

## Review Article

# The use of personal therapy by psychiatrists and psychiatry trainees: a systematic review

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### Abstract

**Background:** It is widely acknowledged that personal therapy positively contributes to the continued personal well-being and ongoing professional development of mental health professionals, including psychiatrists. As a result, most training bodies continue to recommend personal therapy to their trainees. Given its reported value and benefits, one might hypothesize that a high proportion of psychiatrists avail of personal therapy. This systematic review seeks to investigate whether this is the case.

**Aim:** To identify and evaluate the findings derived from all available survey-based studies reporting quantitative data regarding psychiatrists' and psychiatry trainees' engagement in personal therapy.

**Method:** A systematic search for survey-based studies about the use of personal therapy by psychiatric practitioners was conducted in four databases and platforms (PubMed, Scopus, Embase and EbscoHost) from inception to May 2022 following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Studies were assessed for quality using the quality assessment checklist for survey studies in psychology (Q-SSP) and findings summarized using narrative synthesis.

**Results:** The proportion of trainees who engaged in personal therapy ranged from a low of 13.4% in a recent UK based study to a high of 65.3% among Israeli residents. The proportion of fully qualified psychiatrists who engaged in personal therapy varied from 32.1% in South Korea to 89% in New Zealand.

**Conclusion:** This review represents the first known attempt to collect and synthesize data aimed at providing insights into the past and current trends in psychiatrists' use of personal therapy across different geographic regions and career stages.

**Keywords:** Psychotherapy; personal therapy; psychiatrists; psychiatry trainees; systematic review; statistics/numerical data

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### Introduction

Psychotherapy is widely viewed as a key component in the delivery of comprehensive and holistic mental health care. Worldwide, best practice guidelines consistently recommend so called 'combination approaches' (combination of medication and psychotherapy) as the gold standard in most affective and anxiety-based disorder treatments (e.g. Cuijpers *et al.* 2014; Davidson 2010; National Institute for Health and Clinical Excellence 2009; CANMAT 2016).

Given the importance of psychotherapy in the management of most mental health conditions, psychiatrists and psychiatry trainees are expected to possess reasonable levels of knowledge and understanding of the different therapeutic modalities on offer to their patients. Therefore, most psychiatry training programs and accrediting bodies worldwide have minimum requirements regarding trainees' achievement of core competencies in psychotherapy.

In the USA, psychotherapy training is considered a 'defining feature and core value of psychiatric education' (Calabrese *et al.* 2010, p. 13). The most recent program guide of the Accreditation Council of Graduate Medical Education (ACGME 2020) requires residents to develop competence in managing and treating patients using both brief and long-term supportive psychotherapeutic modalities.

In Europe, the Union Européenne des Médecins Spécialistes' (UEMS) charter for training in psychiatry has long considered 'experiential training in psychotherapy' as a 'compulsory component of psychiatry training' (Brittlebank *et al.* 2016, p. 161), adding 'it is crucial for psychiatry... that all psychiatrists are qualified to use psychotherapeutic interventions in everyday treatment of psychiatric patients' (Union Européenne des Médecins Spécialistes 2004).

The UK's Royal College of Psychiatrists (RCPsych) curriculum for core training in psychiatry highlights the importance of psychotherapy in its clinical skills section, and argues that trainees must 'demonstrate appropriate psychotherapeutic capabilities through having delivered treatment in a minimum of two psychotherapeutic modalities over both short and long durations' which is appropriately supervised 'under the governance of the

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Medical Psychotherapy Tutor' (Royal College of Psychiatrists 2022, p. 9). The Irish College of Psychiatrists' curriculum (2016, p. 13) similarly states that 'psychotherapy is a key aspect of psychiatric practice' allowing psychiatrists to 'develop and maintain therapeutic alliances with patients'.

In acquiring required psychotherapy knowledge and skills, trainee psychiatrists are typically expected to both attend didactic psychotherapy teaching and participate in some form of practical learning such as delivering psychotherapy to patients under supervision.

Another widely recognized way to enhance one's knowledge and understanding of psychotherapy is by experiencing one's own course of psychotherapy (Brenner 2006). Most European organizations and training bodies thus consider personal therapy a valuable resource for psychiatry trainees. The European Federation of Psychiatric Trainees (EFPT) views 'personal psychotherapeutic experience' as a 'valuable component of training' (EFPT statement, 2014-2015, p. 4). Similarly, UEMS include 'personal therapeutic experience' in the section covering the 'content considered essential for training in psychotherapy as part of training for psychiatry' (Union Européenne des Médecins Spécialistes 2004). According to Johnson (2017) 'a strengthened statement regarding the crucial place of personal therapy' was introduced to the UK curriculum in 2015 (Royal College of Psychiatrists, 2010/2015a), arguing that 'to develop and maintain the ability to bear and think with people who experience extreme mental disturbance' it is crucial for psychiatrists to have a 'reflective space in which to examine their own emotions in response to the people who come to them'.

Ample evidence exists that mental health care providers across several disciplines including psychiatry, view personal therapy as 'an indispensable element of both their continued personal well-being and their ongoing professional development' (Bike *et al.* 2009, p. 19), and clinicians who engage in personal therapy tend to report 'more personal growth and positive changes, and less burnout' (Linley & Joseph 2007, p. 392). By engaging in their own psychotherapy therefore, specifically vis-à-vis psychoanalytic or psychodynamic oriented psychotherapy, trainees can develop the capacity to recognize and understand the impact of their work on the self and the effect of unconscious identifications with their patients (Brenner 2006).

## Objective

Given the reported value and benefits of personal therapy outlined above, one might hypothesize that high numbers of psychiatrists and trainees elect to have personal therapy. This systematic review was conducted to assess whether this is true.

The objective of this review was thus to identify and evaluate the findings derived from all available survey-based studies reporting quantitative data regarding psychiatrists' and psychiatry trainees' experiences with and opinions of personal therapy.

## Methods

### Search strategy

A systematic review was conducted using the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guidelines (Page *et al.* 2021). A literature search was conducted across the following four databases and platforms: PubMed platform, Scopus, Embase and EbscoHost platform from inception to 15 May 2022.

We used two search concepts: 'personal therapy' and 'psychiatrist'/ 'psychiatry trainee/resident', linked by the Boolean operator 'AND'. Search terms included relevant synonyms, truncations and Mesh terms. Full details of search terms used for the PubMed search are shown in Appendix 1. A similar search was conducted with the other databases and search platforms.

### Inclusion/exclusion criteria

Inclusion criteria were that studies had to report data on the use of personal psychotherapy amongst psychiatrists or psychiatry trainees. Studies were required to have been published as peer-reviewed research papers. The publication date was restricted to the last 30 years (May 1992–May 2022), as this was deemed to be sufficiently representative of contemporary trends in psychiatric practitioners' use of personal therapy. Studies were excluded if they were not written in English. Studies were also excluded if they were not concerned with medical professionals specializing in psychiatry. Studies were included if they reported on the personal psychotherapy experiences of other categories of clinicians as long as psychiatrists were included among the sample of participants surveyed.

