Original Research Article

Psychotherapists Undergoing Personal Therapy: A Qualitative Analysis

Simran Brijwani[1], Avinash Desousa[2]

[1]Psychologist and Research Associate, Desousa Foundation and Private Practice, Mumbai.
[2]Consultant Psychiatrist and Founder Trustee, Desousa Foundation, Mumbai.
Corresponding author: Simran Brijwani
Email – simranbrijwani6@gmail.com

ABSTRACT

Background: Mental health Professionals (MHPs) spend years training and refining their effectiveness through varied resources. Personal therapy is one such resource known to add value to the personal and professional development of MHPs. The paper explores the views and experiences of personal therapy among MHPs.
Methodology: A qualitative analysis was obtained through semi-structured interviews with 15 mental health professionals, aged 23-35. Participants have been in personal therapy for at least six months. Results: The thematic analysis led to eight emergent themes and their respective theme clusters including professional and personal development, professional difficulties, stressors experienced, coping mechanisms, working through countertransference, viewpoints on personal therapy, and experiences as a client in therapy.
Results: Participants echoed the benefits of personal therapy but, had conflicting views on making personal therapy mandatory for students. Findings were consistent with existing literature on personal therapy across the globe.
Conclusions: The findings act as a catalyst in including personal therapy as an optional part of the educational curriculum, provided it is made accessible, affordable, and assures quality care. Future research could consider alternate sources of care for the MHPs that may reap similar outcomes.

Keywords: Personal therapy, psychotherapists, personal development, professional development, thematic analysis.

(Paper received – 30th July 2022, Peer review completed – 15th August 2022, Accepted – 18th August 2022)

INTRODUCTION

Mental Health Professionals (MHPs) support individuals of all ages to lead healthier lives. In doing so, they witness vicarious client narratives that can take a toll on their mental health and affect the quality of care they provide. In addition, MHPs experience burnout, compassion fatigue, emotional isolation, and vicarious trauma from negating their needs, managing intense emotions stemming from clients' painful realities, and a heightened sensitivity to the environment [1]. A therapist's burnout weighs heavy as it directly affects their mental health, the employers, and the clients seeking therapy. Thus, personal therapy can help them alleviate distress and perform better at work [2]. Personal therapy refers to 'psychotherapy for MHPs, including practicing or trainee psychologists.'

Since the 1900s, prominent therapists have concurred that personal therapy is a prerequisite to providing effective psychotherapy. Yalom [3] proposed: "Therapists must work through their neurotic issues; they must learn to accept feedback, discover their blind spots, and see themselves as others see them; they must appreciate their impact upon others and learn how to provide accurate feedback (p. 41)." Contemporary therapists Carl Jung and Marsha Linehan have been in therapy and appear to share similar views [4]. Thus, a central question arises: 'Is it necessary for therapists to be in therapy?'

Existing literature suggests that personal therapy has significant benefits for MHPs [5-6]. However, some studies offer contrary results [7]. In India, while MHPs are pleased with the outcomes of personal therapy, being spotted while entering an MHP's office may suffice to prevent them from seeking help. Self-stigma, social stigma, shame, fear of negative outcomes of self-disclosure, lack of support from loved ones, and fear of being perceived as incompetent are some imaginable deterrents of personal therapy [8-12].

The mental health care field in India poses unique challenges as it is loosely structured with no central licensing body to regulate the professional qualifications and registration of MHPs. Most Masters's programs in India are inclined toward theoretical learning and brief clinical internships or observerships. While personal therapy is a mandatory requirement in most universities abroad, it is unheard of in India barring a few universities. Past research on personal therapy and interrelated factors across the globe is well-documented. However, the literature in the Indian context is scarce. Thus, this article aims to explore the opinions & experiences of personal therapy among MHPs in India.

METHODOLOGY

To ensure that participants' views could be congruent with their personal experiences, researchers used semi-structured interviews with open-ended questions. Therefore, participant responses were qualitatively analysed using thematic analysis.

