Training the Person of the Therapist in an Academic Setting

by

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The Person-of-the-Therapist Training Model

Theoretical Framework

The POTT model calls for mastery of self to meet the personal challenges clients present to us in both the technical venue and the therapeutic relationship. The model proffers three basic goals of the training. First, in order to be able to achieve this personal mastery in the professional context of therapy, therapists must *know* themselves, particularly the dominant personal challenges—psychological, cultural, and spiritual—that mark their lives, along with the history and current status of their struggle with these life themes. Models for the use of self normally focus almost exclusively on the emotional aspects of therapists' lives. The POTT model also lends weight to therapists' culture, values, and spirituality, which are as vital as their psychology in forming their outlooks toward life and its challenges. Second, clinicians must have the ability *to observe, have access to, and exercise judgment* about the emotions, memories, and behaviors that spring from their own personal themes while in the actual drama of the therapeutic process. Third, they must be able to *manage* their own person, with all the emotional, cultural, and spiritual forces operating in them, actively and purposely in line with their therapeutic goals. This last implies the ability of therapists to utilize their personal life history and inner emotional experiences to both *identify* with and *differentiate* themselves from their clients. Therapists must be able to recognize the common elements of the human experience in their clients' life-struggles to the point of being able to track clients' personal journeys through a conscious connection with their own personal journeys. Therapists must also be so grounded in their own life's pilgrimage that they do not so embroil themselves in their clients' affective churnings that they lose the emotional distance necessary to see, and consequently challenge their clients in their reality.

The predecessors of the POTT model focused primarily on self-improvement. Satir spoke of Freud's requirement of a didactic analysis for trainees as a way of preventing therapists from harming patients. Her goal was "the positive use of self [in order to] be of positive value in treatment" (Satir, 2000, p. 26). For her, this meant "becoming a more integrated self" in order to be "able to make greater contact with the other person [the client]" (p. 24). In contrast, POTT lends greater emphasis to training on *how* to use the self in the clinical context, than on how therapists achieve a certain level of personal growth and resolution as a precondition to an effective use of self.

Murray Bowen (1972), on the other hand, aimed for the family therapist "to listen and observe and function from a position at least partially 'outside' the emotional field of the family" (Bowen, p. 112). The training of therapists in the Bowen model "focused on helping the trainee work on his or her own emotional functioning, particularly in his or her own family" (Kerr, 1981, p. 262). Bowen asserted that those trainees who through coaching "had been most successful with their [own] families developed unusual skill and flexibility as family psychotherapists" (Bowen, 1972, p. 164). While the POTT model agrees that resolving personal issues frees a therapist to make a fuller use of self, it attends more emphatically to *how* the therapist works with what he or she brings of the self to the therapeutic process, especially to the existential reality of *today's* encounter.

Bochner (2000) speaks of the use of self in terms of the psychoanalytic concept of *countertransference*. He recognizes that countertransference "has been elevated from an obstacle to be avoided (Freud, 1910) to a tool that is often very useful in understanding the patient" (p. 1). The POTT model agrees except that it views the self of the therapist not just in terms of Bochner's definition of countertransference, namely "the therapist's reactions" to the client based on particular "characteristics of the client or client-family as well as of the therapist" (p. 1). The POTT model also considers the whole person of the therapist, with all that the therapist brings to the therapeutic relationship, including the therapist's human vulnerabilities, as assets through which the clinician practices his or her craft. Certainly, the POTT model concurs that the unique relationship every therapist forms with each client does indeed draw out reactions in both therapist and client that create the singular character of the human connection within the professional context of each therapeutic relationship. However, within the environment of this unique relationship therapists and clients do not simply react to each other. Therapists need to actively contribute from their life experience to the formation of a relationship that supports the technical structure of the therapeutic process. This is why therapists always bear responsibility for how they consciously and purposefully choose to work with and through the therapist–client relationship.