### Study selection

The primary reviewer (RA) screened all titles and abstracts and identified articles as being either 'potentially relevant' or 'irrelevant' to the research question based on the inclusion and exclusion criteria described above. Full-text copies of articles identified as potentially relevant were retrieved and individually assessed for inclusion in the review stage. Further exclusion criteria were applied to determine suitability for inclusion in the final list of included studies (see Fig. 1). Further articles were identified through citation searching and review of relevant gray literature. Discrepancies were resolved by consensus achieved through the supervision process of this study.

### Data extraction

Data from the included studies were extracted and inserted into a table using the following headings: authors and date, study location, objectives, study methods and design, sample size and demographic characteristics of participants, response rate and results/key findings.

### Data synthesis

Meta-analysis is defined as a type of statistical analysis in which the multiple quantitative effect estimates extracted from different studies are grouped together to produce an overall effect estimate. In this review, meta-analysis statistical synthesis was considered inappropriate because the majority of included studies did not report effect estimates along with a measure of precision, such as confidence interval or standard error. There was also considerable heterogeneity in the included studies in terms of methods, participants and survey instruments used. As a result, a narrative approach to synthesis was considered more suitable. The included studies thus underwent quality appraisal followed by a structured narrative synthesis.

The article selection flow diagram based on the PRISMA guidelines (Page *et al.* 2021) is shown in Figure 1.

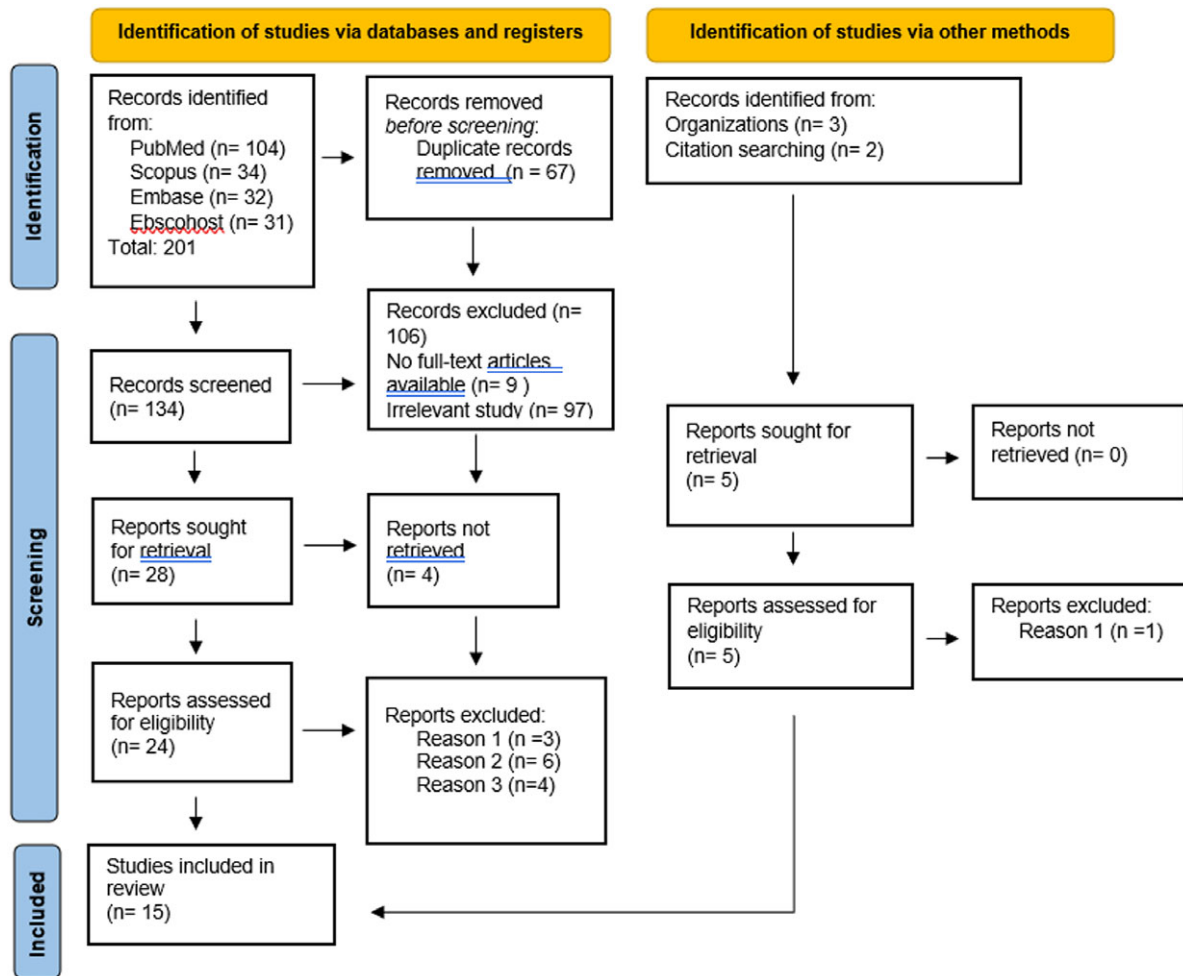


Figure 1. PRISMA 2020 flow diagram depicting the selection process of included studies.

## Results

206 articles in total were identified by the search strategy outlined above. After removing 67 duplicates, titles, and abstracts of 139 studies were screened and 106 excluded for the following reasons: no full-text articles ( $n = 9$ ) or irrelevant study ( $n = 97$ ). 33 full-text articles were sought for retrieval, among which 4 were unable to be retrieved and 29 underwent further screening; 14 were excluded for the following reasons: reason 1: study not concerned with psychiatrists ( $n = 4$ ), reason 2: study not reporting quantitative data about psychiatrist and/or psychiatry trainees' use of personal therapy ( $n = 6$ ) or reason 3: data included in study already reported in another article by same author ( $n = 4$ ). 15 articles fulfilled all requirements and were included in this review. Table 1 summarizes the key findings of each included study.

## Quality appraisal

Quality assessment of the 15 included studies was conducted using the quality assessment checklist for survey studies in psychology (Q-SSP) (Protogerou & Hagger 2020) (see Table 2), a study quality tool specifically designed for appraising studies using survey designs. Based on the number of applicable items, studies are attributed an overall 'acceptable' quality score when receiving a

'yes' score on at least 75% of applicable items. However, it was found that using a 60% threshold resulted in better consensus between experts (Protogerou & Hagger 2020).