Participants

The participants comprised 15 practicing MHPs, ages 23-35. All of them have spent varying lengths of time in personal therapy, ranging from six months to ten years. Participants were recruited through the circulation of a flyer online. The inclusion criteria included MHPs having: a post-graduate degree in Psychology and/or Psychotherapy (1-2 years), at least one year of experience practicing therapy, and having been in personal therapy for at least six months. The researchers did not account for the school of therapy that participants chose to undertake therapy. Of the 40 MHPs contacted, 15 were willing to participate.

The Researchers

The interviews and the initial analysis were conducted by X, a psychologist with 1 year of experience in research. The second researcher, Y, was an experienced psychiatrist, and psychotherapist with 25 years of experience. The researchers regularly discussed interview content and procedure, transcripts, emerging themes, and theme clusters. Before the study, the researchers had no viewpoints or opinions about personal therapy. They were aware of the power/hierarchy involved in interviewing fellow professionals. Therefore, they acknowledged that many MHPs have found it helpful, but did not assume/ generalize the same for all MHPs.

Interview Procedure

One 1 to 3hrs semi-structured interview was conducted with every participant. The interviews were scheduled in a sequence; to gain descriptive accounts of participants' experiences of personal therapy. The interview topics included: (a) being a 'client' in therapy and (b) their views/opinions of personal therapy. The confidentiality and anonymity of participants' details were maintained.

Ethical Aspects

Participants were asked to fill out the informed consent form. The form comprised a brief description of the study, its goals, procedures, and participant rights. The interviews were conducted online, recorded on audiotape, and later transcribed. Participants were asked to read the transcripts, decide whether they accurately reflected their views, and make any changes if needed.

Data analysis

Transcripts were analysed using thematic analysis with the help of inductive coding [13]. After the completion of the interviews, the researchers heard the audiotapes and read the transcripts several times. They created notes for relevant participant statements and noted topics that appeared recurrently. Later,

these were grouped to decode underlying themes. Some overlapping themes clustered together to form a broader theme. Each theme was compared with the transcripts to ensure they accurately described participants' responses. Similarly, they repeated the process for all the transcripts. Formulated themes were arranged into theme clusters that provided an overview of the MHP's experiences and views of personal therapy.

RESULTS

The analysis suggests a consistent pattern of emerging themes across participants. Overall, personal therapy favours personal and professional development among most MHPs. Our analysis obtained eight broad themes and their respective clusters.

Professional development: As most Masters's programs in India incline towards theoretical learning and brief clinical internships, professional development was a common acquisition from personal therapy. The obtained sub-themes were experiential learning, therapist development, and overcoming personal roadblocks.

Sub-theme: Experiential learning

The semblance of personal therapy allowed participants to gain first-hand experience of the therapeutic relationship, and refine their existing knowledge, skills and metaphors they subsequently brought into their work with the clients.

"My therapist engages in self-disclosure in a calculative way. When I was struggling with my career, she'd disclose her career struggles. It felt less alone. I took it back along with her metaphors [P10]."

Participants internalized their personal therapy experiences. These enabled them to gain 'clarity' about the execution of the theories and skills.

"Their body language, code of conduct, approaches, and homework assignments [P7]."

Sub-theme: Therapist development

The training for MHPs may vary depending on the duration, modality, and subsequent emphasis on skill development. Therefore, the personal therapy experience acted as a 'meaningful' vantage point to learn from the demeanour, attitudes, and working style of their therapist.

"Extending space. I had severe panic attacks. My therapist said 'I may not respond instantly, but you can always send me an email or a voice note.' Knowing that someone is accepting you for your vulnerability. I try to replicate it [P3]."

Personal therapy encouraged the participants to reflect upon the 'principles' they resonate with and the 'practices' to avoid in their work.

"I started comparing myself with what my therapist did. Sometimes, I found good practices, but I also found some mistakes, like giving advice [P14]."

In addition, personal therapy increased MHP's in-depth understanding of the therapist-client relationship, their impact on their clients, and the desired therapeutic presence.