Both the Satir and Bowen models underscored that a positive change in the self of the therapist by its very nature translated into a more competent therapist. The POTT model (Aponte, 1994b, pp. 147–167; Aponte & Winter, 2000) encourages the efforts of therapists looking to "free" (Bowen, 1972, p. 164) themselves of dysfunctional ties to their own families and achieve a healthier self. However, it concentrates more closely on therapists' ability to use the person they are *today*, rather than who they aspire to be tomorrow. Moreover, in this article we are weighing in on the challenge of how one conducts this very personal kind of training (Aponte, 1994a) in an academic context.

The Underlying Philosophy and Structure of the Model in the Academic Setting

The POTT model referred to earlier in the Aponte and Winter (2000) article was originally put into practice with postgraduate therapists who committed to the training program one year at a time, but who could recommit from year to year indefinitely. They came from a variety of different agencies and practice settings. The trainees were pledged to confidentiality, and supervisors or administrators were not to be in the same group with someone over whom they held the power or responsibility to evaluate, hire, or fire. This structure allowed the participants

to freely explore their personal issues, and work on them as they manifested themselves in the trainees' clinical practice. The structure encouraged the pursuit of personal insight, and efforts to confront personal issues, although the trainers never assumed the role of therapists to the trainees. The trainers functioned more as coaches in this regard, who supported trainees' efforts to seek changes in their personal lives that would also further their professional development. Trainees also commonly received support to pursue personal therapy while in training. In the original application of the model, more attention was paid to trainees looking to achieve personal growth and change than has been considered appropriate in the academic setting of the Drexel program. For one, the private trainees faced no limits to how long they could continue in this personal training effort. Another reason for the difference was that trainees were contracting explicitly for this personal work, albeit related to their professional performance, which allowed for a structure that did not have to accommodate other considerations, such as the priorities of a graduate program to provide a complete professional training and educational experience.

It was the conviction of the need for more systematic training on the use of self that prompted Marlene Watson (1993), the program director of Drexel's Couple and Family Therapy Department, to invite Harry Aponte to test his POTT model at Drexel. The Drexel program had had a course, "The Therapist's Experience," that helped students become aware of their family-of-origin issues (Braverman, 1997, pp. 352–353), but did not take the next step to teach them what to do in their clinical practice with what they had learned about themselves. It certainly did not attempt to teach them how to make use of their own life's struggles and vulnerabilities to become more insightful and empathic therapists. This latter concept presented the most unique feature of the POTT model.

The person-of-the-therapist training was introduced expressly to hone students' skills in the use of themselves in their therapy. This goal calls for heightened self-awareness at a deep personal level, and the consequent assumption of greater responsibility for one's self and one's issues in the therapeutic encounter with clients. The cornerstone of this personal exploration is the concept of the *signature theme*. The philosophy behind the term is that we all live with our very own unique-to-each-person signature struggles with ourselves and with life. Our biology, our family histories, our gender, race, ethnicity, cultures, and spirituality, along with the effects of the choices we have made in life, all shape who we are today. Woven into the fabric of these life experiences are hurts, disappointments, and losses that form the core of each person's lifelong personal emotional vulnerabilities, which we here label *signature themes*. These personal themes imprint themselves into our attitudes, emotions, and behaviors in both our personal and professional lives.

However, just as in the private version of this model, a fuller, conscious connection with self requires that students be more empathic toward themselves about their struggles with their personal vulnerabilities and failings. This self-acceptance (not to be confused with self-pity or self-indulgence) promotes a freedom from the tyranny of shame about their hang-ups that allows them to actively engage with their vulnerabilities in the service of their therapeutic efforts. Personal growth and change often follow the realization of this freedom, a desirable but incidental result of the training. Students wanting to pursue personal growth often also seek out personal therapy for themselves.

By the very nature of our work, we as therapists deal with the emotional wounds of our clients. We conduct this undertaking of therapy through our own wounds, and so may properly be called "wounded healers" ([Nouwen, 1972](#)). Through our own life's struggles we understand and empathize with the struggles of our clients. Through our shared wounded humanity we connect at an intuitive depth with the personal vulnerabilities of our clients. Hence, the centrality of the concept of the *signature theme.*

Moreover, the ability to relate to clients' efforts to contend with their life battles will be proportionate to the commitment we, as therapists, make to challenge ourselves to engage the journey of our own personal growth and change. This freedom to face our signature themes and grapple positively with them opens us to viewing these personal wounds as portals through which we can reach beyond our usual limitations to new insights and new behaviors. This philosophy about life's troubles, especially those we carry within ourselves, as special opportunities for personal growth and change lies at the center of the POTT model. The school that takes on this training design will be carrying this core philosophy into the classroom and supervisory session.