Where necessary, items or scoring scheme were modified to fit the design of included studies. Firstly, noting that most studies set out objectives or aims rather than specific research questions or hypotheses, the former were also accepted as eligible statements for item 3. For item 8, the term 'response rate' was substituted for 'attrition rate'. For item 9, to obtain a YES score, studies had to mention whether they used any strategies to minimize non-response (see Phillips *et al.* 2016 for a description of recognized strategies). For item 11 to obtain a YES, it was sufficient to state that a copy of all measures was available upon request (by contacting authors). For item 12, it was deemed sufficient to provide a comment on validity or lack thereof of questionnaire used, and/or to provide information about validity of existing tools that the survey instrument included. For item 16, to obtain a YES, it was sufficient for studies to include at least two of the following key demographic characteristics: age, gender, nationality or ethnicity and/or years or level of training/experience as a psychiatrist. For item 19 (participant debrief), as included studies did not involve any form of participant deception, the 'not applicable' code was used for all studies.

**Table 1.** Summary of characteristics of included studies

Authors, year	Study location	Objectives	Type of study/Methods (including recruitment process)	No. and demographic characteristics of respondents (gender, age, level of training)	Response rate	Results and key findings
Bae <i>et al.</i> (2003)	South Korea	To describe the demographic characteristics, professional identification, training, theoretical orientation, career status, and use of PT of a sample of 538 Korean psychotherapists in various MH professions, including psychiatry.	<p>Korean data was collected as part of an international study on the development of psychotherapists initiated in 1989 by a subgroup of the Society for Psychotherapy Research (SPR) who formed the SPR Collaborative Research Network (CRN). Data was gathered with the Korean language version of the DPCCQ.</p> <p>Different data collection strategies were used, involving randomly or exhaustively sampling the membership of professional organizations or sampling published lists of therapists and counselors, solicitation of attendees at professional conferences, or solicitation of students and faculty in academic training centers. Data was collected in two waves.</p>	<p>538 South Korean psychotherapists responded to the survey, among which 346 (64.3%) were psychiatrists.</p> <p>The predominant orientation of Korean psychiatrists practicing psychotherapy was analytic/dynamic, followed by humanistic and cognitive.</p>	A total of 500 questionnaires were distributed during the 1st wave of collection; 123 were returned, for an overall response rate of 25%. The second wave of collection yielded a response rate of 38%.	<p>Overall, only 32.1% of South Korean psychiatrists who responded to this survey indicated that they engaged in their own PT.</p> <p>Another comparison was made including only those respondents who had at least 10 years of practice. Among this group, 52% indicated engaging in PT.</p>
Ball <i>et al.</i> (2021)	UK	To collect information from trainees across the UK about the quality of the PLC training experience, covering rates of completion, barriers to completion, modality of therapy and characteristics, and experience of supervision. In addition, this study contained a few questions about the use of PT by trainees during their PLC.	A cross-sectional survey using quantitative components (rating scales) and qualitative components (free-text boxes), was distributed by e-mail to all 4,169 core and higher psychiatry trainees in the UK from the RCPsych. The response period was open between 6 and 25 February 2019 and entry into a prize draw was offered as an incentive to completion. The survey was hosted on the online platform SurveyMonkey.	598 trainees responded to the survey. 47.1% were core trainees and 52.9% were higher trainees. Respondents' level of training was distributed as follows: CT1: 2%; CT2: 12%; CT3: 33%; ST4: 19%; ST5: 14%; ST6: 17%; ST7: 2%; ST8: 1%.	14.3% of the estimated total number of UK psychiatry trainees (core and higher).	<p>Only 13.4% of respondents availed of PT while completing the PLC, 2.5% preferred not to answer and the remaining 84% did not have PT while completing the PLC. 32 trainees (5.35%) commented that PT could be beneficial during the PLC.</p> <p>Undertaking PT while completing the PLC was associated with more favorable opinions of the effectiveness of the training intervention, although this cannot be taken to be a causal associations it is possible that those trainees with an interest in psychotherapy were more likely to undertake PT.</p>

<p>Bodkin <i>et al.</i> (1995)</p>	<p>North America (USA &amp; Canada)</p>	<p>The primary aim of this study was to investigate the treatment orientation and associated characteristics (including use of PT) of North American academic psychiatrists.</p>	<p>A newly devised 27 item questionnaire was posted to 972 psychiatrists associated with 5 leading medical schools in the USA and Canada: Yale, Duke, Toronto, UCLA and Pittsburg. The questionnaire elicited basic demographic information, as well as data on self-identified treatment orientation, actual clinical practice, and a wide range of personal and professional attributes that might relate to professional orientation.</p>	<p>435 academic psychiatrists returned completed questionnaires. The age distribution of the psychiatrists was as follows: under 40: 29%; age 40-49: 34%; age 50-59: 20% and age 60+: 17%. The majority of respondents were male (80%).</p>	<p>49%</p>	<p>113 (27%) respondents reported performing psychotherapy with less than 25% of their patients and 157 (37%) reported performing psychotherapy with more than 75% of their patients. The study identified these 2 groups as 'biologically oriented' vs. 'psychotherapeutically oriented psychiatrists'.</p> <hr/> <p>There was a much higher frequency of reported engagement in personal psychotherapy in the psychotherapeutically oriented psychiatrists (86%) compared to the biologically oriented psychiatrists, among whom only 44% reported engaging in personal psychotherapy.</p>
<p>Dover <i>et al.</i> (2009)</p>	<p>UK (London)</p>	<p>To establish the proportion of London psychiatry SHOs who undertake PT, the types of PT pursued, the number of SHOs who would consider PT, the reasons given for pursuing PT, the guidance available and the factors that predicted the pursuit of PT.</p>	<p>Four of the eight psychiatry SHO training schemes in London participated in the study. All SHO on these schemes at the time of the study were eligible to be participants except for those in stand-alone, non-training and general practitioner training scheme posts.</p> <hr/> <p>A newly developed anonymous questionnaire was designed and hosted on a web-based survey platform (Survey Monkey). The participating training scheme administrators provided trainees' names and current training posts. They sent an e-mail to all trainees explaining the study and containing a link to the online questionnaire.</p> <hr/> <p>Demographics, training characteristics and psychotherapy experience were examined using descriptive statistics. Predictors of PT status were examined using logistic regression.</p>	<p>140 SHOs completed the survey.</p> <hr/> <p>The mean age of participants was 29 years (s.d. = 3.2) and the majority (<math>n = 87</math>, 63%) of the sample were male.</p>	<p>48.7%</p>	<p>16% of respondents had undertaken PT. The mean length of therapy was 15.2 months (range 0.2–104, s.d.= 23.8).</p> <hr/> <p>The most common type of therapy was psychodynamic (45%), with others including counseling, eclectic, group, systemic therapy and CBT.</p> <hr/> <p>Frequency of therapy ranged between one session per week (68% of participants) and four sessions per week.</p> <hr/> <p>Of the participants who undertook PT, 48% said it was for personal reasons, 39% for both training and personal reasons, and 13% for training purposes alone.</p> <hr/> <p>Of the trainees who had no direct experience of PT, 28 (26%) stated that they had not considered PT and would never consider it.</p>

(Continued)

Table 1. (Continued)