Sub-theme: Overcoming personal roadblocks

Personal therapy helped participants identify their 'blind spots,' overcome the 'savior complex' and work through their unresolved issues. They added: the process of holding space for their fears, resistance, biases, and internal traumas and weaknesses were difficult.

"I believed that, as a therapist, I was here to guide people, and wouldn't need any help. During therapy, I realized that being a therapist yourself doesn't mean I am immune to things. It took time to accept that [P1]."

"It was a struggle getting myself to take medication and finally realize that medicines aren't all bad and can be helpful. My therapist helped me overcome my bias toward medication and recognize what I need for my mental health journey [P15]."

Participant 4 shared: that *"therapists are as vulnerable as their clients."*

Personal development

Personal therapy has been known to facilitate personal growth and development among MHPs. It led to improved emotional regulation, personality development, and an improved relationship with self and others.

Sub-theme: Improved emotional regulation

Personal therapy helped MHPs gain self-awareness, alleviate distress, and recognize themselves as 'human beings.' It enhanced their intellectual and emotional functioning through overcoming 'self-stigma' and permitting themselves to falter, be challenged, and receive support.

"Community care is a two-way process. It involves both providing and asking for help. Earlier, I was okay with providing help but not asking for it. Therapy has changed that. Now it's both ways [P10]."

Personal therapy helped MHPs identify their boundaries and maintain a 'work-life balance.'

"Often, I blur the boundaries between over-working and breaks. Therapy helps me find a balance and take the breaks I need [P2]."

Participants cited that self-awareness complemented their professional life and practice. Being aware of their internal processes helped them remain in the here and now of the therapy room and the therapeutic alliance. It allowed them to rediscover themselves and gain perspective into their own lives.

"I became better at my emotional management. For instance, I have a difficult time with anger. Earlier, I'd experienced resistance when my client experienced anger. Therapy made me realize that it's okay for me to experience it at its full intensity. I apologized to my client. We had a full-fledged conversation about it, and that helped strengthen the therapeutic alliance [P10]."

Sub-theme: Personality development

Personal therapy was crucial in the development of the therapist's 'personhood.' It helped the participants become more open, disciplined, and grounded in their professional space.

"I had an excessive need to control things, but therapy has made me more flexible, psychologically, and cognitively [P3]."

Personal therapy made it viable for participants to shed the silenced parts of themselves and fully connect to others. It made them more secure, confident, comfortable, and resilient to cope with the uncertainties of the nature of work and other emotional demands of their roles.

"Therapy helped build my self-worth. It made me go from a shy, 14-year-old with no friends to an extrovert who stands up for what they believe in, has decent confidence levels, and healthy social life[P15]."

Sub-theme: An improved relationship with self and others

Personal therapy made participants aware of their identities, roles, and their 'personhood' as a therapist. It also facilitated greater self-acceptance and empowerment.

"I understood how my family structure has affected me and my relationships. It brought a huge shift in my perspective about myself, the world, and majorly in my relationships [P11]."

Participant 1 adds: "I feel like I have a voice."

Working through countertransference

Countertransference means 'transference' on the part of the MHP. Participant responses suggest that personal therapy helps recognize and work through countertransference. This can be understood through the therapist's experience of countertransference, their response, and methods to combat it.

Sub-theme: Experience of countertransference

All the participants expressed discomfort working with a certain clientele due to personal preference and lack of relevant skills/expertise. For Participant 5, the area of discomfort varies depending on their current stage in life.

"Last, I remember it was difficult working with mothers because my mother was unwell. Listening to similar narratives, I felt that I started taking up the role of a daughter, more than a facilitator. It is dynamic and varies based on where I am in life [P5]."

Participants 1 and 4 consider countertransference as one of their professional difficulties as it has profoundly affected them.

"Some cases were triggering because they reminded me of some of my raw nerves [P1]."
"Some clients elicit more resonance. I felt the hurt and horror deeply [P4]."

Sub-theme: Therapist's response to countertransference

Countertransference makes it hard to distinguish between the concerns relevant to supervision and appropriate for discussion in personal therapy.