The POTT Model in the Drexel Curriculum

The Master of Family Therapy Program is housed in the Couple and Family Therapy Department at Drexel. The MFT program provides students with full exposure to the major family therapy approaches, and makes a special effort to include schools using larger system and cultural context frameworks. The first year of the program is designed to introduce the foundational knowledge and theories of the field, and to start students in practicum experiences that will socialize them to the profession. It is with the goal of orienting students to the connection between the personal dimension of therapy and technical facet of clinical work that the faculty decided to introduce POTT to students in their first year instead of later in their training. Person-of-the-therapist training would expose these aspiring therapists to the notion that their own person will be engaging very real people with very human struggles, not unlike their own. They would learn to relate to the personal dimension of the therapeutic process even as they become familiar with the theories and techniques of the various schools of family therapy.

Because the early applications of the POTT model ([Aponte & Winter, 2000](#)) were implemented in private settings with graduated therapists, the Drexel program faced a significant task in adapting the model to an academic setting with novice clinicians. The faculty considered POTT's philosophy of normalizing the challenge of our human struggles in life's journey a key contribution to the orientation of aspiring therapists. Giving permission to students to not deny and hide their human flaws along with their personal struggles is an attitude reorientation that challenged their assumptions and fantasies about what makes a "good" or "flawless" marriage and family therapist. Although personal and professional improvement is a lifelong goal, the people who are doing the therapy at any moment in time are the people they are right then with all their human failings. The students could now consider the challenge of their own humanity as a bridge, instead of an impediment, to their clients' humanity.

Implementation of the Model

The Drexel program first tested the model in the fall of 2002 with a volunteer pilot group of six students (refer to "Reflections of Two Trainees,"Lutz & Irizarry, in press). The faculty witnessed a significant growth in the clinical sensitivity and acuity of the students who persevered through the volunteer POTT experience for the full two years. This exposure also confirmed the usefulness of the person-training in helping to identify problems for the structure of the academic program. Because the pilot was a no-credit, volunteer experience, it was an add-on to an already demanding curriculum. The pilot highlighted how the training needed to be fully integrated into the schedule and curricula of the program. Adding such a demanding experience as an extra to a very full schedule drew complaints and dropouts. In the third year, the POTT experience became part of the curriculum for all first-year students, and their class load was adjusted accordingly. (The traditional second-year group supervision by POTT-experienced faculty simply kept the first-year POTT groups intact, making for a primary clinical focus enriched by the person-of-the-therapist perspective.) For the faculty the opportunity of the program to systematically introduce person-of-the-therapist training offered a means not only to enhance students' clinical skills, but also to identify early problematic issues of individual students. Faculty could act promptly to offer students specific support.

The structure of the new classes aimed for no more than ten students per class with two faculty members to lead. Classes ran on quarters. The first quarter emphasized students identifying their personal signature themes. The second quarter looked for students to recognize how their emotional issues and personal values manifested themselves in their work with clients. The third quarter asked students to focus on choosing how they utilized their personal selves therapeutically in their relationships with clients and in the technical aspects of their work, from assessment to goal setting to interventions. Classes were scheduled for 2 hr, with one student presenting each hour. In the first two quarters, they submitted ahead of time a write-up that followed either the *personal* or the *clinical* outline (see appendix). When presenting on their signature themes, students described either a personal incident or clinical experience that highlighted their personal issue. When they presented their clinical work they were expected to play a segment of videotape that they believed provided a good example of their personal issues manifesting in their clinical performance. In both situations the individual student would work with the trainers for about 50 min, leaving the last 10 min for the other students to react to the presentation. The instructions for the nonpresenters were for them to be supportive while offering personal insights about how the presentation spoke to their issues. Sharing the commonality of experience would hopefully promote self-acceptance and empathy among the students. In the third quarter, students had the opportunity to receive live supervision with families played by paid actors who simulated struggles with preplanned issues. The students were instructed to pay special attention to their use of self, and to fill out a questionnaire after the session related to the use of their person (see appendix).