Authors, year	Study location	Objectives	Type of study/Methods (including recruitment process)	No. and demographic characteristics of respondents (gender, age, level of training)	Response rate	Results and key findings
Emmerich <i>et al.</i> (2004)	New York (Manhattan)	To determine the prevalence and types of psychiatric treatment among psychiatry residents working in Manhattan, including use of PT and rates of medication use and to assess residents' attitudes toward various types of treatment.	A 51-item questionnaire was developed. In order to minimize confidentiality concerns, questionnaires were anonymous and did not include any demographic data. Names of residents, along with their mailing addresses, were obtained directly from the administrator or training director of each of the eleven psychiatric training programs located in Manhattan.	The study sample consisted of all PGY2 through PGY4 psychiatric residents training in Manhattan ( $n = 288$ ). The initial sample consisted of 108 PGY2s, 101 PGY3s, and 79 PGY4s.	48% (137/288)	57% (78/137) of respondents were in individual psychiatric treatment. Of those in treatment, the majority (68%) indicated that they were in individual psychotherapy alone. 17% (24/78) were in combination treatment consisting of psychotherapy and medication and less than 1% (1/78) were on medication alone. The modality of PT was overwhelmingly psychodynamic: 77% (59/77) were in psychodynamic psychotherapy, and 13%(10/77) were in psychoanalysis; 9% (7/77) described their psychotherapy as eclectic and 1% (1/77) as supportive. No residents were in CBT or IPT Residents were more likely to tell other residents and faculty about PT than about the use of medication. Residents felt that medication use carries significant stigma, while PT does not.
Gargot <i>et al.</i> (2017)	Europe	To evaluate the actual psychotherapy availabilities in Europe for psychiatry trainees and the implementation of the (UEMS) guidelines in their training.	A cross-sectional survey was conducted from January 2013 to October 2015. An online questionnaire was designed by the EFPT Psychotherapy Working Group, as a result of collective debates considering previous studies and psychotherapy training-related European recommendations. The target population consisted of psychiatrists in training or those within 5 years from qualification.	574 respondents completed the survey. Answers were collected from 22 countries.	Estimated response rate of 2.9% (based on estimated number of European psychiatry trainees.	Only a minority of respondents (40%) reported experiencing PT despite both UEMS and EFPT statements recommending such experience.
Haak & Kaye (2009)	USA	To provide more current and nationally representative data regarding residents' experiences with and views of personal psychotherapy. Data about rates and types of psychotherapy was collected as well as the perceived barriers and attitudes toward personal psychotherapy.	Residency programs in both general and child and adolescent psychiatry were selected using a random number generator from the American Association of Directors of Psychiatric Residency Training's regional list of training programs. Two general and three child programs were chosen from each of the seven regions defined by APA. Training directors were contacted to provide a list of each program's residents and their	107 psychiatry residents completed the survey, of which 55.1% were female. The age distribution of the residents was as follows: age 21–30: 25.2%; age 31–40: 57.9%; age 41–50: 12.1% and age 50+: 4.7%. Respondents' level of training was distributed as follows: PGY1: 11.2%; PGY2: 8.4% ; PGY3: 21.5%; PGY4: 30.8%; PGY5+: 28%	37 programs were contacted, and 25 responded (67% response rate). Of the 390 residents asked to participate, a total of 107 residents completed the survey, yielding a 27% response rate.	31.8% of respondents were currently attending PT at the time of the survey, while 42.1% indicated that they had availed of PT in the past. The majority of respondents sought supportive (33.3%) or psychoanalytic (24.4%) psychotherapy. Respondents indicated their top two reasons for seeking PT during residency as 'for personal issues or problems outside of training' and 'to improve my skills as a psychotherapist.'. Both 'cost' and 'training demands' were cited as the top two barriers preventing residents from engaging in PT during their training. Most respondents currently in PT found it to be helpful to their professional development while previous

			e-mail addresses. Residents were sent e-mails personally addressed to them with an explanation of the study and a request for participation, including a link to an anonymous 21-item questionnaire, hosted by an online survey platform.			engagement in PT was reported as somewhat less helpful to professional development.
Hadjipavlou <i>et al.</i> (2016)	Canada	To gather nationally representative data on Canadian residents' experiences with and perspectives on PT during their psychiatric training.	A 43-item questionnaire was distributed electronically to all current psychiatry residents in Canada ( $n = 839$ ).	400 residents responded to the survey. 69.3% were female 85.6% of respondents were between the ages 25–34 years. Respondents were evenly distributed across levels of training (PGY1:19%; PGY2: 22%; PGY3: 22%; PGY4: 21.3%; PGY5: 14.8%).	47.7%	The prevalence of PT at any time was 55.3% with 42.8% receiving PT during residency. The majority of Canadian residents in PT opted for weekly therapy (59.3%). The most common form of PT was psychodynamic therapy (74.1%) and the majority of respondents indicated having received PT for > 1 year (81.5%). The three most common reasons given for engaging in PT were: 'personal growth', 'need for self-understanding' and 'professional development'. 1/3 of residents identified anxiety, depression or other MH problems as primary reasons for engaging in PT.
Kazantzis <i>et al.</i> (2010)	New Zealand	To explore NZ psychiatrists' and MH nurses' use of didactic teaching, supervision of case-work and PT. The survey included practitioners' evaluations of the usefulness of supervision, training, and PT for their professional development.	Data was collected between 1998 and 2000 by distributing 350 flyers inserted into newsletters of the NZ College of Psychiatrists, New Zealand Nurses Organization and other professional organizations where psychiatrists and nurses might be members. Those who returned flyers were sent a copy of the questionnaire (DPCCQ) and a prepaid return envelope. Participation was entirely voluntary and anonymous.	26 psychiatrists returned completed questionnaires.	57%	The majority of respondents (89%) had experienced PT. Compared with the larger Orlinsky <i>et al.</i> , (2011) survey, The NZ sample had spent the least time in therapy (Mean = 4.8 years), and represented the group with the lowest proportion of current engagement in personal therapy (16%). New Zealand psychiatrists reported that the two activities which had the greatest influence on their professional development were experience with patients and PT.
Kovach <i>et al.</i> (2015)	USA (New Jersey, Pennsylvania and Delaware)	To evaluate psychiatry residents' participation in and description of PT, reasons for engaging in PT and barriers to PT.	Anonymous online survey hosted on SurveyMonkey. The program directors of the 14 residency programs accredited by the Accreditation Council for Graduate Medical Education in New Jersey, Pennsylvania were asked to provide lists of the current residents' e-mail addresses.	133 psychiatry residents responded to the survey. 47.7% male, age 25-29 years: 32.6%; age 30-24: 42.4%; age 35-40: 21.2%; over 40 years: 3.8%. Respondents' level of training was distributed as follows: PGY1: 28%; PGY2: 23.4%. PGY3: 24.2%; PGY4: 24.2%.	40.5%	26.5% of respondents were in PT. Most residents described their PT as psychodynamic (87.9%). The majority of residents (69.7%) attended PT on a weekly basis. Self-awareness and understanding was the most commonly reported primary reason for being in PT. Close to half of respondents indicated that personal stress, substance dependence, mood, anxiety or other MH problems were primary reasons for seeking PT. The most common reasons for not entering PT were time and financial cost.