"There were times I'd talk about a case without disclosing the details in therapy. My therapist would stop me and say it was something I would have to discuss with my supervisor [P15]."

Participants reveal that countertransference made it hard for them to separate clients' feelings from their own. Further, over-identifying with the client's concerns caused them emotional distress.

"I'd ponder over certain client experiences and relate to them if they felt similar to mine. I noticed I was combining the two [P8]."

Participant 12 viewed her 'professional training as a protective factor against countertransference.

"Even if something triggers, we are trained to keep it aside and mentally switch off [P12]."

Sub-theme: Methods used to combat countertransference

Supervision, in addition to personal therapy, helped participants effectively combat countertransference. It enabled them to address their triggers, self-reflect, and reduce the chances of potential countertransference. It also helped MHPs develop a 'third-person perspective' of the client's concerns.

"Earlier, there were enmeshments. I'd mix the client's experiences and my own. Personal therapy and supervision helped me differentiate[P1]."

MHPs are known to keep their radar on to identify countertransference. While some participants further explored countertransference with their supervisors, few others referred their clients to another competent professional.

"I make a mental note of it and immediately connect with my supervisor. We explore it in our sessions [P2]."
"One of the client's complaints was similar to my dad's. I referred him eventually [P14]."

Interestingly, Participant 15 recounted that she abides by some preventive measures to reduce the possibilities of countertransference.

"I set social media boundaries. I don't restrict clients, but I do not tell them my social media handle. I keep it professional, on WhatsApp. I also don't share too much in sessions [P15]."

Three participants mentioned that they did not experience countertransference at all.

Coping mechanisms

The nature of the work may predispose MHP to stressful experiences. Participants commonly cope with stressors using:

- self-care practices;
- adequate rest and breaks;
- support systems;
- alternate care (personal therapy, supervision, community support, training)
- referrals

Participants highlighted the importance of self-care to maintain their life outside work. It involved cultivating spiritual and self-care practices such as journaling, exercise, and mindfulness, in their everyday lives. All of them, in their ways, necessitated taking adequate rest and breaks. Some schedule shorter workdays, spend time away from their devices and have gaps between their sessions. Others go for short vacations and enjoy nature. As a consensus, participants described the importance of having social support outside work. It included their friends, family, colleagues, mentors, peers from allied professions, and community support. Participants underlined that MHPs need personal therapy and supervision throughout their professional journey and not just at the beginning of their careers.

In addition, they reiterated the importance of mental health culture in workplaces as it boosts productivity and enhances employee well-being. Participant 3 elaborated:

"My workplace gives mental health breaks. I can say that I'm not feeling okay, and take a day off. Such work culture itself is a boost, and a healthy mechanism to cope with [P3]."

The pandemic posed unique challenges for MHPs as mental health services entered the most intimate spaces and blurred the physical boundaries between work and home. Participants reiterated the conscious measures to distance themselves from their workspace. Some deconstruct their workspace using cushions and transitional objects. Each of them, in different ways, recognized having a space that allows you to do so as a privilege.

"Home is a personal space. I take sessions in my bedroom and have a conscious practice to sleep in another room to distance myself from my workspace. I've had the good fortune to do that but everyone doesn't [P4]."

Participant 10 keeps an 'English-to-Hindi' list of significant mental health terms to cope with the language barriers that evoke stress for her.

Stressors experienced

This theme extracted varied stressors owing to internal factors and financial constraints. Participants elaborated on internal stressors as antecedents of burnout. These include fear, self-doubt, low frustration tolerance, self-stigma, and a lack of work-life balance. Four participants highlighted feelings of 'inadequacy' due to self-imposed pressure to 'help' clients and cater to the 'gap' between therapist-client expectations of the therapeutic outcome.

Finally, the overwhelming majority expressed concerns over the financial burdens of the career. Most participants juggle between multiple jobs and were dissatisfied with their pay scale. They emphasized the financial costs place training, personal therapy, and professional supervision further out of reach for aspiring MHPs from socio-economically disadvantaged groups and further the grave shortage of MHPs in India.