The Role of Trainers

The decision from the beginning was to use two trainers to lead the groups. Past experience in the private sector had demonstrated that the added trainer provided another source of emotional support, guidance, and insight to the process. Each coleader offers another world vision from the

viewpoint of his or her personal life experiences, and possibly ethnicity, gender, culture, and spirituality. In addition, the cotrainer serves as a professional complement and emotional support to his or her partner. The personal nature of the presentations is emotionally demanding on the trainers, who need to be alert not only to the needs of the student presenting, but also to the other members of the group who are resonating and reacting to the presenter's material. The second group leader is that extra needed resource.

Before each presentation, the trainers review the student's written material and discuss the content. They coordinate their thinking about the issue the student is presenting, and their strategy for handling it. Over time the trainers articulate specific goals and strategies for each student linked directly to how their signature themes relate to their clinical performance. For each student presentation one trainer takes the lead. They usually assume the lead by rotation, but may for particular circumstances decide that on that day one trainer or the other should lead with a particular student. Trainers need to be highly conscious of their particular process with each presenting student.

The very special challenge faculty face in conducting such personal training in an academic setting is the matter of helping students connect deeply with and learn to work with their personal life issues clearly within the boundaries of their roles as therapists. In a process parallel to what students are to learn, the trainers are sensitive to how they use themselves in their work with the presenting students. However, what has to be firmly established from the beginning with the training faculty is that the training is not therapy (Aponte, 1994a). It is a personal preparation for doing professional counseling.

The trainers are guided by three basic objectives. They are to help students conceptualize their signature themes, develop the ability to recognize and be in touch with how their themes relate to their therapy, and, finally, develop the skills to actively utilize their themes for doing better therapy. Conceptualizing the signature theme calls for putting a name and workable description to the signature theme. The aim is to help students gain a handle on their thematic life struggles, making it easier for them to reference their own personal experiences when they are thinking about how to work through their person in therapy. The label gives them some emotional distance from their history and life experience so that they can call on it as needed, and not get so lost in the emotional intensity of their personal issues that they cannot use them as therapeutic tools.

The trainers also want students to achieve a certain comfort and familiarity with their issues to gain them greater freedom to work with and through their personal experience in the therapeutic process. They seek to have students reach into how they experience the memories, needs, hurts, and emotions connected to their signature themes in the context of doing therapy. They attempt to help students recognize how their personal values and worldviews shade and shape their perspectives on clients and client issues. They look to have ongoing dialogue with students about their personal stuff so that it comes to feel quite natural for students to look into themselves as they engage with clients. The faculty leaders help train students to interpret their personal experience in the therapeutic process as clues to understanding their clients, as signals to what in themselves they may be able to use to better connect with their clients, and as indicators about how to utilize themselves strategically in the implementation of technical interventions.

Two Brief Examples

We will relate the stories of two students here, focusing on one's efforts around her signature theme, and the other's personal struggle with a case that touched on both emotional and cultural issues for her.

We will call the first one Mary. She is in her mid-twenties and is a first-year student. Her mother died when she was very young. She is an immigrant who was raised by her father and stepmother in extraordinarily difficult social and economic circumstances. She initially identified her signature theme as her anxiety about doing things "perfectly," especially as it pertained to her academic performance. She laid the blame at the feet of her stepmother. She told the story of being in the fourth grade and receiving all A's on her report card except for one B. Her stepmother "yelled" at her about that B, and called her "all sorts of names." Her stepmother wanted to raise her as an educated, independent woman who could support herself whatever life circumstances she faced. Mary grew up fearful that she would never become as successful as her stepmother expected her to be.

It follows that initially Mary was fearful in class that her presentations would not be good enough to avert criticism from her teachers. Her anxiety could be disabling because when anxious she would be overcome with tears, and find it very difficult to give voice to her feelings. She worried about "freezing" with clients, so fearful of saying the wrong thing that she would be unable to speak.