(Continued)

Table 1. (Continued)

Authors, year	Study location	Objectives	Type of study/Methods (including recruitment process)	No. and demographic characteristics of respondents (gender, age, level of training)	Response rate	Results and key findings
Lanouette <i>et al.</i> (2011)	USA	To examine psychiatry residents' attitudes towards learning psychotherapy, practicing psychotherapy in the future, and overall identification as psychotherapists.	The University of California, San Diego Training Director posted a study description and invitation to participate on the Association of American Directors of Psychiatry Residency Training listserv, which includes approximately 150 programs.	249 residents completed the survey. 61.3% were female. Respondents' level of training was distributed as follows: PGY1: 23.1%; PGY2: 24.3%; PGY3: 23.1%; PGY4: 22.3%; PGY5: 6.9%; PGY6: 0.4%.	15 out of 150 eligible residency programs participated in the study. From the participating programs, surveys were completed by 249 of 567 psychiatry residents (43.9% response rate).	Approximately half of respondents (47%, $n = 118$ ) reported previous or current PT; 49% ( $n = 122$ ) had not been in psychotherapy, and 4% ( $n = 7$ ) did not respond. Most psychiatry residents agreed or strongly agreed with the statements 'I am proud to be a psychotherapist' (79%), 'being a psychotherapist is integral to my sense of identity as a psychiatrist' (81%), and 'psychotherapy training influences my life outside of work' (77%). 9%-13% gave neutral responses, and 5% and 12% disagreed or strongly disagreed, respectively. Residents with PT experience and PGY1 residents were more likely to identify as psychotherapists, plan to pursue further psychotherapy training post residency, and anticipate psychotherapy being central to their future practice.
Shachar <i>et al.</i> (2016)	Israel	To explore and map the attitudes of psychiatrists in Israel regarding psychotherapy and psychotherapy training during residency (including their use of and attitude towards PT). The study made comparisons between residents vs. specialists, peripheral vs. central institutions and mental health vs. medical centers.	The study was a cross-sectional survey conducted among residents and specialists in psychiatry in Israel, according to registration of the psychiatry residents' organization (240 residents with listed e-mail addresses) and of the Israel Medical Association (1,262 registered specialists; 748 of whom with listed e-mail addresses) between November 2010 and July 2011. Questionnaires were distributed electronically by e-mails and manually during psychiatry conventions and at MH centers.	157 specialists and 72 residents completed the survey. 41.7% of residents were male v. 60.5% of specialists. The age distribution of residents was as follows: age 25–35: 55.6%; age 36–45: 34.7%; age 46–55: 8.3% and age > 55: 1.4%. Most residents had seniority of < 10 years (91.4%). The age distribution of specialists was as follows: age 25–35: 3.2%; age 36–45: 38.8%; age 46–55: 28.7% and age > 55: 28.2%. Most specialists had seniority of > 10 years (75.5%).	15.2%	65.3% of the residents surveyed ( $n = 47$ ) reported they received PT compared to 77.7% ( $n = 122$ ) of the specialists. The most common psychotherapy was dynamic psychotherapy, reported by 96.4% ( $n = 163$ ) of the respondents. Psychiatrists (both residents and specialists) who received PT had more favorable attitudes towards psychotherapy compared to those who did not and reported higher levels of knowledge and clinical skills in psychotherapy.
Orlinsky <i>et al.</i> (2011)	International (USA, Canada, UK, ROI, NZ and Australia)	To study the prevalence of PT use by MH professionals in 6 English-speaking countries and to investigate factors associated with use versus nonuse of PT by country, professional identity, theoretical orientation, career level, age, and gender.	Data was gathered with the DPCCQ, a self-administered questionnaire using mainly structured-response items covering a wide range of topics, and usually takes from 1 hour to 1 1/2 hours to complete. The Australian survey was completed using an online version. CRN members collected information using the DPCCQ between 1991-current time of study.	163 psychiatrists responded to the questionnaire.	Unclear	29.4% of psychiatrists indicated that they never experienced PT, thus representing the second lowest prevalence of PT among the MH professions, after nursing.



Sathanandan & Bull (2013)	UK	To identify the number of psychiatry core trainees at University College London Partners (UCLP) training scheme who were undertaking PT and to explore their thoughts about the value of PT in current psychiatric training.	A newly designed, anonymous questionnaire was designed and hosted on an online survey platform (SurveyMonkey). The answers were all free text. E-mail addresses of the trainees on the UCLP training scheme were obtained from the training scheme administrator. A link was sent out to all current UCLP CT1–3 trainees in September 2011.	48 psychiatry trainees completed the online questionnaire, of which 36% were female. The age distribution of the residents was as follows: age 25–39: 58.3%; age 30–34: 29.2%; age 35–39: 12.5% Respondents' level of training was distributed as follows: CT1: 14.5%; CT2: 41.7% ; CT3: 43.8%	60.7%	68.7% of trainees had never undertaken any form of PT and 31.3% had undertaken or were currently in PT. 33.3% started PT for purely personal reasons, 6.7% started for professional reasons and 60% started for both personal and professional reasons. 93.3% of the respondents reported personal and professional benefits to engaging in PT. The two most common forms of PT were psychodynamic psychotherapy (46.7%) and psychoanalytic psychotherapy (33.3%). Only 1 respondent reported engaging in each of CBT, CAT and transpersonal psychotherapy.
Weintraub et al. (1999)	USA	To provide longitudinal data regarding residents' engagement in PT. The authors hypothesized that current psychiatry residents would engage in PT less than former residents.	A 66-item anonymous questionnaire was sent by post to all current residents of the authors' 3 local psychiatry residency programs as well as to all former residents of one psychiatry residency program for whom mailing addresses could be obtained through the residency training office and the APA Directory.	96 current residents and 114 former residents returned completed surveys.	The response rate was 81% for the current residents and 55% for the former residents.	Current residents (20%) partook less frequently in PT during residency training than did former residents (70%). Bivariate analysis showed that AMGs were more likely to engage in PT than IMGs (62% v. 26%).

PT, personal therapy; MH, mental health; UK: United Kingdom; USA: United States of America; NZ: New Zealand; ROI: Republic of Ireland; DPCCQ: Development of Psychotherapists Common Core Questionnaire; CRN: Collaborative Research Network; CBT, Cognitive Behavioral Therapy; CAT, Cognitive Analytic Therapy; SHO, senior house officer; PTC, Psychiatric Trainees' Committee; RCPsych, Royal College of Psychiatrists, UK; PLC, psychotherapy long case; AMG, American medical graduate; IMG, international medical graduate; IPT, interpersonal therapy. CT, core training; ST: specialist training; PGY: post-graduate year; APA, American Psychiatric Association.