Viewpoints on personal therapy

Some participants maintained that personal therapy enhanced therapist effectiveness. Others view it as a privilege and disprove mandatory personal therapy. This section broadly categorizes therapists' preferences and mandatory personal therapy.

Sub-theme: Therapist's preference

The process of personal therapy begins from the point one decides to seek help. Participants considered professional aspects, such as the therapist's professionalism, experience, personal connection, theoretical orientation, ethics, and confidentiality before choosing a therapist. Some cited age, gender, similar values, familiarity, and sliding scale to be relevant considerations. The majority of participants considered the therapist's gender, their feelings toward the therapist, and their location. Few others preferred trauma-informed and queer affirmative therapists.

Sub-theme: Mandatory personal therapy

Participants shared their opinions about making personal therapy mandatory for students to ensure personal and professional development. While all of them emphasized the benefits of personal therapy, many of them offered conflicting views about mandating it. They argued that therapy being a privilege is not as urgent a requirement as basic needs. Other participants emphasized that the course requirement allowed them to seek help.'

"In India, often people don't go to therapy because they can't afford it. It's not an immediate need as rent, food, or nullities, so if you ask students to pay from their pockets knowing it's expensive then I feel it's unfair [P15]."

Two participants believed therapists who do not undergo personal therapy are clear 'red flags' therefore they don't refer clients to them. Most participants emphasized personal therapy in addressing their personal biases, facilitating empathy, and providing quality care. They viewed the semblance of the experience as an 'embodiment' of the theoretical concepts learned in classrooms.

"It's different to read about the Taj Mahal and different when you see the Taj Mahal. It's the same logic here [P10]."

Further, they raised concerns about the financial, cultural, and quality-of-care components of personal therapy in India. Few favoured making personal therapy mandatory in a way that is accessible and affordable to the students.

"It'd be helpful if it were pro-bono, a part of the course fee, or subsidized, especially in India. We don't have student insurance. So, if we're making it mandatory, we ought to make it financially accessible and ensure multiculturally competent care. Imagine if a future therapist has a harmful experience in therapy. What would it do to their understanding of the space? [P4]."

Several other participants critiqued mandating personal therapy for various reasons. First, an additional cost for personal therapy could discourage students from pursuing further education. Second, the students may have opted for personal therapy and may not want to continue but might feel obliged to continue it to create a favourable impression. Third, seeking therapy is a personal decision and may be beneficial when pursued willingly. Finally, a few others assert that while personal therapy was a 'protective factor' for MHPs but not going to therapy cannot become a benchmark to question their work ethic.

Being a client in therapy

Participants talked about their anxieties and vulnerabilities of being a client in therapy. It involves the role of personal therapy and being on the 'other side of the chair.

Sub-theme: Role of personal therapy

Most participants sought personal therapy to cope with personal crises. However, the motivations to continue therapy changed with time. For most, after entering the field, the reasons are connected to the profession. Two participants sought therapy to explore the process and orient themselves to it.

Sub-theme: Being on the 'other side of the chair

Participants revealed that experiencing the other side of the process made the process more 'human.' It enabled them to offer space to their clients, empathize with their vulnerabilities, and understand 'client resistance' before the first session.

"Without being a client, we wouldn't know how sensitive a client's headspace could be…how adding a smiley in a text would matter[P5]."

Participants shared that it was difficult to shed self-judgment and challenge the notion of 'having better coping because of being a therapist.' Personal therapy helped with pacing their work with the clients.

"It helped me realize how difficult certain things are as clients. With this knowledge, I tackle those concerns in the initial stage so that my clients don't have the same issue [P12]."

Being a client allowed the participants to witness different therapeutic interventions and deepen their understanding of the 'what' and 'how' of therapy in real-time. This may reduce the risk of being overtly technical in implementing techniques. Further, the experience provided them with a reference point for developing their therapist's persona. Some participants found it 'difficult' to 'let go of the therapist's chair' in personal therapy.

