a decrease in overall distress over the course of therapy whereas clients of counselors without PT experience averaged an increase in overall distress. A plausible idea could be that trainees who have engaged in personal therapy may have the ability to connect more quickly and more deeply to their clients, which in turn may facilitate a stronger therapeutic relationship. There may also be a level of comfort or familiarity that eases them into the counselor role.

Further group comparison of mean differences in overall client distress indicated that clients whose counselors reported PT experience during graduate training had the largest amount of distress reduction over the course of therapy versus either clients of trainees reporting PT experience prior to graduate training or clients of trainees reporting no PT experience. Counselor trainees who have engaged in personal therapy while in their graduate programs may have especially benefitted from such an experiential activity. Participation in personal therapy at the time trainees are also learning about the therapy process may provide for a unique developmental experience. Perhaps the immersion of themselves into treatment as clients serves as a useful reference point later when performing the therapist role as trainees. They may also be
able to connect some of the concepts discussed in their courses and/or through readings, for example, to what is acquired experientially from their own personal engagement with their therapists. This idea is consistent with findings from the learning and memory literature, where Bjork and Bjork (2011) state that “learning requires an active process of interpretation—that is, mapping new things we are trying to learn onto what we already know” (p. 62). Moreover, these trainees are exercising a form integrative learning, which illustrates how connections and deeper comprehensions result from approaching learning with high levels of self-awareness and an understanding of one’s own processes (Huber & Hutchings, 2004).

Arguably, counselor trainees who have not had personal therapy may struggle to perform what they believe is correct when conducting therapy. For example, their frame of reference in working with clients is likely limited to what they have learned in courses and practiced in role-playing experiences. In session, they may question how to help their clients and perhaps, might try harder to assist, drawing on course-acquired knowledge versus attending in the moment (i.e., something more experiential). This could result in missed opportunities to connect with their clients. Certainly they possess the skills necessary to effectively build the therapeutic relationship and take on the counselor role; however, there may be other obstacles to work through such as when something unexpected occurs and they struggle in their response and/or are at a loss for what to do. Whereas it is expected that all trainees are new and will make mistakes, the treatment experience is entirely new to those who have never been a client.

The mixed results regarding how counselor trainee PT experience might relate to overall reductions in client psychological distress both suggest ideas related to the absence or the presence of an association between the variables. Given that differing findings offer multiple interpretations of what is or is not occurring, the core idea emerging in this study points to
implications for future research. Overall, further study is needed to address this research question. Suggestions for future research are presented in the third section of this chapter.

**Counselor trainees’ personal therapy and client rate of change.** The personal therapy experience of counselor trainees was found to relate to the rate in which client distress decreased for clients who met with PT-experienced counselor trainees versus clients whose counselors denied PT experience. Client rate of change was also found to be associated with counselor trainees who indicated that they engaged in personal therapy during their graduate programs. Moreover, this was evident for clients who began treatment either within or outside of the clinical population; however, the reduction in distress over time resulted in faster rates for clients who began therapy with clinical levels of psychological distress. A relationship was not found between trainees who indicated that they currently were in personal therapy and their clients’ rates of change.

The speed at which clients reduced in their psychological distress was measured at the beginning of treatment where no variation existed between clients in session number (i.e., Session 1 for all clients indicated they had met once with their respective counselor trainees). This means that clients were relatively similar as far as their developing therapeutic relationships. Research on psychotherapy has found that there is often an initial period of rapid healing in the first few sessions of therapy (Lambert, 2010, 2012, 2013) and that what occurs in these initial sessions has been found to account for a majority of outcome variance (Lambert, 2013). Thus, focusing on the rate of change in early sessions was appropriate for identifying differences. Additionally, clients entering treatment with higher levels of psychological distress have been shown to make larger gains (i.e., reduction in distress) during treatment (Lambert et al., 2004). This may have accounted for the boost in rate of change for clients who began
treatment with clinical levels of psychological distress, especially if they dropped in distress within the first few sessions. For clients beginning treatment with nonclinical levels of distress, there was a slight increase in distress scores per session if they met with counselor trainees who did not report having personal therapy experience.

Certainly there are many factors to consider as to why client distress levels increased with trainees reporting no PT experience; however in focusing on the early development of counselor trainees and applying what they have learned, client concerns may have become worse over time because trainees, so new to the provision of therapy, may have failed to retrieve specific helping skills learned earlier in their training. The differential with counselor trainees who have been to therapy is that their PT experiences may have enhanced the acquisition of skills not only when learning them, but since learning them. Bjork and Bjork (2011), in a discussion about information storage and memory, explain how new material is stored by meaning. They suggest that new information is encoded and retained by the relationship to what is already known. That is, learning involves mapping and linking new information to what is in storage. Thus, counselor trainees, who all complete a counseling skills training course prior to the practicum experience, may differ in how much they retain newly acquired skills because of the potential to make associations with previous PT experience.

In terms of performance, all trainees in the practicum course are new to navigating the therapeutic relationship and it is expected that it will take time to “settle in” to the new experience. Trainees who had never engaged in personal therapy however, might have possibly struggled more so in the initial stages of treatment with clients than trainees who had participated in personal therapy. For example, counselor trainees reporting no previous experience in personal therapy may have had difficulty being empathic and/or normalizing the process for their
clients. Likewise, they may have been more uncomfortable than their PT-experienced peers at potential “stuck” points, such as when the treatment process seemed stagnate. Conversely, trainees with PT experience may have been able to draw upon their own experiences as a resource and connect to what had been learned, thus more effectively moving the healing process forward.

Personal therapy experience on the part of the counselor trainee appears to matter in the speed in which their clients reduce distress. Something about engaging in the experience of receiving one’s own therapy perhaps leads to quicker and deeper connections with clients, certainly facilitating a stronger therapeutic relationship. It could be a level of comfort in participating in the process or a familiarity with what to expect. Trainees may also exhibit more confidence in attending to their clients, especially in the belief that they will feel better. In turn, this could help clients feel safe more quickly and respond more favorably to treatment.

Perceived benefit findings. This subsection provides summaries and interpretations of research findings regarding the perception of benefit of personal therapy by counselor trainees. Findings describe counselor trainees’ perceptions of the benefits of personal therapy, the potential impact of perceived benefits of personal therapy on client outcome, and the relationship of perceived benefits of personal therapy on client rate of change.

Counselor trainees’ perceptions of personal therapy benefits. The second research question asked “To what extent do counselor trainees perceive their personal therapy experiences to be beneficial?” There were 25 counselor trainees that reported personal therapy experience and subsequently provided ratings as to the potential benefits of each experience. Potential benefits were separated into two categories: benefits to personal well-being and benefits to professional training. Analyses focused on counselor trainees’ most recent experience in
personal therapy. Trainees indicated how helpful (i.e., on a 5-point scale) the experience had been to specified aspects of both personal well-being and professional training. Ratings ranged from not helpful to extremely helpful and higher total scores represented higher perceptions of benefit. On average, each individual aspect of personal well-being and professional training listed was rated as being between somewhat helpful and very helpful, with very helpful being the most frequent response. Average ratings were slightly higher for personal well-being benefits compared to professional training benefits. Regarding benefits to personal well-being, the highest average rating among all trainees was in response to the notion that personal therapy was helpful to increasing insight and self-awareness. Additionally, the idea that personal therapy was helpful in offering emotional relief was endorsed most frequently as a very helpful benefit. Regarding benefits to professional training, the highest average rating among all trainees was in response to believing in the effectiveness of therapy. The benefit rated the most frequently as very helpful to professional training was that personal therapy helped increase empathy towards clients.

The specific aspects chosen as potential benefits of personal therapy were gathered largely from previous qualitative studies so counselor trainees endorsed items consistent with what has already been discovered regarding the perceived helpfulness of personal therapy. Although both lists of potential benefits were preselected for trainees to respond to, they did not have to rate the various components highly. Given that the average rating across all potential benefits was very helpful to personal well-being and professional training, trainees in this study appeared to agree with prior findings. Furthermore, a recent qualitative study with 30 experienced clinical social workers explored the ways in which their own personal therapy influenced their professional work (Probst, 2015). Emergent themes included skillful use of the
self, putting the client first, sharing control, the external reflecting the internal (i.e., the therapy environment), keeping it fresh (i.e., on-going development), and giving back (i.e., therapist impact on clients). Current findings are consistent with themes described by Probst, especially regarding the skillful use of the self (e.g., belief in the effectiveness of therapy), putting the client first (e.g. increased empathy towards clients), and keeping it fresh (e.g., increased insight and awareness and offering emotional relief). Social work participants all had considerable experience in their field which appeared to be reflected in the amount of insight offered through their statements.

Counselor trainees who reported PT experience indicated that it was generally very helpful to personal well-being and professional training. The rating of very helpful was the second highest rating possible for all possible benefits so it does appear that counselor trainees reflect positively upon their experiences in personal therapy. When reflecting on potential benefits to personal well-being, the ideas presented could have been easier to endorse as the majority of trainees pursued counseling for personal reasons. The decision to seek help for emotional concerns takes a fair amount of courage so it is likely that those who sought personal therapy also expected to feel emotional relief and gain insight through the process. An important consideration though, is the potential influence of cognitive dissonance. It seems likely that counselor trainees learning to provide mental health services to others would find it rather disconcerting if they did not view therapy as helpful or hold it in high positive regard. Thus, benefits to personal well-being could have been reported more favorably than actually experienced.