**Table 2.** Quality assessment checklist for survey studies in psychology (Q-SSP)

Item #	Research domain	Quality item
1	Introduction (Rationale)	Was the problem or phenomenon under investigation defined, described, and justified?
2	Introduction (Rationale)	Was the population under investigation defined, described, and justified?
3	Introduction (Rationale)	Were specific research questions or hypotheses stated?
4	Introduction (Variables)	Were operational definitions of all study variables provided?
5	Participants (Sampling)	Were participant inclusion criteria stated?
6	Participants (Sampling)	Was the participant recruitment strategy described?
7	Participants (Sampling)	Was a justification/ rationale for the sample size provided?
8	Data (Collection)	Was the attrition rate provided? (applies to cross-sectional and prospective studies)
9	Data (Analyses)	Was a method of treating attrition provided? (applies to cross-sectional and prospective studies)
10	Data (Analyses)	Were the data analysis techniques justified (i.e. was the link between hypotheses/ aims / research questions and data analyses explained)?
11	Data (Measures)	Were the measures provided in the report (or in a supplement) in full?
12	Data (Measures)	Was evidence provided for the validity of all the measures (or instrument) used?
13	Data (Collection)	Was information provided about the person(s) who collected the data (e.g. training, expertise, other demographic characteristics)?
14	Data (Collection)	Was information provided about the context (e.g. place) of data collection?
15	Data (Collection)	Was information provided about the duration (or start and end date) of data collection?
16	Data (Results)	Was the study sample described in terms of key demographic characteristics?
17	Data (Discussion)	Was discussion of findings confined to the population from which the sample was drawn?
18	Ethics	Were participants asked to provide (informed) consent or assent?
19	Ethics	Were participants debriefed at the end of data collection?
20	Ethics	Were funding sources or conflicts of interest disclosed?

Results of quality assessment conducted for the 15 included studies are summarized in Table 3.

Despite the modifications made to the Q-SSP items, over a third of included studies (6/15) failed to reach the 75% threshold originally recommended for 'acceptable' quality, however none of the studies fell below the more consistently rated 60% threshold.

The six areas where most studies fell short related to information about the following: measurement description, measures against non-response bias, validity of survey instrument used, survey participants' provision of consent, person(s) collecting the data, and disclosure of funding sources or conflict of interests. Overall, given the observational and descriptive nature of the included studies and the specific factors contributing to the quality ratings, the quality of evidence was considered acceptable for the purpose of the syntheses carried out in this review.

### Discussion of key findings

This review brings together findings from 15 survey-based studies which collected data on the proportion of psychiatrists who received personal therapy. Over half of the studies reviewed had this as their primary objective (Dover *et al.* 2009; Haak & Kaye 2009; Emmerich *et al.* 2004; Hadjipavlou *et al.* 2016; Kovach *et al.* 2015; Orlinsky *et al.* 2011; Sathanandan & Bull 2013 and Weintraub *et al.* 1999), while the remaining studies only discussed personal therapy as part of a larger investigation into psychiatric practitioners' experiences with and attitudes towards psychotherapy training and/or their experiences and opinions regarding delivering psychotherapy.

### Trends in personal psychotherapy use: variations across time and location

Most included studies were conducted in North America (Bodkin *et al.* 1995; Emmerich *et al.* 2004; Haak & Kaye 2009; Hadjipavlou *et al.* 2016; Kovach *et al.* 2015; Lanouette *et al.* 2011 and Weintraub *et al.* 1999). Three studies took place in the UK (Ball *et al.* 2021; Dover *et al.* 2009 and Sathanandan & Bull 2013); and one each in New Zealand (Kazantzis *et al.* 2010), Israel (Shachar *et al.* 2016) and South Korea (Bae *et al.* 2003). Two studies sought to gather data from multiple countries (Orlinsky *et al.* 2011; Gargot *et al.* 2017).

#### 1995–2009

Bodkin *et al.*'s (1995) survey sought to investigate the treatment orientation (biologically vs. psychotherapeutically oriented) and associated characteristics (including use of personal therapy) of North American academic psychiatrists. There was significantly higher frequency of reported engagement in personal psychotherapy in psychotherapeutically oriented psychiatrists (86%) compared to biologically oriented psychiatrists (44%). Considering the known rise of biological psychiatry since the 1990s, it is possible this could account for some of the declining engagement rates in personal therapy reported in subsequent studies included in this review.

By the start of the 21<sup>st</sup> Century, engagement in personal therapy by psychiatry residents was clearly on the decline in the USA. Weintraub *et al.* (1999) found that current residents were much

**Table 3.** Quality assessment of included studies using the quality assessment checklist for surveys in psychology (Q-SSP)

Study	Introduction (rational/variables) score (items 1–4)	Participants (sampling/recruitment) score (items 5–7)	Data score (items 8–17)	Ethics score (items 18 + 20)	Overall score	%	Result
Bae <i>et al.</i> , (2003)	4/4	3/3	6/10	0/2	13/19	68.42%	Q
Bodkin <i>et al.</i> (1995)	4/4	3/3	7/10	0/2	14/19	73.68%	Q
Ball <i>et al.</i> (2021)	4/4	3/3	7/10	0/2	14/19	73.68%	Q
Dover <i>et al.</i> (2009)	4/4	3/3	5/10	2/2	14/19	73.68%	Q
Emmerich <i>et al.</i> (2004)	4/4	3/3	5/10	0/2	12/19	63.16%	Q
Gargot <i>et al.</i> , (2017)	4/4	3/3	8/10	0/2	15/19	78.95%	A
Haak & Kaye (2009)	4/4	3/3	7/10	2/2	16/19	84.21%	A
Hadjipavlou <i>et al.</i> (2016)	4/4	3/3	8/10	2/2	17/19	89.47%	A
Kazantzis <i>et al.</i> , (2010)	4/4	3/3	8/10	1/2	16/19	84.21%	A
Kovach <i>et al.</i> (2015)	4/4	3/3	8/10	1/2	16/19	84.21%	A
Lanouette <i>et al.</i> (2011)	4/4	3/3	7/10	1/2	15/19	78.95%	A
Shachar <i>et al.</i> (2016)	4/4	3/3	8/10	1/2	16/19	84.21%	A
Orlinsky <i>et al.</i> , (2011)	4/4	3/3	5/10	0/2	12/19	63.16%	Q
Sathanandan and Bull (2013)	4/4	3/3	9/10	0/2	16/19	84.21%	A
Weintraub <i>et al.</i> (1999)	4/4	3/3	8/10	0/2	15/19	78.95%	A

A, acceptable quality; Q, questionable quality.

less likely (20% vs. 70%) to engage in personal therapy than former residents.