In later class presentations and in her journal notes, she dug deeper into what was going on inside her. She got in touch with how the death of her biological mother at a tender age left her with the fear of losing a second mother. She also came to realize how "enmeshed" she was with her stepmother. A key insight she had during the course was that her stepmother, anxious for her husband's approval, was trying to prove herself a good wife and mother by making Mary a success. It became clearer to Mary that, on her part, she had grown to believe that for her to gain the acceptance of this new mother, it was crucial that she fulfill her stepmother's aspirations for her. Mary reported that through the training experience she had begun to realize that she could "survive without having to always please [her stepmother]." Today, she has come to see that she does not need to continue to carry her stepmother's anxieties. From these insights, Mary has drawn some implications for her clinical work.

This is important in my future clinical work. . . . I don't think I have to necessarily "work-out"— but understand my many issues with my [step]mother so that I am aware of how these issue[s] can paralyze me in my personal life as well as in my clinical work. If I am aware, then I might be able to treat a client mother as a human being if she reminds me of my [step]mother. If I am able to treat her like a human being then I will be able to build a relationship with her.

Mary also progressed in her ability to manage her anxiety. She began to appreciate that she was more afraid of the "feeling of failure" than of failure itself. Over time she became more comfortable with the notion of failure as a universal human experience, rather than it being her own private nightmare. The emotional distance from these intense reactions gave her greater ability to harness her emotions when she became anxious. Subsequently in one of her class

presentations she played a video segment of herself frozen into the dreaded silence on witnessing a client mother harshly criticize her son. However, during the presentation she recognized that she had not been able to address the behavior because she felt "critical" of the mother who was treating her son as Mary's stepmother had treated her. She subsequently reported that in her next session with the client, she was able to see past the behavior and engage with the mother as a person, as woman to woman.

In the second case, we also have someone who as a first-year graduate student was a novice to the world of therapy. This student, whom we shall call Sue, is in her thirties; becoming a therapist is a second career. She too is an immigrant. Sue grew up in a large family where she was the oldest, and carried a great deal of responsibility for the care of the younger children. In her family of origin she had accepted her role as culturally expected. However, in retrospect she recalls feeling great pressure to reach all of her mother's standards for the care of the children, putting aside her own needs as a young girl.

Sue at first identified her signature theme as needing to be "in control." Behind that need lay much anxiety about making mistakes, of failing. She was also fearful of confrontation, arising from her dread of disappointing her mother. In that light it is understandable that she repressed feelings having to do with her own emotional needs. Over the course of a number of presentations, Sue became progressively more conscious of how deeply suppressed were her emotions. In her clinical work she became aware of how she put pressure on herself to ensure results, but with little attention to what was happening in the process to her relationship with clients. As a consequence of her presentations, she awoke to the connections between the pressure to succeed as a new therapist and to perform perfectly as a parentified child.

On one occasion she presented a case that highlighted in bold type this link between the personal and the professional. Sue described an immigrant family from her own country in which the parents had left their very young son behind when they moved to the United States to set up a business and start a new life. Their son, who is now 12, did not rejoin his parents until he was 9 years old. As a result of the early separation, the boy had not bonded with his parents, and became a major disciplinary problem for them. In school he was inattentive and unproductive. He grew to be a source of embarrassment and distress for his bewildered parents. His behavior was culturally dissonant to them.

The boy's father presented Sue with the greatest challenge. First of all, the parents worked in the family business day and night, and had little time to develop a relationship with the boy. Yet, the father in particular expected obedience, respect, and industriousness from his son, as fitting for a child of their culture. Sue, who had painful childhood memories of just such demands on her, had difficulty witnessing these pressures on the boy when he was receiving so little nurturance from the parents. She expressed it in these terms:

However I felt frustrated that Tom's father only focused on Tom's problems. He did not spend time with Tom. He insisted that only harsh discipline would change Tom's behavior.

Sue was candid about how her cultural training about male authority figures affected her reactions to the father:

I felt that I was intimidated by Tom's father. He was trying to use his parental authority to discipline Tom. He wanted me to be on his side to point out Tom's shortcomings and force Tom to change. He tried to control his son and my therapy. And yet, I hesitated to confront him.