Additionally, counselor trainees were just starting to provide therapy for the first time. They may have been less aware of how their personal therapy experiences might link to their
work as professionals. Counselor trainees’ assessments of the potential benefits of personal therapy to professional training were not yet influenced by level of experience and time in the profession. This could possibly be one reason that benefits to professional training were rated slightly lower. Trainees may have not been able to apply how their own experiences in personal therapy might translate to their work as therapists, especially given that they had not accrued many direct clinical service hours. Furthermore, with respect to possible cognitive dissonance, trainees may have concluded that they should expect these benefits to professional training and thus, rated them more highly than they actually had been experienced.

**Personal therapy benefits and client overall change.** The fourth research question asked, “Do counselor trainees’ clients produce larger reductions in psychological distress as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?” Although counselor trainees who reported experience in their own personal therapy had rated it as helpful overall to personal well-being and professional training, perceived benefits of therapy did not demonstrate a statistically significant relationship with reduction of client distress. Benefits to personal well-being and professional training were measured in two different ways which represented perceptions related to trainees’ most recent PT experience and the highest-rated PT experience. Neither representation was shown to associate with overall client change.

One reason associations between trainees’ perceived benefits of personal therapy and client reduction in distress were not detected could be that the effect was too small to detect with the current number of participants’ clients. There also may not have been enough variation in benefit ratings to detect associations with clients’ reductions in distress. Because nearly all of the counselor trainees reporting PT experience rated the benefits similarly, the few without PT experience perhaps were not enough to support identification of a difference in client outcomes.
**Personal therapy benefits and client rate of change.** The sixth research question asked “Do counselor trainees’ clients produce reductions in psychological distress more quickly as a function of how beneficial counselor trainees perceive their personal therapy experiences to be?” Perceiving personal therapy to be beneficial to personal well-being and professional training was also not found to associate with client rate of change. Preliminary model testing did show some very small effects when PT experience occurring during graduate school was modeled with the highest rating of perceived benefits to personal well-being; however, the association with client rate of change was indistinguishable from 0. Thus, any detected possible relationships were not shown to provide a better representation of the optimal model chosen to describe the study data. Furthermore, introducing variables representing counselor trainee perceived benefit of personal therapy also changed the significance of other aspects of the results which was in part considered in selecting an optimal model.

Similarly to not finding a relationship between counselor trainees’ perceived benefits of personal therapy on overall client distress reduction, it may also have been the case that associations between perceived benefit variables and client rate of change were too small to detect. Likewise, with limited variation in perceived benefit ratings, a relationship may have been too difficult to detect, especially with such similarity in counselor trainees’ perceptions of the benefits of personal therapy.

For both client overall distress reduction and speed of distress reduction, the impact of perceived benefits of personal therapy on the part of counselor trainees’ may have not yet been thoroughly developed. Recall that perceived benefits were derived from research largely studying experienced mental health practitioners. Perhaps time in the field facilitated the development of increased insight into how personal therapy seemed beneficial. As counselor
trainees gain more experience providing therapy, their endorsements of its benefits may also grow. At this point in their training, it may be too early for them to have incorporated the benefits of personal therapy without more experience and more time to evolve in their thinking about the impact of personal therapy on various components of providing therapy. Thus, it is possible that with more experience over time, insight will connect perceived benefits to what and how things were learned.

**Supplemental findings.** This subsection provides summaries and interpretations of additional research findings from questions that arose during the data analysis process. Findings describe the impact of potential outlier data, the relationship between counselor trainee personal therapy experiences and client session totals, and an unexpected finding regarding participants who reported current personal therapy use.

**Removal of outlying data.** Preliminary analyses revealed the possibility of outlier data from two cases. Once the optimal model was chosen to represent the study data, the possible outliers were removed and the optimal model was tested again. Results for the intercept in the optimal model (i.e., initial estimated levels of psychological distress) indicated that without the possible outlying observations, the intercept was still significant. With the removal of outliers, client initial levels of psychological distress were still significantly different from 0. The slope in the optimal model (i.e., the rate at which clients change in distress levels over the course of treatment) lost significance when outliers were removed. Without the outliers present, client rates of change were not predicted to differ from 0. Thus, clients were not predicted to change in distress levels over the course of treatment. Furthermore, values on predictor variables indicating initial clinical levels of psychological distress (SC0CL) and/or counselor trainee personal therapy experience (PERSTX) were also not significant with the possible outliers
removed. This means that without the possible outliers present, clients were not predicted to change in distress levels, regardless of where initial levels of psychological distress were at the start of therapy. They also were not predicted to change in distress levels regardless of if they met with counselor trainees reporting PT experience or not.

Removing possible outliers from the data set and performing additional analyses potentially may have resulted in modifications of current findings. Both outlying observations appeared to represent extreme values. Once removed, less variance existed in the data set and previous associations between some variables were no longer found. This could be interpreted as counselor trainee PT experience being unrelated to client rate of change or that the relationship was not strong enough to be detected. While the results were no longer statistically significant once the outliers were removed, the pattern and magnitude of effects were very consistent with the previous results. Thus, results from this supplemental analysis provided mixed support for the initial findings. More specifically, the supplemental results suggest that the relationships identified in the optimal model remain plausible though the strength of those relationships do not reach statistical significance in a sample with more limited variation in outcomes.

In addition, the cases questioned as possible outliers are arguably not so different from typical clients considering the breadth of psychotherapy outcome research by Lambert and his colleagues that has reiterated the variability in psychological distress scores and fluctuations in growth trajectories (Lambert et al., 2004; Lambert, 2010, 2012, 2013). Furthermore, Wampold and Bolt (2006) demonstrated how removing outliers can drastically reduce therapist variance, which then eliminates therapist effects. They argue that if therapist data are removed due to seemingly unusual client outcome scores, then all of those therapists’ cases should be taken out
of the data, likely resulting in the disappearance of any effects. Moreover, they assert “that any reasonably constructed model that attends to the important aspects of the therapeutic endeavor will reveal sizable therapist effects” (p. 186). The relevance to the current study is that if the two potential outlying client cases were removed, then the counselor trainees who were seeing those clients should also be removed, resulting in the elimination of more client cases. Because this would cause further reduction in the current sample, retaining the outlying cases was deemed sensible and appropriate.

**Personal therapy and client number of sessions.** One question that arose during the study that warranted further exploration was if there were differences in the total number of sessions attended by clients who met with counselor trainees who reported PT experience versus clients who met with counselor trainees who reported no PT experience. Thus far, research findings from this study regarding the association between the personal therapy experience of counselor trainees and client distress suggest that something unique may exist in those trainees who have also participated in their own personal therapy. Perhaps they carry certain attributes, further development, or more familiarity with the therapy process than trainees who have not had engaged in personal therapy. Whatever the potential differences may be, it follows that clients working with PT-experienced counselor trainees may participate longer in treatment than clients working with trainees without PT experience. A comparison of session totals between the two groups did not reveal differences though, suggesting that the number of sessions attended by clients in this study does not appear to be associated with counselor trainee personal therapy experience.

Recall that one of the early measures of client outcome was the length of time clients stayed in treatment and rates of termination. Some studies indicated that there were no
differences in client length of stay between therapists who had PT experience and those who did not (Katz, et al., 1958; MacNair et al., 1963) whereas others reported that therapists who had been to personal therapy kept their clients significantly longer than therapists with no PT experience (McNair et al., 1964; Greenspan & Kulish, 1985). Although these studies are outdated considering current methods and analyses, the present study also did not detect differences in client session totals between PT-experienced trainees and trainees with no PT experience. Given the parameter of time in this study, it may have been difficult to identify differences in client session totals based on counselor trainee personal therapy experience. The practicum courses were limited to one semester which means trainees are enrolled for typically 15 weeks. There is some variation in how instructors conduct the course but generally counselor trainees have the opportunity for semester-long weekly client contact. This structure points to a few possible reasons why differences were not found in counselor trainees’ client session totals. First, client outcome data was retrieved from participating counselor trainees if clients had attended at least 3 sessions. Exceptions were made for six cases where only 2 sessions were listed. Perhaps there was not enough variation between 2 and 12 sessions to illustrate an effect. Moreover, it could be that such an effect would not be evident until more sessions were attended. Alternatively, there may have been clients who did not return after 1 or 2 sessions whose outcome data were not included. Perhaps differences existed in early terminations based on counselor trainee factors. Finally, although client reasons for seeking counseling were not obtained for this study, one clinic is known to receive referrals per conditions of probation. If some clients were attending sessions because they were mandated to, it is not known how this may have connected to the number of sessions attended, or the honesty with which responses were given.
**Current personal therapy and client distress.** One unexpected finding emerged during preliminary model testing regarding counselor trainees who reported current participation in personal therapy. When initial estimates of client psychological distress were calculated, time was focused on the beginning of treatment. Thus, counselor trainee personal therapy experience was not expected to show an association with client initial distress. The two variables are conceptually unrelated given that client distress scores at the beginning of treatment were measured before they met their respective counselors; however, an association was found suggesting that counselor trainees who reported current personal therapy use worked with clients exhibiting higher initial psychological distress. Although it is not possible for client distress prior to the start of therapy to be linked to counselor trainee personal therapy use, by chance (or some other factor) those trainees currently in therapy happened to meet with clients with higher initial distress. The assignment of clients to counselor trainees typically varies by supervisor. Some may assign clients based on trainees’ desired population interests or presenting concerns whereas others may allow trainees to select clients that they would like to work with. Therefore, it is possible that some trainee characteristics observed by supervisors could have influenced client assignment. Likewise, trainees currently in therapy may have been drawn to clients with higher levels of distress, possibly influencing client selection.