"At one point, I was analysing my therapy. I was trying to predict their next move, and compare it to how I would react if a client said this to me [P15]."

Participants noticed a different power dynamic and expectations upon experiencing both sides of therapy.

"As a client, I can cry in front of my therapist and sit in whatever way. Even though I practice a decentred stance in therapy, when I'm a client, I expect my therapist to be an expert and tell me what I want. In my practice, I don't advise as I can't make life decisions for my clients, but as a client, I want my therapist to do that for me [P10]."

Professional difficulties

The steep care gap deems India at risk of a mental health crisis shortly. Mental health stigma inhibits people from seeking help and drastically affects the field. The challenges highlighted by participants include the nature of work, stigma, private practice, and systemic difficulties.

Sub-theme: Nature of work

Participants described that the nature of their work can be profoundly distressing yet ultimately fulfilling. Given the occupational hazards of the profession, they expressed concern regarding burnout and compassion fatigue due to work overload. In particular, participants found it challenging/stressful to

manage high-risk situations. However, they indicated that the impact of different stressors may vary based on life stages.

Sub-theme: Stigma

In India, mental health stigma is a major barrier to seeking help. It motivates families to conceal or suppress distress due to perceived shame, substantially delays timely care, and negatively impacts both therapists and clients.

"Most of my clients whose parents fund them don't know it is for therapy. So, in case of any crisis that I have to manoeuvre through, I have to take the responsibility of finding alternate sources of care for the clients, especially if it's legal services [P3]."

"There's little support outside therapy. Even rich students look for a sliding scale because their parents don't know they are here. Ultimately, the therapist is at a loss [P5]."

Sub-theme: Private practice

In the Indian context, private practitioners experience significant challenges due to the absence of a regulatory body, and inconsistency in skill development training. The human resources shortage in India adversely impacts the accessibility of MHPs accessibility to professional supervision and personal therapy.

"In the Indian context, I've experienced challenges due to the lack of logistics and resources. Most of my energy goes into marketing myself on Instagram instead of spending that time building my resources [P11]."

Further, the income entirely depends upon whether a client shows up for a session. Thus, a lack of a steady income emerged as a common stressor.

Sub-theme: Systemic difficulties

All the participants expressed concerns about the lack of uniformity in licensing of MHPs in India. This enables pseudo-psychologists with fake credentials to pose as experienced professionals thereby spreading misleading information. Mistakenly working with these individuals may further aggravate clients' concerns and harm the reputation of the field.

"Many of my clients have come with damage done not because they didn't get therapy but because they went to the wrong therapists. While undoing the damage, I think about how the person is paying me to undo the damage that they paid the previous professional to do. There has to be a central body that governs the field [P5]."

Participants described that most available psychological assessments and mental health concepts are westernized and irrelevant to the Indian context. Thus, there is a dire need to develop Indian norms to understand and interpret the psychological risks in Indian patients. Further, Indian avenues of learning need to align with the requirements of MHPS in practice.

"*How do I concretize the westernized approach to something culturally relevant? How do I talk about the concept of boundaries to someone from a vernacular origin? They won't understand it because it's foreign to their culture itself. I'm not saying we don't use Indian ideas but are we speaking and learning enough about them? [P3]."*

DISCUSSION

The purpose of the study was to explore the opinions and viewpoints of MHPs toward personal therapy. Despite the diverse backgrounds of the participants, there was a consensus on the emerging themes and their clusters. These convey the role of personal therapy in the personal and professional development of MHPs, professional difficulties, the stressors experienced, coping mechanisms, viewpoints, and experiences as a client in therapy. While participants acknowledged the benefits of personal therapy, they highlighted therapy as a privilege and had conflicting views on mandatory personal therapy for students. Given the nascent stage of the mental health field in India, it appears crucial to make personal therapy an optional part of the academic programs, provided it is accessible, affordable, and assures quality care. Sodhi & Kakkar [14] assert that in the Indian context, where mental health stigma is rampant, personal therapy being a mandatory requirement would reduce resistance from family members and allow students to access it. Our reflexive analysis suggests that personal therapy may help MHPs access care, however, does not necessarily equate

to positive client outcomes. Participants emphasized the role of personal therapy in personal and professional development, from learning about their personal biases and triggers to later benefit their practice. Our results are consistent with observations shared by other studies [5-6, 15].