In class, Sue showed a video clip of her session with the father and son. With the help of the group leaders she readily saw how the urgency with which she tried to convince the father of the wrongness of his approach was only resulting in a therapeutic logjam. The father became only more insistent on the need for harsh discipline. As Sue pressed her point, he shut out her voice.

Once Sue accepted the invitation to reflect on her own early home life, she was able to gain some distance from the intensity of her feelings. She had viscerally identified with a boy who received little parental nurturance, and whose experience of his father was of intimidating demands to conform and perform—all too close to what she knew as a youngster at home. Taking a fresh look in class at what was happening between her and the father freed her to look beyond the father's stern demeanor. She considered the likelihood that he was anxious about seeing his son as a failure, and feeling guilt about the years he had left his son behind. Sue eased up on the pressure she felt to change the father's attitudes and behavior. She decided to meet with both parents alone, making space to become better acquainted with them. She knew they needed to feel empathy from her about their pain over their son's troubles. Hopefully her patience and understanding with them would allow them to be more patient and understanding with their son. She would give them something of what she had wished she had had from her parents, and what she believed their son needed from them. Sue was able to use her life experience to convert the pressure "to do" into the compassion to understand. She voiced that this training episode represented a pivotal shift within her in her personal view of herself and the use of herself as a therapist. The changes in Sue were evident in her follow-up presentations. As she let up on the self-imposed pressure to perform, she related more to the people who were her clients.

Other Training Aides

Students are eased into this intense personal training experience with a period of time intended to facilitate not only their becoming acquainted with the model, but also their getting a more personal feel for the faculty. They hear descriptions of the training model, the thinking behind it, and how it works. Students also view and discuss videotapes of therapy sessions that the teachers use to demonstrate how therapists can and do work with and through their own person. They engage in discussions based on readings about the POTT model. Some of the reading materials used in this introduction to the POTT model are as follows:

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    The Use of Self in Therapy, Second Edition ([Baldwin, 2000](#))

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    The Person and Practice of the Therapist: Treatment and Training ([Aponte & Winter, 2000](#))

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How Personal Can Training Get? ([Aponte, 1994a](#))

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Spirituality: The Heart of Therapy ([Aponte, 2002](#))

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The Soul of the Marriage and Family Therapist ([Aponte, 2003](#))

They get a chance to share with the faculty and each other questions and concerns about what to expect. The teachers begin to create an environment in which it is normal to speak of the personal in the context of the professional. The students need to feel some comfort and trust in an unusual class environment, one that is going to call for some personal risk.

Videotaping and journaling are also used to help students better see themselves and get in touch with their own process during the training. Each training session is videotaped so that students can review their own presentations after class. When presenting, students expectedly are anxious, and their memories of what happened are colored by their emotional state during the work on their material. Viewing the tape of their presentation *with another student who was present* gives them some emotional distance from the experience, and allows them to better take in what they learned. At the end of the year, students receive a CD recording of all their presentations. Reviewing the videotapes also helps them to better hone the skill to observe themselves, and draw judgments about themselves while in the emotional throes of a therapeutic encounter.

Students are also asked to maintain journals of their experience of the training sessions, whether they are presenting or observing, which they are to submit to their trainers each month. Like the videotaping, this is another learning device meant to help them develop their ability to reflect on their personal experience in an environment dealing with their professional lives. This platform of self-observation prepares them to create the distance that will allow them to make deliberate choices about how to use themselves while engaged with clients. The journals also serve the faculty as a data source about the students' individual progress, as well as about the effectiveness of the training program in general. The article in this trilogy of papers entitled "Reflections of Two Trainees" ([Lutz & Irizarry, in press](#)) provides a window into the students' views of this experience.

Discussion

Challenges to Implementation for Students

Because this training model is very personal, it follows that the school needs to articulate a well-defined policy about the treatment of personal information. However, this is easier said than done because enforcing strict confidentiality about a student's personal material that is shared in POTT classes is impossible in a program that expects students to purposely take into account

their personal issues when talking about their clinical practice. Nevertheless, an important distinction can be made between students' signature themes and their personal histories. On the one hand, personal signature themes are core issues that students will need to address openly with trainers and supervisors to the extent they affect their work with clients. On the other hand, their personal histories, which are tied to their genograms and explored in the POTT classes, need not be shared in other parts of the program.