Counselor trainees in this study who were currently in personal therapy were presumably at a point in time where they were experiencing enough psychological distress to seek treatment. Given that they likely initiated seeking treatment, especially in that there are no training program requirements to participate in personal therapy, their experience in the practicum course while in their own therapy could introduce additional factors not accounted for. It is likely that these trainees were dealing with their own levels of psychological distress at the time they met their
clients for the first time. This suggests that they had an additional task of trying to process their own concerns while also learning and trying to counsel others. Because they may have had difficulty managing this and separating their own concerns from their clients’ concerns, they represent a unique subset of trainees creating specific implications for future research. Alternatively, it is possible that they may have become more skilled at balancing personal and professional demands because they learned to provide therapy while in therapy. Regardless, this finding potentially requires that measures be taken to address such a subset in future studies.

**Limitations of Findings**

Limitations of the current study focus on design considerations, variable measurement, and statistical decisions. This section presents limitations in three subsections. The first subsection addresses issues related to descriptive field designs. The second subsection consists of concerns regarding the measurement of variables. The third subsection explains decisions made regarding statistical analyses.

**Design issues.** This study used a descriptive field design because one of the goals was to observe what naturally occurs in the psychotherapy treatment setting with minimal interference. Outcome data were obtained from what is routinely archived during psychotherapy treatment at two psychology training clinics and the extent of counselor trainee participation was limited to information provided at the time of recruitment. Without random assignment and variable manipulation, results were limited to the detection of associations between counselor trainee personal therapy experience and reductions in client psychological distress. Findings suggested that clients in treatment with counselor trainees who reported experience in personal therapy produced larger reductions in psychological distress than clients in treatment with trainees who denied personal therapy experience. Moreover, counselor trainee personal therapy experience
was found to relate to the speed in which client psychological distress reduced over the course of treatment. Unfortunately, it is not known if these associations could be causal or if other factors not accounted for in this investigation influenced the effects. Implementing a true experimental design could provide more clarification regarding cause and effect; however, as noted in other literature (Orlinsky, Norcross et al., 2005; Macran et al., 1999), such a design would be nearly impossible to carry out. Regardless, observation of the natural treatment environment is more preferable in psychotherapy outcome research for the purpose of generalizing the results.

Perhaps one of the biggest threats to the internal validity of this study is the number of factors unaccounted for in this unique sample of counselor trainees. Recall that this is their very first experience providing therapy to “real” clients. Prior to this practicum course, their experience was likely limited to role-play scenarios when learning to use counseling micro skills. Although both types of experiences are naturally anxiety-provoking, there are many environmental factors in the treatment setting that may have added or detracted from associations found. Moreover, clients also present for counseling with differing levels of therapy experience. Many of them transfer from one counselor to another once the practicum course ends. Thus, it is possible that clients become more familiar with the process of treatment in a training clinic which also may influence results.

Another threat to the internal validity of this study is the possibility that how counselor trainees provide therapy may have been influenced by items on the CIQ. For example, a trainee who reported experience in personal therapy may not have realized that the experience offered potential benefits to professional training until rating the various aspects in the CIQ. Knowledge gained about the potential impact of personal therapy could have an effect on how one subsequently works with clients. Thus, the link between personal therapy experience and client
outcome may not be about the experience alone but rather, the insight gained from becoming aware of the potential benefits. Likewise, counselor trainees not reporting personal therapy experience may or may not have read through the remainder of the questionnaire, which in turn could influence how they work with clients. The study was designed to stagger recruitment points so that comparisons could be tested among those who were exposed to the CIQ at early, middle, and late stages; however, only middle and late stages were included.

Although one of the advantages of using the descriptive field design for this study was the strength in external validity, a larger sample size may have provided more information that could increase the generalizability of the results. The participant sample was taken directly from the environment that the phenomena were naturally occurring in and all participants available from the counselor trainee population were recruited purposively. Whereas the sample size may have limited power, the level of participation obtained in this study (i.e., 100%) provides confidence in generalizing results to a similar sample of counselor trainees. The following subsections address how decisions made about how to measure and operationalize variables, as well as decisions regarding the multilevel modeling analyses, could also influence generalizability of results.

**Measurement concerns.** Concerns over how variables were measured are divided into two parts. The first part addresses independent variables representing counselor trainee personal therapy experience and perceptions of potential benefits of therapy. The second part addresses the dependent variable representing client outcome data.

**Independent variables.** Counselor trainees’ experiences in personal therapy were explored using the Counselor Information Questionnaire (CIQ) which was developed solely for this investigation. Information provided by participants was used to create independent variables
One concern regarding the operationalization of counselor trainee variables from CIQ data is that information was provided by respondents via self-report. Typical of these types of measures, responses often cannot be checked for accuracy or clarification. Responses are also limited to the interpretations of the scorer. Likewise, participants are subject to their own interpretations of what is being requested when they respond.

Another concern that potentially influenced counselor trainee variables was the comfort level of participants in responding to requests for sensitive information. Although participant names did not appear on CIQs, there was still a possibility that identity could be discovered if the coding system implemented was breached. Procedures taken to increase the difficulty of linking participants to their responses were explained; however, participants still may have been leery to answer some questions for fear of being identified. For example, the stigma associated with seeking help for emotional concerns may have compromised how participants answered. Some may have denied personal therapy experience when they actually had it or they may have withheld information regarding the experience (e.g., attendance requirements, reasons for therapy, length of time in therapy, etc.). Moreover, they may have represented themselves in accordance with, or in opposition to, how they perceived the investigator wanted them to appear. Additionally, cognitive dissonance could have influenced responses regarding the perception of
benefit of personal therapy if participants experienced discomfort associated with not perceiving therapy to be beneficial.

Furthermore, the acquisition of participant information could have been limiting in that participants were asked specific questions in describing their personal therapy experiences and perceptions of potential benefits according to what the CIQ requested. For example, participants were asked to mark reasons for attending therapy from a list of common concerns. A few participants added to the list to more accurately describe why they sought out personal therapy. Others may have also had clearer or additional reasons to report but did not include them. It is not known whether additional information may have been lost by the constraints of particular items. Another example is in how participants perceived the potential benefits of personal therapy. They were asked to rate how helpful personal therapy was to certain aspects of personal well-being and professional training. It is questionable whether the potential benefits could have been measured more accurately due to the possibility that multiple interpretations exist in deciphering how helpful personal therapy was to a particular aspect (e.g., improving interpersonal relationships) versus how beneficial it was to that same aspect.

**Dependent variable.** Client levels of psychological distress served as the dependent variable and data were obtained from psychology training clinic archival records where participants were recruited. Psychological distress was assessed via the OQ-45.2 which has been shown to be a valid and reliable instrument measuring client outcome; however, it also is subjected to issues of potential biases. It is a self-report measure so score accuracy depended upon client honesty. If some clients wished to present well, they could have responded accordingly. For example, in cases where clients were mandated to attend counseling, they may have desired to present psychologically healthy, as if they did not need mental health treatment.
If there were enough of these cases in this study, results could have been affected. Additionally, although the OQ-45.2 has computerized scoring available, the paper and pencil version was still the method used for many clients in this study. Thus, correct calculations of client measures of distress were dependent on counselor trainees scoring instruments properly. Likewise, even with correct scoring, it was still possible that mistakes could have been made when transferring the computed score to an outcome graph where scores were logged. Moreover, the investigator had to rely on clinic personnel designated to retrieve outcome scores from client files to report the information accurately. Given these potential discrepancies, it is possible that some outcome data could have been obtained with inaccuracies.

**Analyses decisions.** Issues that arose in conducting this study that potentially had an impact on statistical analyses are discussed in three parts. The first part describes decisions made regarding sample size and subject inclusion. The second part details decisions made on the multilevel modeling (MLM) structure. The third part addresses decisions about predictor variables.

**Sample size.** The MLM structure and the number of levels included needed to be considered when decisions were made regarding the size of the participant sample. Recommendations from simulation research suggest that a sample size of at least 30 on the second level have found unbiased estimates of regression coefficients, standard errors of regression coefficients, and variance components (Maas & Hox, 2005). Initially, a sample of at least 50 counselor trainees was decided upon for this study. When recruitment took place, there were a total of 31 potential participants. Although all 31 counselor trainees consented to participate, one participant’s data was not used because of missing data. Thus, the participant sample consisted of a total of 30 counselor trainees.
One advantage of using MLM for data analyses is that missing data can be tolerated, as long as it is on the lowest levels of the analyses (e.g., on level 1 in a two-level design or on levels 1 and 2 in a three-level design). Any data missing on the highest level will not be included in analyses, which in turn eliminates data linked to it on lower levels. Because the participant level in this study was the highest level, the elimination of one participant’s data resulted in losing data at each lower level in the MLM design. Thus, the decision in the current study to not use one participant meant that data from two clients and data from 14 sessions would also not be included on lower levels.

Fortunately, there was enough complete data nested within the remainder of participants to still create the desired predictor variables; however, this points to the importance of sample size decisions when using MLM and the subsequent impact measuring variables. For example, when participants in this study completed the CIQ, they were asked at the end of the questionnaire to provide an overall impression of how beneficial personal therapy was overall to personal well-being, and then to professional training. The information requested in these items may have resulted in another way to represent the perceived benefit variables. Unfortunately, a few participants missed responding to these final items. If predictor variables were desired that incorporated this information, the impact would have been further data loss because perceived benefit variables had been predictors on the highest level.

**MLM structure.** Another important issue regarding statistical analyses pertained to the structure of the multilevel model in terms of choosing the number of levels to house the data. Ideally, for a study such as this one where the data structure consists of time nested within clients nested within counselors, a three-level design was preferable. At the first level, time (e.g. in sessions) would have been used to predict client distress scores. At the second level, client
sessions would have been grouped within each client. The third level would have then consisted of counselor trainees who would each have had their own group of clients. This three-level structure, which philosophically made more sense, would have depicted the nested models more clearly as each level was a subset of a larger grouping unit. Unfortunately, the current data presented some obstacles to using a three-level structure and a two-level structure was chosen instead. The rationale for choosing the MLM structure and number of levels follows.