Using data collected as part of Orlinsky *et al.* (1999) collaborative international study on development of psychotherapists, Bae *et al.* (2003) sought to describe demographic characteristics, professional identification, training, theoretical orientation, career status, as well as personal therapy engagement in a sample of 538 South Korean psychotherapists in various mental health professions, including psychiatry. Overall, only 32.1% of psychiatrists who responded to this survey indicated engaging in their own personal therapy, however in the sub-sample of respondents who had at least 10 years of practice, this proportion increased to 52%. This again seems to align with the emerging trend that psychiatry trainees in more recent years are less likely to engage in personal therapy.

Emmerich *et al.* (2004) gathered survey data about proportions of Manhattan based psychiatry residents availing of personal psychiatric treatment. Over half (57%) of respondents indicated they were receiving personal psychiatric treatment. Of those, 68% indicated they were receiving individual psychotherapy alone, 17% reported receiving a combination of psychotherapy and medication, and fewer than 1% reported receiving medication alone.

Haak & Kaye (2009) conducted a survey investigating current American psychiatric residents' experience with and opinions about personal psychotherapy. Fewer than one-third of residents (31.8%) reported receiving current therapy, while 42% reported receiving therapy at some point in the past. Dover *et al.* (2009) surveyed UK core psychiatry trainees in a similar time period, finding that only 16% were engaging in personal therapy, again suggesting this downward trend was occurring across different geographic regions.

### 2010-present

Orlinsky *et al.* (2011) conducted an international survey on experiencing personal therapy among 3,995 psychologists,

counselors, social workers, psychiatrists, and nurses in 6 English-speaking countries, including Ireland. Among the 163 psychiatrists who completed the questionnaire, 29.4% indicated never experiencing personal therapy, representing the second lowest prevalence of personal therapy among mental health professions after nursing. Only one psychiatrist among the limited Irish sample indicated that they had received personal therapy in the past but were not currently receiving therapy.

Using data collected as part of Orlinsky *et al.*'s study, Kazantzis *et al.* (2010) investigated New Zealand psychiatrists' and mental health nurses' use of didactic teaching, supervision of case-work and personal therapy. The vast majority of respondents (89%) experienced personal therapy at some point previously. However, when compared to participants in the larger Orlinsky *et al.* (2011) survey, New Zealand psychiatrists spent least time in therapy (Mean = 4.8 years) and had the lowest proportion of current engagement in personal therapy (16%).

Lanouette *et al.* (2011) conducted a survey aiming to examine psychiatry residents' attitudes towards learning psychotherapy, practicing psychotherapy in the future, and their overall identification as psychotherapists. The questionnaire contained four questions relating to the use of personal therapy. Approximately half of the respondents (47%,  $n = 118$ ) reported previous or current personal therapy; 49% ( $n = 122$ ) had never been in psychotherapy, and 4% ( $n = 7$ ) did not respond.

Sathanandan & Bull (2013) sought to identify numbers of psychiatry core trainees from the University College London Partners (UCLP) training scheme engaging in personal psychotherapy and to explore trainees' views regarding the value of personal psychotherapy in their psychiatric training. Only 31.3% of trainees reported having undertaken personal therapy previously or were currently having personal therapy. Nonetheless, this represents nearly double the proportion of London based core trainees who reported being in

therapy four years earlier (Dover *et al.* 2009), which can be seen as somewhat of an outlier in relation to the observed trend.

In their 2015 survey, Kovach *et al.* investigated American residents' participation in and characterization of personal therapy, including their reasons for entering therapy and barriers to seeking personal therapy. They found that only 26.5% of residents were in personal therapy at the time of the survey, which indicates a further decrease when compared to rates of receiving personal therapy reported by residents in several older USA studies.

The EFPT aimed to evaluate actual provision of psychotherapy training for European psychiatry trainees as compared to UEMS guidelines. From 2013 to 2015, the EFPT collected 574 responses from trainees of 23 European countries by online surveying (Gargot *et al.* 2017). While this large-scale study was more generally focused on how psychotherapy training was delivered for psychiatry trainees across Europe (Ireland was not included), it also enquired about receiving personal therapy, results indicating that personal psychotherapy was received by only 41% respondents despite both UEMS and EFPT statements recommending such experience (Gargot *et al.* 2017).

Hadjipavlou *et al.* (2016) conducted a national survey of all Canadian psychiatry residents to investigate their experiences with and perspectives on personal therapy during their residency training. Results indicated that 55.3% received personal therapy at any time, and 42.8% received personal therapy during residency, (much higher compared to USA figures).

Shachar *et al.* (2016) explored attitudes of psychiatrists in Israel regarding psychotherapy and psychotherapy training during residency, including use of and attitude towards personal therapy. The study made comparisons between residents vs. specialists, practicing in peripheral versus central institutions, and mental health vs. medical centers. 65.3% of residents surveyed ( $n = 47$ ) reported receiving personal therapy compared to 77.7% ( $n = 122$ ) of the specialists. Despite higher overall rates of receiving personal therapy by psychiatry residents in Israel, this finding parallels US results in suggesting a downward trend in receiving personal therapy by newer generations of psychiatrists.

More recently, Ball *et al.* (2021) surveyed UK psychiatry trainees nationally regarding the quality of psychotherapy long-case (PLC) training experience during their 'core training' years (i.e. before advancing to higher speciality training). The survey used in this study also contained several questions about receiving personal therapy during their PLC. They found that only 13.4% of respondents received personal therapy while completing the PLC, 2.5% preferred not to answer these questions, and the remaining 84% reported no therapy while completing the PLC. While 13.4% seems low, it must be noted that there is no obligation for core trainees to engage in personal therapy. Also, in higher speciality training in the UK there are six higher specialities and three further sub-specialities, and only the higher speciality 'Medical Psychotherapy' requires trainees to participate in regular personal psychotherapy during training.

### Therapy modalities

Several studies investigated the modalities of psychotherapy experienced by psychiatrists and trainee psychiatrists for their personal therapy. Emmerich *et al.* (2004) found that among residents who engaged in psychotherapy, 77% were in psychodynamic psychotherapy, 13% were in psychoanalysis, 9% described their psychotherapy as eclectic and only 1% indicated receiving supportive therapy. No residents were in CBT or IPT. In Dover

*et al.* (2009), psychiatry trainees similarly reported most commonly engaging in psychodynamic psychotherapy. In Haak & Kaye (2009) study, most respondents were in psychoanalytic psychotherapy (58.8%), while the next most popular choice was supportive psychotherapy, which was selected by 17.6% of respondents. In Kovach *et al.* (2015), the majority of residents also indicated being in psychodynamic psychotherapy (87.9%) while only 3% indicated being in CBT. Similar results were found in Hadjipavlou *et al.* (2016), with nearly three quarters of respondents indicating they received psychodynamic psychotherapy and approximately one quarter availing of supportive psychotherapy. Only 8.9% of respondents indicated receiving CBT. No other modality was selected by more than 1% of respondents.