Therapy work is inherently isolating as the therapeutic alliance is one-sided where a therapist ought to be warm, empathetic, and genuine while keeping all their needs and emotions aside. The strains MHPs experience are threefold: intrinsic to the job, internal stressors, and systemic difficulties unique to the Indian context. All the participants, except for one, utilized their therapy as an explicit coping mechanism to alleviate stress inherent in the profession. One participant indicated that sometimes personal therapy triggered 'imposter syndrome' and made her preoccupied during the therapy sessions. Past studies [16-17] validate the viewpoint.

MHPs utilized personal therapy as a space to explore their internal processes and experience core conditions of person-centred care, enriching their work with the clients. Half of the participants felt that personal therapy contributes significantly to entering the client's inner world and alleviating distress. Others suggested that alternate avenues of care such as supervision (individual or peer), support groups, community care, and self-work during training might help achieve similar outcomes. Their view aligns with past research by Orlinsky [6] as they consider various avenues to expand learning possibilities.

As it's true for most qualitative studies, our results are tentative and do not offer decisive conclusions. The limitations lie in the methodological weaknesses comprising the sample size and procedure, which limits its generalizability. The sample was small and not representative of therapists in general. Different themes would likely have emerged if we were to study a different set of MHPs. In addition, some interviews took 45 minutes while a few others lasted 3 hours.

A serious systematic drawback was that the sample comprised MHPs deliberately interested in reflecting upon their personal therapy experience. Thus, it is likely that only those who experienced positive outcomes in their therapy volunteered to participate in the study. However, this was not a part of the criteria set by the researchers. It is worth noting that participants were readily able to recall instances when their personal therapy experience yielded unhelpful outcomes. Further, the perspectives of MHPs who did not opt for personal therapy have been amiss from the scope of the study. It may also be plausible that MHPs who are currently in personal therapy and had sought therapy in the past may have different viewpoints.

Finally, one potential limitation would be that the study did not account for the extent to which positive outcomes of personal therapy were influenced by impression management or a cognitive bias to represent a career in mental health.

The study broadly documented therapists' experiences of personal therapy. Therapists who have undergone personal therapy themselves stress its value. However, the concerns raised by participants about the professional difficulties and stressors experienced have further opened up avenues for future research. As the mental health field in India is in its nascent stage of development, it was crucial to evaluate the relevance of personal therapy for MHPs. Making personal therapy a part of the graduate and post-graduate curriculum may encourage young professionals to seek help. It might further validate the utility of the career and encourage people to view therapists as human beings. Moreover, it may normalize help-seeking behaviours and reduce stigma and discrimination toward people with mental health concerns. Some participants suggested that their viewpoints on personal therapy took birth during their professional training and through dialogues with their faculty members. This is particularly relevant for India, where courses run six out of seven days. The attitudes held by faculty members towards personal therapy have the potential to exert influence on the minds of young professionals. Future research can explore the role of professional training and faculty members on students' attitudes toward personal therapy.

While most participants sought personal therapy voluntarily, a couple of them undertook it because it was a mandatory course requirement. It would be interesting to compare the experiences and outcomes of personal therapy between the two groups. In addition, some participants cited supervision and other professional development alternatives to yield similar results. Future research could examine the learning avenues contributing to the professional development of MHPs in India. In addition, a longitudinal research design would provide valuable insights into the contribution of personal therapy to the personal and professional development of MHPs over time.