One obstacle to using a three-level structure was the lack of units available to provide sufficient nesting. The current data set could not be nested in three levels because many counselor trainees (i.e., 13) had only one client assigned to them. This means that many trainees who were individually their own “group” (i.e., an organized unit) at level 3 had only one member at level 2. Each upper level unit needs to include at least two observations on lower levels to be considered nested. If only one observation exists within an upper level unit, then relationships cannot be separated and the sampling is confounded (Nezlek, 2012).

Another obstacle to implementing a three-level structure was the lack of predictor variables included on level 2. Clients were not recruited as participants for the study so client factors that contribute to their levels of psychological distress could not be evaluated at level 2. The client data obtained were archival from what is routinely collected at the training clinics where counselor trainee participants were recruited. Because no client data other than outcome scores were released, there were limited options of variables for inclusion on level 2. One idea was the creation of a predictor variable that represented the degree of psychological distress (i.e., clinical versus nonclinical) present at the beginning of treatment; however, it did not solve the issue of needing more clients per counselor trainee to constitute a group. Other ideas for level 2
variables that could be retrieved from archival data include client presenting concerns and prior experience in therapy.

Given the issues in data structure regarding insufficient units per group and limited predictor variables on level 2, the resolution was to condense the three-level design into two levels, moving counselor-level variables onto the client level. Because clients did not have any predictor variables at level 2 (i.e., other than the clinical distress indicator), counselor trainee variables were added as level 2 predictors. Adding counselor trainee variables to this level meant that client predictors also consisted of information about what counselor trainee they had in therapy. For example, level 2 predictors included if clients began therapy with clinical levels of psychological distress as well as information about clients’ counselors, such as if they had experience in personal therapy or not. Moreover, the decision to use a two-level structure was advantageous in terms of the level 2 sample. Although the number of participants with sufficient data was 30, the number of clients served as the sample size for level 2. Thus, level 2 actually consisted of 47 units of analyses or “groups,” falling within the range recommended from simulation studies (Maas & Hox, 2005).

**Predictor variables.** Decisions regarding predictor variables include the number of variables chosen and how the variables were constructed to represent the data. On the first level, the sole predictor variable was time. Although that is typical for growth curve modeling, the amount of variance explained on that level was limited to that which was accounted for by time. Additional predictor variables tested on level 1 may have continued to cause a decline in the residual variation; however, no other predictors on level 1 were included in this study.

On the second level, predictors included the *clinical range, personal therapy,* and *perceived benefit* variables. For the *personal therapy* and *perceived benefit* variables, decisions
needed to be made about how to sufficiently represent the data. Personal therapy experience was represented as a dichotomous variable for all three representations. This may have limited the data in that less was known about the variation within each group and the variation between groups may have been obscured. Additionally, perceptions of potential benefits for each personal therapy experience created challenges in how to accurately portray this predictor variable. Two versions of the perceived benefit variables were created. One version represented ratings from the most recent PT experience. The second version represented ratings from the highest-rated PT experience. The rationale was that stronger perceptions of benefit, regardless of when developed, could still have a lasting effect on impressions of personal therapy. A difficulty emerged however, in determining the most appropriate pairing of perceived benefit predictor variables with the personal therapy predictor variable that represented the experience occurring during graduate training. Although the rationale for creating a highest-rated perception variable was that perceptions from any PT experience could have an impact on how one views the benefits of therapy, the ideas behind a variable representing PT experience in graduate school implied that perceptions of benefit regarding that most recent experience might be a better fit. Thus, model testing of PT experience occurring while in graduate training was compromised. Given that significant group differences existed for the personal therapy during graduate training variable (compared to PT experience before graduate training and to no PT experience variables), further investigation is suggested as it could be quite valuable. Thus, continued exploration of effective ways to measure perceived benefits of personal therapy is also warranted.
Implications of Findings

Findings in the current study point to implications for research and training. Overall, there were two main discoveries in exploring associations between counselor trainee personal therapy and client reduction in psychological distress. First, associations were found between reductions in client psychological distress and the personal therapy experiences of counselors in training. Clients of counselor trainees who reported experience in personal therapy produced larger reductions in distress over the course of therapy than clients of counselors who reported no PT experience. Moreover, clients working with counselor trainees who reported PT experience occurring during graduate training produced the largest reductions in psychological distress, compared to clients of counselors who reported PT experience prior to graduate training and clients of counselors who denied PT experience. Second, clients of counselor trainees who indicated that they had PT experience were found to reduce distress more quickly than clients of counselors who indicated no experience in personal therapy. Reductions in distress were also significantly faster for clients of counselors who specifically indicated PT experience during their graduate programs (i.e., compared to clients of trainees who reported either no PT experience or having PT experience before graduate training). Additionally, distress reduction was augmented for clients who presented for therapy with initial levels of psychological distress above the clinical cutoff on the outcome measure (i.e., OQ-45.2). Implications for future research are discussed next, followed by implications for future training.

Future research. One of the main implications for future research involves the use of updated and more sophisticated methods and analyses in the study of counselor trainees’ personal therapy experiences and the relationship to client outcome. The current study helped to address inconsistencies and discrepancies portrayed throughout the history of inconclusive
findings on the subject. Outcome measures now include reliable and valid instruments designed to regularly track the amount and rate of client change over the course of treatment. Likewise, advanced statistical techniques have resulted in increased capabilities for discovering relationships within and between groups in multilevel and nested data. Therefore, the first suggestion is to replicate this study with a larger sample of counselor trainees. It would be advantageous to utilize the current design and implement the same methods, yet with a larger sample so that further discovery can add to present findings. Results could inform future directions as far as confirming, clarifying, and/or suggesting next steps.

Another suggestion is to update and revise this study to improve upon potential limitations identified. First, a larger sample of counselor trainees would be helpful for comparison with present findings and for generalization purposes. It would also be helpful to increase the number of clients per trainee to at least two so that each trainee qualifies as a grouping variable. Second, a three-level structure for analyses could be used to better partition groups where sessions are nested within clients who are nested in counselor trainees. The first level would still include time as the predictor variable, yet other variations of time such as a higher order polynomial functions (i.e., $t^2$ and $t^3$) could also be included to explore other possible non-linear forms (e.g., quadratic and/or cubic curvature) of the change trajectory (Curran et al., 2010; Singer & Willett, 2003). These alternative forms provide specific information about the acceleration of the instantaneous rate of change from one time point to the next (Kahn & Schneider, 2013; Raudenbush & Bryk, 2002). Thus, how clients change early in treatment could be examined from the first session to the second session and so on, investigating acceleration differences in slope as a function of trainee PT experience.
The second level of the suggested three-level structure for future studies could include client-specific predictor variables. For example, in addition to a variable representing initial levels of clinical psychological distress, variables could also include client presenting concerns and/or past therapy experience, with the purpose of still using archival data. Moreover, clients could also be recruited for the study in which case other variables could be examined such as client working alliance, attachment style, and session ratings. On the third level, therapist variables could include factors related to PT experience and perceived benefits and/or introduce additional factors to explore. For example, variables related to life experience (e.g., familial history of mental illness, stages in lifespan development), personality (e.g., attachment style, locus of control), and the training environment (e.g., level of confidence, self-efficacy, perceived helpfulness) could be introduced to explore how these variables may reduce variance.

Furthermore, in using repeated measures of client psychological distress as the outcome variable, client scores could be included if at least three sessions were attended for such a design. Although two session measures are acceptable to use, Curran, Obeidat, and Losardo (2010) advise that three measures “over-identifies a linear trajectory” (p. 125) where observed information exceeds estimated information, which is preferable for the majority of cases included. Additionally, outcome could be assessed via measures of clinically significant change, which have been shown to be more precise and valid in regards to treatment benefits and effects (Lambert & Bailey, 2012). In the OQ-45.2 literature, Lambert et al. (2004) used the Jacobson-Truax method (Jacobson & Truax, 1991) to establish measures of clinically significant change. Client final status is represented by four categories (i.e., recovered, improved, deteriorated, and unchanged) that involve meeting the criteria for the reliable change index (RCI) and passing a cutoff score into a functional range from a nonfunctional range. These categories as measures of
client outcome in a future study might provide further insight into how clients are changing as a function of counselor trainee personal therapy experience.

Research in the area of the effects of psychotherapist personal therapy on client outcome began with a broad focus on how the presence of PT experience might influence clinical treatment. There was a shift into exploring what aspects of personal therapy are believed to be helpful to psychotherapists in their professional development. In the past few decades, researchers have called for research on psychotherapist personal therapy use to focus on effects regarding the process of therapy versus the outcome. Currently, there seems to be interest more specifically in how the experience of engaging in personal therapy leads therapists to believing they have become more effective and thus, measuring those aspects with therapy process and outcome. Two recent studies are discussed below that explored how therapist personal therapy might be associated with certain aspects of the therapist that translate to client outcomes.

Gold, Hilsenroth, Kuutmann, and Owen (2015) examined graduate clinicians’ ratings of the working alliance in their own personal therapy and the potential relationship to the psychotherapy process and outcome with their clients. One of the findings indicated that the higher clinicians rated the working alliance in their own personal therapy, the more their clients reported that they felt improvement. The authors suggested that higher therapeutic working alliances in therapists’ personal therapy are associated with how they provide therapy, thus leading to higher outcome ratings by their clients. Conversely, the higher clinicians rated their personal therapy as being helpful to clinical work, the lower they rated the alliance in their work with their clients. The authors offered that this could be due to the amount of criticism graduate clinicians tended to place on themselves in their own performance of their work, especially the more they looked up to their own therapists. An important aspect of the current study is that
multilevel modeling analyses were implemented to control for therapist effects related to the impact of PT experience on the working alliance. Granted, more research is needed, but the results were promising in discovering associations related to therapist personal therapy experience.