### Reasons for engaging vs. not engaging in personal therapy

Half the studies included in this review contained some exploration into the reasons psychiatrists and psychiatry trainees chose to undertake personal therapy and/or the reasons for not engaging in therapy (Bodkin *et al.* 1995; Weintraub *et al.* 1999; Dover *et al.* 2009; Haak & Kaye 2009; Kovach *et al.* 2015; Hadjipavlou *et al.* 2016; Sathanandan & Bull 2013). Bodkin *et al.* (1995) reported 52% of survey respondents sought therapy for a diagnosable disorder while 66% sought therapy for 'other reasons' (these were not specified). In their survey of current and former American residents, Weintraub *et al.* (1999, p. 16) found that both groups 'overwhelmingly listed personal reasons as the primary reason for seeking therapy, with professional or other reasons a distant second and third'.

Dover *et al.* (2009) also found that most (48%) of the psychiatry trainees who responded to their survey indicated seeking personal therapy for personal reasons. However, a significant portion (39%) indicated undertaking personal therapy for both training and personal reasons, and 13% for training alone. In Sathanandan & Bull (2013) survey, only one-third of respondents indicated starting personal psychotherapy for purely personal reasons while 60% reported starting therapy for both personal and professional reasons. Only one respondent indicated seeking therapy for professional reasons alone. In Haak & Kaye (2009) study, American psychiatry residents indicated their top two reasons for engaging in personal therapy were 'for personal issues or problems outside of training' and 'to improve my skills as a psychotherapist'. Kovach *et al.* (2015) found that self-awareness and understanding were the most commonly reported reasons for engaging in personal therapy. However, a significant proportion of American residents (44.5%) listed personal stress, substance abuse/dependence, or mood symptoms, anxiety or other mental health problems as the primary reasons for seeking personal therapy (Kovach *et al.* 2015). Most Canadian residents listed the pursuit of personal growth, a need for self-understanding and enhancing professional development as being among their main reasons for personal therapy engagement. Approximately one-third also reported anxiety, depression or another mental health problems as their primary reason for seeking personal therapy (Hadjipavlou *et al.* 2016).

When it came to exploring reasons for not receiving therapy, Weintraub *et al.* (1999) found that cost and time were the most commonly listed reasons. Interestingly, current residents were more likely to list cost as the primary reason preventing them from seeking personal therapy, while former residents were more likely to list time. Financial cost and time were consistently cited as survey respondents' primary reasons for not engaging in therapy in

several other studies (Haak & Kaye 2009; Kovach *et al.* 2015; Hadjipavlou *et al.* 2016).

### **Psychiatrists' opinions and attitudes regarding the value of personal therapy**

Several studies found that psychiatry trainees who had received personal therapy tended to express more favorable opinions towards psychotherapy in general (in terms of its importance as a form of patient treatment, and as a valuable skill for residents to develop during their training), and particularly personal therapy, in terms of impact on personal and professional development. Weintraub *et al.* (1999) found that current residents who received personal therapy (as opposed to those who did not) placed greater professional value on it and were more likely to believe that psychiatry training should include learning to deliver psychotherapy.

In Lanouette *et al.* (2011) survey, respondents with personal psychotherapy experience were consistently more positive about psychotherapy in responses to questions relating to identity as a psychotherapist. For instance, they were more likely to express pride in being a psychotherapist, to believe that being a psychotherapist is integral to a psychiatrist's identity, and to report that practicing psychotherapy is the most rewarding aspect of their work.

In Kazantzis *et al.* (2010), New Zealand psychiatrists considered personal therapy to be highly influential in their professional development as psychotherapists when compared to formal didactic training. Kovach *et al.* (2015) found that residents who had received personal therapy tended to view this as having a more important role in their training compared to those who had not. Similarly, Hadjipavlou *et al.* (2016) found that residents who experienced personal therapy generally reported more confidence in their psychotherapy skills than those who had not.

### **Strengths, limitations and areas for further research**

This review represents the first known effort to provide a synthesis of available international survey-based data concerning use and characterization of personal therapy by psychiatrists and psychiatry trainees over the last three decades. Adherence to PRISMA 2020 guidelines (Page *et al.* 2021), use of several recognized databases, and the reporting of all eligible peer-reviewed survey studies are among the strengths of this review.

A limitation of this review is that in order to maximize the data available for synthesis, not all included studies were primarily focused on questions related to receiving personal therapy by survey respondents. Some studies only contained a few questions about the proportion of respondents who received therapy while the remainder of the survey was concerned with the aim of investigating broader topics such as attitudes towards psychotherapy and psychotherapy training. As a result, it was difficult to make comparisons between studies.

Another related limitation concerns the quality of included studies. In particular, none of the studies seeking to investigate the use of personal therapy as their main objective utilized the same standardized questionnaire. This additional heterogeneity in the data may have limited the validity of comparisons made between different populations and settings.

Another limitation is that most studies did not specify whether personal therapy was considered a mandatory component of participants' training programs. Indeed, whether or not psychotherapy was seen as mandatory may have influenced the proportions of

participants engaging in personal therapy during their training years, as well as the reasons they gave for engaging in personal therapy. As mentioned above, Medical Psychotherapy is recognized as a distinct sub-specialty of Psychiatry in the UK and trainees who choose this training pathway are required to engage in their own personal therapy. Further research on the opinions of this specific cohort as regards the impact of personal therapy on their ability to provide psychotherapy would offer valuable additional insights.

Finally, restricting the inclusion criteria to reports written in English may inevitably have led to a proportion of data being overlooked, thus limiting the fully 'international' aspirations of this review. In addition, while data was gathered from multiple geographical regions, formulating hypotheses relating to the potential presence of culturally mediated differences accounting for the variation in rates of psychotherapy engagement between studies was beyond the scope of this review. While the authors did not find among the included studies any mention of particular barriers or facilitators to psychotherapy access that could be considered culture or context specific, investigating this further could present an area for future research.

### **Conclusion**

Despite its limitations, this review represents the first known attempt to collect and synthesize data aimed at providing insights into past and current worldwide trends in psychiatrists' use of personal therapy. Rates of receiving personal therapy varied greatly from country to country, and depending on whether participants were asked about current or previous personal therapy engagement.

Across many studies, trainees who had received personal therapy tended to express more favorable opinions towards psychotherapy in general and particularly personal therapy, in terms of impact on personal and professional development. This warrants further investigation, particularly the impact of burnout in this cohort and the potential of engagement in one's own personal psychotherapy to help alleviate this concern.

Although beyond the scope of this paper, many psychiatry training programs encourage trainees to participate in Balint groups; when facilitated by a senior clinician with experience in psychotherapy and group dynamics, this can provide a safe space for trainees to explore with curiosity the complex dynamics at play within clinician-patient interactions. This in turn may act as a stepping stone to trainees seeking out personal therapy for themselves.

Despite covering data from across four continents over a 30-year time period, this systematic review did not identify any studies concerned with trends in personal therapy receipt by psychiatrists and/or psychiatry trainees based in Ireland, thus exposing a significant gap in the literature.

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