At the time of this writing, the school has not codified its confidentiality policy. Students are asked to keep what they learn about each other in the POTT class among themselves, and to speak to such personal information outside the POTT class only to the extent that the individual being referenced is present and invites the conversation. The only exception to this agreement occurs when students journal on the impact of other students' personal information on them as part of their personal reflections in their confidential class journals. Students are told not to feel obligated to reveal personal history in other classes, or in group or individual supervision. Moreover, it is made clear to them that in all circumstances what they decide to reveal about themselves to faculty and other students is strictly their choice. Students are made aware that the personal material they share in their POTT presentations is not kept confidential from faculty who have responsibility to make judgments about their professional development. However, school faculty do not share students' personal histories from their POTT classes with field supervisors or anyone else in their field placements. The school is working on a confidentiality policy for this program that treats respectfully personal information about students in an environment that encourages the purposeful and responsible integration of the personal with the professional on the part of a therapist.

Nevertheless, it is worth noting that while the public presentation in-group may at first feel risky to a student, it also produces benefits not available in individual supervision. Our experience has been such that as students see others presenting on their signature themes, they grow more comfortable sharing their own stories. More importantly, however, they often tell of gaining insights from seeing issues like their own being addressed in the presentations of their colleagues that they had not gleaned when making their own presentations. As witnesses to their colleagues' presentations, students are less anxious, and therefore less in need of defending against self-insight. They also feel freer to do more creative thinking about how they can utilize in their clinical practice what they are learning about themselves. Finally, they have a chance to exercise an empathy toward their colleagues that they need for themselves about their own issues, and eventually for their clients whom they have learned also share similar issues. The faculty were able to note these changes in the students not only from their ongoing presentations in class, but also from what some of the same faculty saw of the students' clinical presentations in group supervision. However, the most compelling feedback came from the students themselves, who spoke in class and journaled about how much more they were able to see of themselves in their interactions with clients, and how much more open emotionally they were to their clients. They felt more personally in command of themselves when working with clients.

Challenges to Implementation for Faculty

For faculty, they found a need to reorient their attitudes about the place of therapists' hang-ups in the conduct of their therapy. The faculty had to learn to prioritize not how difficult were

students' personal issues, but how well they were able to responsibly work with and through their issues for the benefit of their clients. The faculty needed to learn to measure not the brokenness of students, as much as their capacity to use that brokenness to make themselves better clinicians. Nevertheless, ethically the program must intervene when students' personal issues override their ability to be helpful to their clients. At times, students needed some individual help from their faculty advisors with issues raised for them by their presentations. Of course, when all else fails, counseling out of the program is always the option of last resort.

Administratively, the POTT facet of the Drexel program required careful coordination. The Associate Director of the master's program who was responsible for organizing its clinical components also oversaw POTT. This role involved assigning students to their personal training groups, as well as to their practicum, while interfacing with teaching faculty and clinical supervisors. The coordination needed to take into particular account the personal match-ups in the training and supervisory groups. The arranging sought a healthy mix in the groups by gender, age, race, culture, and life experience. What was learned about students' personal life and issues also influenced decisions about the kind of clinical experience these novice therapists should first have.
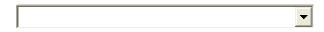
In another related area, an important concern was providing orientation for all clinical supervisors to the POTT model, and its implications for individual supervision. The supervisors were required to participate in an orientation, and were also offered the opportunity to volunteer time for a direct personal experience of their own with the model. The program emphasized how supervision, in contrast to training, within the POTT model is exclusively focused on students' use of themselves within their clinical practice. Unless the issues directly relate to their clinical practice, supervisors are not to explore personal material of the students in supervision even if the students volunteer personal information. Personal material is to be looked at only in the light of how it affects the cases students present for supervision, and to determine how to use the self more effectively with clients. The outline developed in the accompanying article of this trilogy of papers, "An Instrument for Person-of-the-Therapist Supervision" (Aponte and Carlsen, in press), is designed specifically to help supervisors and students take into account the use of self in the context of a clinical focus. Moreover, a crucial message for supervisors was that the POTT model is not limited to any one school of therapy, but can be applied across all therapeutic approaches in which therapists are expected to make a conscious use of self in their clinical practice. The training experience in school works with both the personal and the professional while the supervisor's job is to remain focused on the clinical.