Another recent article presented a literature review on therapist personal therapy use with the purpose of identifying findings related to therapist development of reflective practice (Wigg, Cushway, & Neal 2011). The authors retrieved findings that they deemed representative of various aspects of reflective practice and constructed a tentative model to explain the process that practitioners might move through in their personal and professional development to become more reflective. The authors theorized that the impact of this process might transfer to being more effective in therapy. They advocated for further research linking therapist personal therapy to the development of reflective practice, and bridging how that might have an impact on client outcome.

The current study implemented methods and statistical analyses that might be valuable to related research ideas about therapist personal therapy and therapist effectiveness. Specifically, the theoretical model developed by Wigg et al. (2011) could be expanded to include measurement of reflective practice that could serve as a therapist-level variable in a multilevel model structure. Wigg et al. discuss the push for students in clinical psychology programs to become more reflective and that personal therapy is an important way to develop reflexivity. Whereas these new ideas offer exciting research options, the current findings point to the importance of using advanced research design and sophisticated analyses for discovery. Perhaps the shift needed in this topic area is not to become more specific in identifying underlying aspects of therapist personal therapy, professional development, and treatment process, but rather
to reexamine and expand the methods in which the phenomenon is captured. The current study adds to the evidence base in an area that was once deemed too difficult to detect, suggesting that associations between therapist personal therapy and client outcome are not only possible, but promising.

**Future training.** Findings from the current study have important implications for the training of mental health practitioners as well. One of the reasons trainees in their first practicum experience were sought out for this study was to control for level of experience potentially confounding *personal therapy* variables. Because prior research has largely investigated this topic with seasoned professionals, the idea was to isolate the impact of trainee personal therapy as much as possible without the interference of clinical experience and/or time in the profession. Likewise, investigating the potential personal and professional benefits of personal therapy might also be free from experience-related influences. Unfortunately, the addition of *perceived benefit* variables did not improve model fit during the analysis process. Regardless of whether there actually may have been an association or not, it was noted that personal therapy was perceived to be more helpful to personal well-being versus professional training. Both overall and individual item means were slightly higher pertaining to personal benefits in comparison to professional benefits. One explanation suggested that trainees may have not yet developed the insight to recognize how experience in personal therapy might influence professional training. Moreover, trainees may have been more likely to connect to personal benefits because they likely experienced these gains through treatment and noticed changes within their personal lives. Given that they were new to the provision of therapy, they had not yet experienced how personal therapy might enhance professional practice. Thus, appreciating how personal therapy might be beneficial to professional training may be a product of experience and time in practice.
The literature continues to suggest considerable personal therapy use by mental health practitioners along with the idea that it is professionally beneficial, especially to enhance clinical practice. Not only is personal therapy use highly endorsed, it is strongly recommended by experienced professionals and respected scholars in the field. In an autobiographical account of how personal psychotherapy affected her practice as a psychotherapist, McWilliams (2013) discusses the most important benefit of her personal therapy being “faith in the process” (p. 623) and the way in which she has learned to convey that to her clients. She adds that her experience as a client increased her empathy regarding client vulnerabilities and therapist limitations in how much she could control. Geller (2013), in a recent narrative on his career trajectory, revealed how his on-going personal therapy at different points in his life contributed to how he evolved professionally, stating that personal therapy allows for a “vital contribution to the education of psychotherapists” (p. 628).

In their book regarding the development of therapist mastery, *On Being a Master Therapist: Practicing What You Preach*, Kottler and Carlson (2014) combine decades of experience with scholarly work and esteemed opinions to offer those in the mental health field sage advice. They list “sitting in the client’s chair” (p. 250) as one of the components most likely to contribute to excellence in the profession. Moreover, they assert that most of what they know, understand, and do as therapists was learned from the experience of being a client and appreciating what worked and didn’t work. Additionally, Kottler’s (2015) recent volume, *The Therapist in the Real World: What You Never Learn in Graduate School (But Really Need to Know)*, addresses subjects and issues he learned throughout his career that would have been helpful if taught in graduate school. Pertaining to maximizing one’s potential, he advocates for
the importance of practitioners taking the opportunity to practice what they preach, admit vulnerabilities, and strive for congruence between personal and professional identities.

Both texts, which appear to be written more for graduate students and mental health practitioners earlier in their careers, imply that the knowledge and information provided could be advantageous to enhancing development and practice if acquired at the beginning of the career trajectory. Perhaps counselor trainees, in particular, might benefit during training from the exposure to such insights of experienced leaders in the field. Whereas it may be more common for training programs to simply recommend personal therapy experience and possibly acknowledge some of the benefits, trainees might be served better if they were taught what and how the experience in personal therapy can inform their development. Research findings consistently indicate that approximately three-quarters of practitioners have been or are in personal therapy, so to not offer guidance for trainees on how to enhance their competence from these experiences seems like a disservice in their training. It could be quite valuable to spend time helping trainees reflect on how engaging as a client can help them clarify who they are, where they came from, who they want to become, and how they want to practice. Moreover, there was a recent call for more attention towards the development of clinical wisdom for graduate trainees and how to introduce these concepts during training (Levitt & Piazza-Bonin, 2015).

A shift into providing knowledge about the benefits gained through therapy might help students connect experience to insight in a way that facilitates learning new skills. Early courses in their training that teach them counseling techniques and micro skills could draw on these and other findings to demonstrate how to incorporate personal therapy to augment training. Huber and Hutchings (2004) discuss a variety of methods for integrative learning including the bridging
of skills and knowledge from multiple sources and applying theory to practice in various settings. For those who have never experienced personal therapy yet are training to provide it, they might see personal therapy as an opportunity to enhance their training and further their professional development, especially if instructors and supervisors provide more transparency on the topic and are intentional about teaching it (Norcross, 2005). As Kottler (2015) so eloquently concludes, “But that is truly the greatest gift of our profession—that we have this incredible opportunity to walk our talk, to practice what we preach, to be who we wish our clients to become” (pp. 289-290).
REFERENCES


Rizq, R., & Target, M. (2009). ‘The power of being seen’: An interpretive phenomenological analysis of how experienced counselling psychologists describe the meaning and clinical


*Counselling Psychology Review, 23*, 70-78.


APPENDIX A

Counselor Information Questionnaire
COUNSELOR INFORMATION QUESTIONNAIRE

The information provided in this questionnaire will remain strictly confidential. Please DO NOT put your name anywhere on this document.

Please provide the following demographic information:

Age_________ Gender______________ Race/Ethnicity__________________________
Relationship Status_____________________ Sexual Orientation____________________
Veteran Status_________________________ Disability Status____________________

Please indicate your department course of study:

☐ [ ] Counselor Education – clinical mental health counseling
☐ [ ] Counselor Education – school counseling
☐ [ ] Counselor Education – college counseling
☐ [ ] Counselor Education – rehabilitation counseling
☐ [ ] Counselor Education – marriage, couple, and family counseling

Please answer the following questions to the best of your knowledge:

1. How many hours of therapy have you provided to clients prior to starting CECP 6120? ______

2. How well prepared did you feel to provide therapy to clients at the start of CECP 6120?
   □ 0 – Not prepared
   □ 1 – A little prepared
   □ 2 – Somewhat prepared
   □ 3 – Very prepared
   □ 4 – Extremely prepared

3. What was your level of confidence in providing therapy to clients at the start of CECP 6120?
   □ 0 – Not confident
   □ 1 – A little confident
   □ 2 – Somewhat confident
   □ 3 – Very confident
   □ 4 – Extremely confident

4. How many client hours do you currently have in CECP 6120? __________

5. What theoretical orientation(s), if any, are you using in your work with clients?
6. Have you ever engaged in your own personal therapy as a client prior to starting CECP 6120?

☐ Yes, I have been in personal therapy in the past and am currently in personal therapy now.
☐ Yes, I have been in personal therapy in the past but am not currently in personal therapy now.
☐ No, I have not been in personal therapy in the past but am currently in personal therapy now.
☐ No, I have never been in personal therapy and am not in personal therapy now.

The following questions refer to your experience(s) in personal therapy. If you have never attended personal therapy you may skip this section and go to the end of the last page.

Please answer the following questions regarding your personal therapy experience(s) beginning with the most recent time you attended therapy (include current experience) and going back to your first experience. There is a separate series of questions for you to report information about each time you have participated in personal therapy.

7. Current or most recent personal therapy experience:
   a. Approximately what was your age at the time of this experience? _______
   b. Did this personal therapy experience occur while you were a graduate student in your counselor training program?
      ☐ Yes
      ☐ No
   c. How voluntary would you describe the experience?
      ☐ I sought out personal therapy on my own accord.
      ☐ I sought out personal therapy on the encouragement of others.
      ☐ I attended personal therapy as part of a requirement (e.g. premarital counseling, school and/or work problems, family therapy, personal growth group experience, etc.).
      ☐ It was not voluntary.
   d. How would you categorize your presenting issues or reasons for attending therapy?
      Please check all that apply.
      ☐ Depression ☐ Anxiety ☐ Relationship concerns ☐ Grief counseling
      ☐ Premarital counseling ☐ Couple’s therapy ☐ Family therapy ☐ Anger
      ☐ Fluctuating moods ☐ Substance abuse ☐ Career counseling
      ☐ School and/or Work problems ☐ Personal growth group experience ☐ Mandated
e. Approximately how many sessions of therapy did you attend during this time period? Try to give your best estimate. You might want to think about it in terms of how many sessions per week multiplied by the number of weeks, or estimating a monthly total and multiply by the number of months. (For example, you may have attended weekly for about 6 months which could either be figured by 1 time per week X 24 weeks or 4 times per month X 6 months, both equaling about 24 sessions).

\[
\text{_____ time(s) per week for _____ week(s) = ______ total sessions}
\]

- OR -

\[
\text{_____ time(s) per month for _____ month(s) =_______ total sessions}
\]

f. Please rate how helpful this personal therapy experience was to your personal well-being by placing a check mark in the appropriate box next to each corresponding statement:

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- **Lessening the severity of presenting symptoms**
- **Offering emotional relief**
- **Improving mood/outlook**
- **Improving self-esteem/confidence**
- **Increasing insight/self-awareness**
- **Improving interpersonal relationships**
g. Please rate how **helpful** this personal therapy experience was to your *professional training* by placing a check mark in the appropriate box next to each corresponding statement:

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8. Second most recent personal therapy experience:

a. Approximately what was your age at the time of this experience? ________

b. Did this personal therapy experience occur while you were a graduate student in your counselor training program?