CONCLUSION

The present study offers unique insights through MHP's experiences of personal therapy. Participants reiterated that personal therapy allows for a deeper exploration of self, and therapists seeking personal therapy make the discourse enriching. The emerging themes and their clusters blended through participants' thoughts, feelings, and experiences of personal therapy. It would be helpful to include the relevance of personal therapy in educational curriculums to reduce the stigma toward mental health concerns and normalize help-seeking behaviours.

Table 1. Emerging themes and theme clusters

Emerging Themes	Theme Clusters
1. Professional development	1.1. Experiential learning 1.2. Therapist development 1.3. Overcoming personal roadblocks
2. Personal development	2.1 Improved emotional regulation 2.2 Personality development 2.3 Improved relationship with self & others
3. Working through countertransference	3.1. Experience of countertransference 3.2. Therapist's response to countertransference 3.3. Methods used to combat countertransference
4. Coping mechanisms	-
5. Stressors experienced	5.1 Internal factors 5.2 Financial constraints
6. Viewpoints on personal therapy	6.1 Therapist's preference 6.2 Mandatory personal therapy
7. Being a client in therapy	7.1 Role of personal therapy 7.2 Being on the 'other' side of the chair
8. Professional difficulties	8.1 Nature of work 8.2 Stigma 8.3 Private practice 8.4 Systemic difficulties

REFERENCES

1. Rupert PA, Morgan DJ. Work Setting and Burnout Among Professional Psychologists. Profess Psychol Res Pract 2005;36(5):544–50.
2. Dearing RL, Maddux JE, Tangney JP. Predictors of Psychological Help-Seeking in Clinical and Counseling Psychology Graduate Students. Profess Psychol Res Pract 2005;36(3):323–9.
3. Yalom ID. The gift of therapy: An open letter to a new generation of therapists and their patients. Basic Books: UK; 2002.
4. Norcross JC, Bike DH, Evans KL, Schatz DM. Psychotherapists who abstain from personal therapy: Do they practice what they preach?. J Clin Psychol 2008;64(12):1368-76.
5. Bike DH, Norcross JC, Schatz DM. Processes and outcomes of psychologists' therapy: Replication and extension 20 years later. Psychother Theory Res Pract Training 2009;46(1):19–31.
6. Orlinsky DE, Rønnestad MH, Hartmann A, Heinonen E, Willutzki U. The personal self of psychotherapists: Dimensions, correlates, and relations with clients. J Clin Psychol 2020;76(3):461-75.
7. Atkinson P. Personal therapy in the training of therapists. Eur J Psychother Counselling 2006;8(4):407-10.
8. Barnett JE, Baker EK, Elman NS, Schoener GR. In pursuit of wellness: The self-care imperative. Profess Psychol Res Pract 2007;38(6):603–12.
9. Dearing RL. Clinical and Counselling Psychology students in Personal Psychotherapy: Predictors of help-seeking. George Mason University: USA; 2001.
10. Norcross JC, Bike DH, Evans KL, Schatz DM. Psychotherapists, who abstain from personal therapy: Do they practice what they preach? J Clin Psychol 2008;64(12):1368-76.
11. Tay S, Alcock K, Scior K. Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. J Clin Psychol 2018;74(9):1545–55.

12. Aavrita A. The impact of self-stigma of seeking help & perceived social support on burnout among clinical psychologists. Kasturba Medical College, Mangalore Theses and Dissertations; 2021.
13. Braun V, Clarke V. Thematic analysis. American Psychological Association: New York; 2012.
14. Sodhi K, Kakkar S. Youth and counselling in India. Int J Pub Ment Health Neurosci 2014;1(1):23-33.
15. Grimmer A, Tribe R. Counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development--an exploratory study. Counselling Psychol Quart 2001;14(4):287–301.
16. Macran S, Shapiro DA. The role of personal therapy for therapists: A review. Br J Med Psychol 1998;71(1): 13-25.
17. Von Haenisch C. How did compulsory personal therapy during counseling training influence personal and professional development? Counsel Psychother Res 2008;11(2):148–55.

****

Acknowledgements – We like to thank all participants who participated wholeheartedly in the study.
Conflict of Interest – Nil
Funding – Nil