Positioning POTT in the Curricula

Administrators and faculty have learned that the POTT experience calls for some special planning consideration. There needs to be recognition that students engaged in this personal training will undergo some significant emotional reactions. When these personal training classes are held, thought should be given to the emotional energy required of students, and allow for downtime after the classes of at least an hour.

Moreover, in order for POTT to be successfully implemented, faculty requires personal exposure in the model, and at least two years of apprenticeship conducting POTT groups. Faculty who

aspire to be trainers in the POTT model are expected to undergo a personal training experience with a seasoned trainer on the relationship of their signature themes to their clinical practice (or supervisory practice). This training experience should mimic the training they will be offering, and should therefore be done in-group, with videotaped examples of their work, and with at least one personal and one clinical presentation. Like the students, faculty members should only expose personal themes that they are interested in exploring in relation to their professional work. The two-year apprenticeship with a senior trainer should follow. Once the personal training is launched with the students, a monthly meeting of the training faculty to share experiences, questions, and issues regarding the training would also be supportive of the entire training effort. Dealing with the personal experiences of students presents issues that affect their academic and clinical development. Inevitably questions arise about how best to handle delicate and sometimes highly charged issues that surface in the training for the students. Faculty will benefit from sharing their collective wisdom and support. The greatest challenge to date in implementing the POTT program has been in finding the time to train faculty to lead these labor-intensive groups.

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Conclusions

Person-of-the-therapist training is not just a method. It is also a philosophy. It is a way of thinking about the use of self in therapy. It is a belief that because the medium through which we do therapy is our "selves" in relationship with clients, we need training about the use of our own person—our history, culture, values, family life experiences, personal psychology, and thematic personal struggles—in the development of ourselves as therapists. A key component of this philosophy is the view that we are wounded healers, and that these very wounds can enable us to relate more effectively to the wounds of our clients. However, this use of self requires not only self-knowledge, but also the skill to use this self-awareness in clinical practice. The POTT experience is meant to complement and infuse life into the technical formation of the professional therapist. The POTT training is now an integral part in the first-year curriculum of the Drexel program. In the second year the group supervisors, who have been trained in the model, will be overseeing the cases from a person-of-the-therapist perspective. Whether to extend the intensive formal courses into the second year is being considered.

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Appendix

Person of the Therapist Training Outline for Case Presentation

Your Signature Theme(s).

(Briefly describe how you conceptualize your signature theme(s) today.)

Case Identification.

(Names, ages, and relationships among clients; auspices of treatment; when treatment began, and number of sessions to date)

Genograms: Client's & Yours.

(To be attached)

Focal Issue.

(What you and the clients have agreed to work on)

Clinical Hypotheses.

(Contributing individual and family dynamics; history and motivation that help explain why the client(s) faces this issue today)

Treatment Process—Clinical Strategy & Use of Self.

(Describe your therapeutic strategy, the actual course of the therapy, and its effectiveness and lack of effectiveness. Include how you purposefully used yourself.)

Person of Therapist.

(How are you meeting the personal challenges you face in this case in regard to both the focal issue of the case and the relationship with the client?)

Questions.

(What specific questions do you have today about the case, your clinical strategy, and your use of self?)

Person of the Therapist Training Personal Outline

Your Signature Theme.

(Briefly remind the group of your signature theme. This formulation should include modifications or insights you have made from previous presentations.)

Your Genogram & Client's Genogram, if presenting yourself in the context of a case.

(To be attached)

The Event Reflective of the Signature Theme You Will Present on Today.

(Describe a personal or clinical event that may help us understand how your signature theme presents a challenge for you today.)

Your Hypotheses About the Significance of the Event.

(What individual and family dynamics—history and motivation—do you believe explain what drives the issue in today's event?)

How You Tried/Are Trying to Meet the Challenge.

(How effective have your efforts been, and what have you learned about yourself from this experience?)

Person of Therapist.

(How do you believe these personal issues play out in your clinical practice?)