☐ Yes  ☐ No

c. How voluntary would you describe the experience?

☐ I sought out personal therapy on my own accord.
☐ I sought out personal therapy on the encouragement of others.
☐ I attended personal therapy as part of a requirement (e.g. premarital counseling, school and/or work problems, family therapy, personal growth group experience, etc.).
☐ It was not voluntary.

d. How would you categorize your presenting issues or reasons for attending therapy? Please check all that apply.

☐ Depression  ☐ Anxiety  ☐ Relationship concerns  ☐ Grief counseling
☐ Premarital counseling  ☐ Couple’s therapy  ☐ Family therapy  ☐ Anger
☐ Fluctuating moods  ☐ Substance abuse  ☐ Career counseling
☐ School and/or Work problems  ☐ Personal growth group experience  ☐ Mandated
e. Approximately how many sessions of therapy did you attend during this time period? Try to give your best estimate. You might want to think about it in terms of how many sessions per week multiplied by the number of weeks, or estimating a monthly total and multiply by the number of months. (For example, you may have attended weekly for about 6 months which could either be figured by 1 time per week X 24 weeks or 4 times per month X 6 months, both equaling about 24 sessions).

\[ \text{______ time(s) per week for ______ week(s) = ______ total sessions} \]

-OR-

\[ \text{______ time(s) per month for ______ month(s) =______ total sessions} \]

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9. Third most recent personal therapy experience:

a. Approximately what was your age at the time of this experience? _______

b. Did this personal therapy experience occur while you were a graduate student in your counselor training program?
   □ Yes
   □ No

c. How voluntary would you describe the experience?
   □ I sought out personal therapy on my own accord.
   □ I sought out personal therapy on the encouragement of others.
   □ I attended personal therapy as part of a requirement (e.g. premarital counseling, school and/or work problems, family therapy, personal growth group experience, etc.).
   □ It was not voluntary.

d. How would you categorize your presenting issues or reasons for attending therapy? Please check all that apply.
   □ Depression □ Anxiety □ Relationship concerns □ Grief counseling
   □ Premarital counseling □ Couple’s therapy □ Family therapy □ Anger
   □ Fluctuating moods □ Substance abuse □ Career counseling
   □ School and/or Work problems □ Personal growth group experience □ Mandated
e. Approximately how many sessions of therapy did you attend during this time period? Try to give your best estimate. You might want to think about it in terms of how many sessions per week multiplied by the number of weeks, or estimating a monthly total and multiply by the number of months. (For example, you may have attended weekly for about 6 months which could either be figured by 1 time per week X 24 weeks or 4 times per month X 6 months, both equaling about 24 sessions).

   ______ time(s) per week for ______ week(s) = ______ total sessions
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f. Please rate how helpful this personal therapy experience was to your personal well-being by placing a check mark in the appropriate box next to each corresponding statement:

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<tr>
<td>Increasing empathy towards clients</td>
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<td>Learning/incorporating the role of the therapist</td>
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<td>Navigating the client-counselor relationship</td>
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<tr>
<td>Trusting the therapeutic process</td>
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<tr>
<td>Believing in the effectiveness of therapy</td>
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</table>

10. If you have experienced personal therapy additional times in your life prior to what is listed above, please use the space provided to describe the nature of the experience in the format used above (e.g., how old you were, how voluntary it was, the reasons you attended, how many sessions you had, and how helpful it was to your person well-being and professional training).
11. Taking into account all of the time periods in personal therapy listed above, what is your overall impression of how beneficial you perceive your personal therapy experience to be in general, to your personal well-being?

☐ 4 – The experience was extremely beneficial.
☐ 3 – The experience was very beneficial.
☐ 2 – The experience was somewhat beneficial.
☐ 1 – The experience was a little beneficial.
☐ 0 – The experience was not beneficial.

12. Taking into account all of the time periods in personal therapy listed above, what is your overall impression of how beneficial you perceive your personal therapy experience to be in general, to your professional training (e.g., your preparation and approach to clinical work)?

☐ 4 – The experience was extremely beneficial.
☐ 3 – The experience was very beneficial.
☐ 2 – The experience was somewhat beneficial.
☐ 1 – The experience was a little beneficial.
☐ 0 – The experience was not beneficial.

13. Taking into account all of the time periods in personal therapy listed above, what is your overall impression of how harmful you perceive your personal therapy experience to be in general, to your personal well-being?

☐ 4-The experience was extremely harmful.
☐ 3-The experience was very harmful.
☐ 2-The experience was somewhat harmful.
☐ 1-The experience was a little harmful.
☐ 0-The experience was not harmful.

14. Taking into account all of the time periods in personal therapy listed above, what is your overall impression of how harmful you perceive your personal therapy experience to be in general, to your professional training (e.g., your preparation and approach to clinical work)?

☐ 4-The experience was extremely harmful.
☐ 3-The experience was very harmful.
☐ 2-The experience was somewhat harmful.
☐ 1-The experience was a little harmful.
☐ 0-The experience was not harmful.

Please return your completed questionnaire to the container labeled “CIQ”

THANK YOU FOR YOUR TIME AND PARTICIPATION
APPENDIX B

Outcome Questionnaire 45.2
### Outcome Questionnaire (OQ®-45.2)

**Name:**

**Date:**

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<tr>
<th>Almost</th>
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<th>Sometimes</th>
<th>Frequently</th>
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**Instructions:**
Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and fill the circle completely under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

*Developed by*
Michael J. Lambert, Ph.D.
Gary M. Borlingame, Ph.D.

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**WEB:**
WWW.OQFAMILY.COM
TOLL-FREE: 1-888-MH SCORE (1-888-647-2073)
FAX: 1-801-434-9730

1. I get along well with others................................. o  o  o  o  o  o
2. I tire quickly.................................................. o  o  o  o  o  o
3. I feel no interest in things................................. o  o  o  o  o  o
4. I feel stressed at work/school............................ o  o  o  o  o  o
5. I blame myself for things................................. o  o  o  o  o  o
6. I feel irritated............................................. o  o  o  o  o  o
7. I feel unhappy in my marriage/significant relationship... o  o  o  o  o  o
8. I have thoughts of ending my life........................ o  o  o  o  o  o
9. I feel weak................................................... o  o  o  o  o  o
10. I feel fearful................................................ o  o  o  o  o  o
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”)
12. I find my work/school satisfying........................ o  o  o  o  o  o
13. I am a happy person......................................... o  o  o  o  o  o
14. I work/study too much.................................... o  o  o  o  o  o
15. I feel worthless............................................. o  o  o  o  o  o
16. I am concerned about family troubles.................. o  o  o  o  o  o
17. I have an unfulfilling sex life......................... o  o  o  o  o  o
18. I feel lonely................................................ o  o  o  o  o  o
19. I have frequent arguments............................... o  o  o  o  o  o
20. I feel loved and wanted.................................. o  o  o  o  o  o
21. I enjoy my spare time..................................... o  o  o  o  o  o
22. I have difficulty concentrating........................ o  o  o  o  o  o
23. I feel hopeless about the future....................... o  o  o  o  o  o
24. I like myself................................................ o  o  o  o  o  o
25. Disturbing thoughts come into my mind that I cannot get rid of... o  o  o  o  o  o
26. I feel annoyed by people who criticize my drinking (or drug use)... o  o  o  o  o  o
   (If not applicable, mark “never”)
27. I have an upset stomach................................. o  o  o  o  o  o
28. I am not working/studying as well as I used to........ o  o  o  o  o  o
29. My heart pounds too much................................ o  o  o  o  o  o
30. I have trouble getting along with friends and close acquaintances... o  o  o  o  o  o
31. I am satisfied with my life............................... o  o  o  o  o  o
32. I have trouble at work/school because of drinking or drug use...... o  o  o  o  o  o
   (If not applicable, mark “never”)
33. I feel that something bad is going to happen............ o  o  o  o  o  o
34. I have sore muscles....................................... o  o  o  o  o  o
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth. o  o  o  o  o  o
36. I feel nervous............................................. o  o  o  o  o  o
37. I feel my love relationships are full and complete....... o  o  o  o  o  o
38. I feel that I am not doing well at work/school.......... o  o  o  o  o  o
39. I have too many disagreements at work/school........... o  o  o  o  o  o
40. I feel something is wrong with my mind................ o  o  o  o  o  o
41. I have trouble falling asleep or staying asleep.......... o  o  o  o  o  o
42. I feel blue................................................ o  o  o  o  o  o
43. I am satisfied with my relationships with others........ o  o  o  o  o  o
44. I feel angry enough at work/school to do something I might regret... o  o  o  o  o  o
45. I have headaches....................................... o  o  o  o  o  o
APPENDIX C

HSIRB Approval Letter
Date: October 1, 2014

To: Mary Anderson, Principal Investigator
    Bonnie VanderWal, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 14-09-31

This letter will serve as confirmation that your research project titled “The Effects of Counselor Trainees’ Personal Therapy Experiences on Client Outcomes” has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., you must request a post approval change to enroll subjects beyond the number stated in your application under “Number of subjects you want to complete the study.”) Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: September 30, 2015
APPENDIX D

Participant Recruitment Script
The following items were discussed with potential participants during each recruitment session:

- You are being invited to participate in a study that aims to learn more about how therapist factors relate to counseling outcomes. Therapist factors include those things that are part of the therapist that may or may not be evident in the therapeutic relationship and that might have an impact on treatment. Therapist factors are varied and vast, but may include the following: demographics such as age, race, or gender; characteristics such as attitude or perception; and types of experiences one has had throughout life (e.g. participation in personal therapy).
- Your participation is completely voluntary and is not connected to any course responsibilities. Likewise, your decision to either accept or decline will have no evaluative benefit or penalty to your progress in this course.
- Should you decide to participate, you will be asked to sign a consent form and complete a brief questionnaire.
- The time commitment will be approximately 15 minutes and upon submitting the consent form and questionnaire, your participation will be complete.
- A system to protect your privacy will be used so that your personal information is kept strictly confidential. Your name will not appear on the questionnaire that asks you to report on your experiences. A numerical code will be listed instead on the questionnaire and you will be asked to provide your name and questionnaire code on a separate sheet before turning in research materials. Your name and code will be recorded on a master participant list that will only be accessible by the student and principal investigators. Consent forms, questionnaires, and the master list will all be stored separately from one another in independent secure containers.
- To thank you for your time, you may choose one of the following items: a [gift card], a [gift card], a parking validation ticket [ ], or a [gift card]. All items have the same value.
- You will all be given a study packet to review. Whether you decide to participate or not, you will return this paperwork to the investigator who will wait outside of this meeting room. If you participate, you will deposit your consent form and questionnaire into separate secure containers and choose among the compensation options. If you decline to participate, you will return the blank study packet.
- Are there any questions?
APPENDIX E

Informed Consent Form
Western Michigan University
Counselor Education and Counseling Psychology

Principal Investigator: Mary Z. Anderson, Ph.D.
Student Investigator: Bonnie L. VanderWal, M.A.
Title of Study: The Effects of Counselor Trainees’ Personal Therapy Experiences on Client Outcome

You have been invited to participate in a research project titled "The Effects of Counselor Trainees’ Personal Therapy Experiences on Client Outcome." This project will serve as Bonnie VanderWal’s dissertation research for the requirements of the Doctor of Philosophy degree. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely, and please ask any questions if you need more clarification.

What are we trying to find out in this study?
This study will look at some things that counselors in training bring to their beginning work with clients, and if these things might influence how clients do in therapy. For example, mental health practitioners have indicated in past research that they have been to personal therapy both before and after completing training in their field. Some have also said that their experiences in personal therapy have helped them in their professional work to be better (i.e., more effective) in how they help their clients. Studies that attempted to test this claim were not able to show if the personal therapy experience of therapists had any impact on their clients. Over time this idea has continued to be thought of as too difficult to study; however, the ways in which client progress is measured is more advanced now. There are also newer methods used to analyze data that are capable of detecting the kind of relationship that might occur between factors of the therapist and how clients change. Therefore, this study is being conducted to find out if the use of newer measures and methods might identify a connection between counselor trainees’ experiences and how they have an impact on their clients.

Who can participate in this study?
Graduate student counselor trainees who are currently enrolled in counseling practicum courses (e.g., in the department of at are eligible to participate in this study.

Where will this study take place?
This study will take place in the
What is the time commitment for participating in this study?
The overall time it will take you to complete this study from beginning to end will be approximately 15 minutes and will occur immediately following the invitation to participate.

What will you be asked to do if you choose to participate in this study?
If you choose to participate in this study, you will be asked to provide written information to a brief questionnaire and return it to a secure locked container once you are finished with it.

What information is being measured during the study?
The information that will be obtained as a result of participating in the study will consist of personal factors that you as a counselor trainee bring to your work with clients. These factors may include demographic information (e.g., age, gender, race/ethnicity, etc.), level of preparedness to engage in therapy with clients, and general details regarding experiences (or lack thereof) in personal therapy. Additionally, outcome scores (as routinely measured by the training clinics) will be obtained from clients that you have worked with during your practicum.

What are the risks of participating in this study and how will these risks be minimized?
The risks associated with participating in this study have to do with the potential emotional and/or psychological discomfort that could result from providing personal information. For example, answering questions about past experiences could be uncomfortable depending on the nature of those experiences. Likewise, disclosing sensitive information may cause some anxious feelings related to how confidentiality is maintained. Additionally, taking time out of the practicum class period to complete a survey may be considered an inconvenience.

To minimize the impact of these potential risks, you may discontinue participation at any time and for any reason without penalty. If any questions are upsetting to you, you do not have to answer them. Please know that you are also welcome to discuss with investigators the methods used to protect your identity as well as to keep your responses private and unconnected from identifying information.

All data collected in this study will be coded in effort to protect your privacy and confidentiality. The student investigator will use the following coding system so that your name will not be connected to your responses. Consent forms will be separated from the study packet and will be kept separately from other research materials. The information questionnaires will contain numerical codes and once completed, will be deposited into a separate secure locked container. You will write your name and associated code number on a separate sheet of paper, also to be stored securely and independently from consent forms and questionnaires. Your name and code number will be used to generate a master participant list that will only be accessible by the student and principal investigators. This list, consent forms, and questionnaires will all be stored in the principal investigator’s departmental office, but independent of one another. You will not report identifying information on the information questionnaire.
What are the benefits of participating in this study?
Your participation in this study helps the researchers learn more about how therapist factors potentially have an impact on client outcome, essentially contributing to the knowledge base and possibly having implications for training programs and practices. You may benefit from knowing how important your experiences are to providing new insights in this research area. You may also find that answering the research questions helps you learn more about yourself, reflect upon your experiences, and possibly view things from a new perspective. Whereas you potentially may feel that your involvement in this study is beneficial, others may not experience similar conclusions. Thus, potential benefits to participation will vary among participants.

Are there any costs associated with participating in this study?
There are no costs associated with participating in this study.

Is there any compensation for participating in this study?
If you consent to participate in this study, fill out the study questionnaire, and return these items to the noted secure container in the possession of the investigator, you will receive a gift of appreciation for your participation. You may choose one of the following: a gift card, a gift card, a parking validation ticket for , or a gift card. All options have the same value and the variety is intended to appeal to participants at in both locations.

Who will have access to the information collected during this study?
The student investigator will have access to the information collected in this study. There is the potential for those required by HSIRB policy (i.e., the principal investigator and possibly IRB members) to have access to your information; however, your name will not be located on the questionnaire where you provided information. In the case that this study is published and/or presented during any professional conferences, participant names will not be identified or linked to the presentation of results. Participation in this study as well as response data will not be shared with anyone external to this research project. To protect your identity, a coding system will be used that assigns a number to each questionnaire which will be stored separately from consent forms that contain participant signatures, and separate from the participant master list.

What if you want to stop participating in this study?
You may choose to stop participating in the study at any time and for any reason. You will not suffer any prejudice or penalty by deciding to stop participation. Additionally, you will experience NO consequences either academically or personally should you choose to withdraw from this study. Likewise, participation in this study can also be stopped by the investigators at any time without participant consent.

Should you have any questions prior to or during the study, you can contact the primary investigator, Dr. Mary Z. Anderson, at 269-387-5113 or mary.anderson@wmich.edu.
You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

Please Print Your Name

Participant's signature    Date
APPENDIX F

Statement of Professional Intent
Statement of Professional Intent

(Please read and take to your first session. Do not sign if you have questions.)

Welcome to [Blank]. As a possible client, it is important that you know about practices and procedures.

First, whatever you share with counseling staff is considered confidential. The staff will break confidentiality only when we have a duty to warn. Duty to warn means that potential harm to self or others seems likely to occur. In such an instance, we are obliged to act. In most cases, you as a client will be the first to know. Duty-to-warn situations occur very rarely.

Most individuals experience counseling as positive and find their sessions to be helpful in resolving problems. Occasionally, however, discussions about problems may cause negative feelings. If this occurs, please tell your counselor as soon as you can. Discussion of negative feelings is important in evaluating our work with you.

The counselors are advanced master's and doctoral degree students studying to be professional counselors and psychologists. They work under the direct supervision of a faculty member who is responsible for their training. Supervising faculty are professional counselors and/or licensed psychologists. For the purpose of being supervised, the students may have to audio or video tape some or all of their counseling sessions. Therefore, [Blank] can accept you for its services only if you sign a release that permits the audio or video taping of your sessions.

To insure proper service, the first visit here is considered to be an intake interview. During this interview, you are expected to tell why you came to [Blank] and what you would like to gain. Based on your needs, a student counselor will be assigned to you and a second appointment made. If we cannot respond to your needs, we will give you a referral.

The also serves as a site for developing a better understanding of counseling through research. Research in [Blank] is designed so that information is treated confidentially. Code numbers rather than names are used confidentially, and reports offer information only in the form of group data. Your signature on the specific release indicates your willingness to allow staff members to obtain information on file for the purpose of research.

Finally, to maintain a high level of service to clients, [Blank] must charge fees. The intake counselor will discuss the amount of your fee with you during the first interview. Thereafter, your counselor will collect the fee at the end of each session. You may pay with cash or a check made out to [Blank].

We encourage discussion and questions about any aspect of your service at [Blank]. If you have problems with the service you receive that you do not want to discuss with your counselor, please contact [Blank] at [Blank].
I have read and understand this statement and have had the chance to discuss it before sharing personal information.

________________________________________________________

Signature and Date
APPENDIX G

Client Growth Trajectories Grouped by Counselor
APPENDIX H

Client Intercepts and Slopes of Growth Trajectories
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APPENDIX I

Graphs of Individual Regression Models for Each Client in Data Set
CLT ID: 1111

$R^2$ Linear = 0.099
CLT ID: 1141

R² Linear = 1
CLT ID: 1222

R² Linear = 1
CLT ID: 1411

R² Linear = 0.774
CLT ID: 2251

R² Linear = 0.189
CLT ID: 2263

$R^2$ Linear = 0.785
APPENDIX J

Results of Linearity Testing with Level 2 Predictor Variables
$r^2$ Linear = 0.041

$\gamma = 2.4 + 0.15x$
APPENDIX K

Results of Normality Testing on Levels 1 and 2
Normal Q-Q Plot of OLINTRCPT1

Normal Q-Q Plot of OLSESSION
APPENDIX L

Results of Homoscedasticity Testing on Levels 1 and 2
APPENDIX M

Frequencies for Counselor Trainees’ Additional Episodes in Personal Therapy
Table M1

*Personal Therapy (PT) Experiences of Counselor Trainee Participants (2\textsuperscript{nd} Most Recent)*

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<tr>
<th>Category</th>
<th>( f )</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>45.5%</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
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<td>1</td>
<td>9.1%</td>
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<tr>
<td>52</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>100</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td><strong>Pursuit of Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual choice</td>
<td>6</td>
<td>54.5%</td>
</tr>
<tr>
<td>Encouraged by other(s)</td>
<td>2</td>
<td>18.2%</td>
</tr>
<tr>
<td>Part of requirement</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>Involuntary/mandated</td>
<td>2</td>
<td>18.2%</td>
</tr>
<tr>
<td><strong>Time of Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During graduate program</td>
<td>4</td>
<td>36.4%</td>
</tr>
<tr>
<td>Prior to graduate program</td>
<td>7</td>
<td>63.6%</td>
</tr>
<tr>
<td><strong>Reasons(^a)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>3</td>
<td>9.4%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>5</td>
<td>15.6%</td>
</tr>
<tr>
<td>Relationship concerns</td>
<td>7</td>
<td>21.9%</td>
</tr>
<tr>
<td>Grief counseling</td>
<td>4</td>
<td>12.5%</td>
</tr>
<tr>
<td>Premarital counseling</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Couple’s therapy</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Family therapy</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Anger</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fluctuating moods</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Career counseling</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>School and/or work problems</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Personal growth group experience</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Mandated</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Note.* \( N = 11 \).
\(^a\)Participants were asked to select the reason(s) that led them to seek personal therapy. Several participants (\( n = 7 \)) identified more than one reason for seeking treatment so frequencies listed are computed from the total number of reasons indicated (\( N = 32 \)).
Table M2

**Personal Therapy (PT) Experiences of Counselor Trainee Participants (3rd Most Recent)**

<table>
<thead>
<tr>
<th>Category</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>40.0%</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td>16</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td>21</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td><strong>Pursuit of Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual choice</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Encouraged by other(s)</td>
<td>4</td>
<td>80.0%</td>
</tr>
<tr>
<td>Part of requirement</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td>Involuntary/mandated</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Time of Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During graduate program</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td>Prior to graduate program</td>
<td>4</td>
<td>80.0%</td>
</tr>
<tr>
<td><strong>Reasons</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
<td>21.1%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3</td>
<td>15.8%</td>
</tr>
<tr>
<td>Relationship concerns</td>
<td>3</td>
<td>15.8%</td>
</tr>
<tr>
<td>Grief counseling</td>
<td>2</td>
<td>10.5%</td>
</tr>
<tr>
<td>Premarital counseling</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Couple’s therapy</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Family therapy</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Anger</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Fluctuating moods</td>
<td>2</td>
<td>10.5%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Career counseling</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>School and/or work problems</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Personal growth group experience</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Mandated</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Note. N = 5.*

*Participants were asked to select the reason(s) that led them to seek personal therapy. Most participants (n = 4) identified more than one reason for seeking treatment so frequencies listed are computed from the total number of reasons indicated (N = 19).*
APPENDIX N

Definitions of Models Tested in Table 8
<table>
<thead>
<tr>
<th>Model</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Mixed Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>[OQSCR_0 = \pi_0 + e_i]</td>
<td>[\pi_0 = \beta_{00} + r_{0i}]</td>
<td>[OQSCR_0 = \beta_{00} + r_{0i} + e_i]</td>
</tr>
<tr>
<td>B</td>
<td>[OQSCR_0 = \pi_0 + \pi_i^* (SESSION_n) + e_i]</td>
<td>[\pi_0 = \beta_{00} + r_{0i}]</td>
<td>[OQSCR_0 = \beta_{00} + \beta_{10}^* (SESSION_n) + e_i]</td>
</tr>
<tr>
<td>C</td>
<td>[OQSCR_0 = \pi_0 + \pi_i^* (SESSION_n) + e_i]</td>
<td>[\pi_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + r_{0i}] [\pi_i = \beta_{10} + r_{1i}]</td>
<td>[OQSCR_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{10}^* (SESSION_n) + e_i]</td>
</tr>
<tr>
<td>D1</td>
<td>[OQSCR_0 = \pi_0 + \pi_i^* (SESSION_n) + e_i]</td>
<td>[\pi_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{02}^* (PERSTX_i) + r_{0i}] [\pi_i = \beta_{10} + \beta_{11}^* (SC0CL_l) + \beta_{12}^* (PERSTX_i) + r_{1i}]</td>
<td>[OQSCR_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{10}^* (SESSION_n) + \beta_{11}^* (SC0CL_l) + \beta_{12}^* (SC0CL_l) + \beta_{13}^* (PERSTX_i) + r_{0i} + r_{1i} + e_i]</td>
</tr>
<tr>
<td>D2</td>
<td>[OQSCR_0 = \pi_0 + \pi_i^* (SESSION_n) + e_i]</td>
<td>[\pi_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{02}^* (PTGRPRG) + r_{0i}] [\pi_i = \beta_{10} + \beta_{11}^* (SC0CL_l) + \beta_{12}^* (PTGRPRG) + r_{1i}]</td>
<td>[OQSCR_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{02}^* (PTGRPRG) + \beta_{10}^* (SESSION_n) + \beta_{11}^* (SC0CL_l) + \beta_{12}^* (SC0CL_l) + \beta_{13}^* (PTGRPRG) + r_{0i} + r_{1i} + e_i]</td>
</tr>
<tr>
<td>E1</td>
<td>[OQSCR_0 = \pi_0 + \pi_i^* (SESSION_n) + e_i]</td>
<td>[\pi_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{02}^* (PERSTX_i) + \beta_{03}^* (PERMAX) + r_{0i}] [\pi_i = \beta_{10} + \beta_{11}^* (SC0CL_l) + \beta_{12}^* (PERMAX) + \beta_{13}^* (PERMAX) + r_{1i}]</td>
<td>[OQSCR_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{02}^* (PERSTX_i) + \beta_{03}^* (PERMAX) + \beta_{10}^* (SC0CL_l) + \beta_{11}^* (PERMAX) + \beta_{12}^* (PERMAX) + r_{0i} + r_{1i} + e_i]</td>
</tr>
<tr>
<td>F1</td>
<td>[OQSCR_0 = \pi_0 + \pi_i^* (SESSION_n) + e_i]</td>
<td>[\pi_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{02}^* (PERSTX_i) + \beta_{03}^* (PROMAX) + r_{0i}] [\pi_i = \beta_{10} + \beta_{11}^* (SC0CL_l) + \beta_{12}^* (PERSTX_i) + \beta_{13}^* (PROMAX) + r_{1i}]</td>
<td>[OQSCR_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{02}^* (PERSTX_i) + \beta_{03}^* (PROMAX) + \beta_{10}^* (SC0CL_l) + \beta_{11}^* (PERSTX_i) + \beta_{12}^* (PROMAX) + \beta_{13}^* (PROMAX) + r_{0i} + r_{1i} + e_i]</td>
</tr>
<tr>
<td>G1</td>
<td>[OQSCR_0 = \pi_0 + \pi_i^* (SESSION_n) + e_i]</td>
<td>[\pi_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + r_{0i}] [\pi_i = \beta_{10} + \beta_{11}^* (SC0CL_l) + \beta_{12}^* (PERSTX_i) + r_{1i}]</td>
<td>[OQSCR_0 = \beta_{00} + \beta_{01}^* (SC0CL_l) + \beta_{10}^* (SESSION_n) + r_{0i} + r_{1i} + e_i]</td>
</tr>
</tbody>
</table>
\[ G2 \quad OQSCR_i = \pi_0 + \pi_1 S(SESSION_i) + \epsilon_i \quad \pi_0 = \beta_{00} + \beta_{01} S(SC0CL_i) + r_0 \\
\pi_1 = \beta_{10} + \beta_{11} S(SC0CL_i) + \beta_{12} S(PTGRPRG_i) + r_1 \]

\[ OQSCR_i = \beta_{00} + \beta_{01} S(SC0CL_i) + \beta_{10} S(SESSION_i) \\
+ \beta_{11} S(SC0CL_i) S(SESSION_i) \\
+ \beta_{12} S(PTGRPRG_i) S(SESSION_i) \\
+ r_0 + r_1 S(SESSION_i) + \epsilon_i \]