In recent years, the number of students with psychiatric difficulties enrolled in higher education has dramatically increased (Blanco et al., 2008; Gallagher, 2008). This is evident also in the growing number of students with psychiatric difficulties studying health care subjects in general and social work in particular (GlenMaye & Bolin, 2007; Manthorpe & Stanley, 1999). A unique study of 68 social work students showed that they were coping with as high or even higher levels of mental health difficulties than students in other disciplines (Gail Horton, Diaz, & Green, 2009). This should come as no surprise, because the choice to study social work is often influenced by psychological crises, experiences of loss, and other serious life events (Barnett, 2007; Farber, Manevich, Metzger, & Saypol, 2005; Rompf & Royse, 1994).

A term coined many years ago, the “wounded healer,” was developed specifically to describe these professionals who are coping with an illness themselves (Groesbeck, 1975; Zerubavel & Wright, 2012). Nevertheless, the manner in which these experiences—specifically of living with a mental illness—influence development into a health care therapist has been hardly explored. In an attempt to fill this gap, in this article we focus on social work students with psychiatric difficulties, who described and reflected on their experiences during their studies.

As part of their academic and professional education, students of social work and other therapeutic and health professions are exposed to discussions about mental health and mental pathology. These discussions and explorations occur both in the theoretical content studied (such as in mandatory pathology courses) and in their field work when treating patients who are coping with a mental illness (Gillis & Lewis, 2004).

The interaction between the three factors—namely the theoretical materials discussed, field work, and the students’ own lived experiences—might result in various challenges and complexities. Moreover, among social work students with psychiatric difficulties, the interaction between experiential knowledge (Borkman, 1976), the knowledge they acquire by their own personal experience with their illness, and professional knowledge, might raise additional conflicts and dilemmas. These might arise while reflecting on their values, attitudes,
actions, and reactions to the encountered content (Stromwall, 2002). This personal–professional reflective process might pose a challenge at the meeting point between the patient and therapist parts within them, or it can provide an opportunity for personal and professional growth.

Some students with mental illness are at risk of becoming impaired/incompetent professionals because of the impact of their illness. Impairment is defined as professional dysfunction and inability to provide proper care as a result of a mental illness (Laliotis & Grayson, 1985; Reamer, 1992). Impairment can affect both the patient and the student by overidentification, involvement, and enmeshment (Johnston, Smethurst, & Gowers, 2005; Rance, Moller, & Douglas, 2010); however, having a mental illness does not necessarily mean that the student is either unfit to practice or impaired (General Medical Council, 2013).

The importance of personal characteristics during social work students’ and health care students’ developmental process is recognized (Chamberlain, Catano, & Cunningham, 2005), and the impact of life events on the development of a professional identity is understood (Rønnesstad & Skovholt, 2003). Nevertheless, the mental health status of the students and the understanding of the impact of living with a mental illness on professional development have received inadequate research attention. Barely any reference has been made to the students’ own life experiences in the professional literature. Therefore, in the present article, we examine the phenomenon of social work students with psychiatric difficulties by exploring the experience of those students and the personal and professional path they follow on the way to becoming a therapist.

As opposed to social workers’ role in different countries, social workers in Israel are involved and many times are focused on individual psychotherapy (Weiss & Gal, 2001). Within their training they receive supervision toward individual therapy, systematic intervention, community work, and group facilitation. When assessing their perceptions and preferences they tend to prefer focusing on the psychological level (Buchbinder, Eisikovits, & Karnieli-Miller 2004).

Method

We used the immersion/crystallization narrative analysis method to hear and understand the students’ personal stories and experiences during their studies (Crabtree & Miller, 1992; Karnieli-Miller, Taylor, Inui, Ivy, & Frankel, 2011). This allows the presentation of students’ perspectives regarding their feelings, thoughts, and experiences concerning their social work studies (Clandinin, 2006; Clandinin & Huber, 2010).

Sampling Procedure

The focus of this study was on a hard-to-reach population (Abrams, 2010), and it was necessary, therefore, to integrate a mixture of sampling methods to recruit participants. We used two types of purposive sampling: criterion sampling and snowball sampling (Patton, 2002). The participation criteria were: being, or having recently been, a social work student (up to 2 years previously) in a recognized academic facility for higher education in Israel, and self-identification as a person coping with a psychiatric difficulty (Stanley, Ridley, Harris, & Manthorpe, 2011).

To recruit participants, we advertised on relevant forums and Web sites, as well as on mailing lists for people with an interest in mental health rehabilitation. In addition, we put up notices in schools of social work around the country. Most participants were recruited in this way (n = 11); one was recruited through snowball sampling. Each participant received an initial explanation of the main research goals. Although given the choice between face-to-face and email interviews (Meho, 2006; Stanley et al., 2011), only one participant chose email and the rest chose a face-to-face interview. Before the interview, the participants were asked to sign the informed consent form. This study was approved by the ethics committee of the Faculty of Health and Social Welfare Sciences at the University of Haifa.

Research Participants

The final number of participants (N = 12) was determined during data collection and analysis, when theoretical saturation of content was reached. This was established when it was clear that no new content and themes were emerging (Marshall, 1996). The participants were asked to fill in a demographic questionnaire relating to personal details, such as age, and marital status, and questions about their psychiatric disorder and treatment. The participants’ ages ranged from 25 to 45 years (M = 30, SD = 6), and most of them were single (n = 9, 70%).

Participants self-identified as coping with diverse psychiatric difficulties such as major depression, eating disorder, schizoaffective, bipolar, personality disorder, anxiety, and obsessive–compulsive disorder. The absolute majority of the participants were using psychotropic medication on a regular basis (90%, n = 11), and more than 50% reported at least one psychiatric hospitalization in their past. The number of hospitalizations ranged between one and five. The majority of the participants were under psychiatric care (90%, n = 11) during their social work studies (80%, n = 10). All of the participants were in some sort of psychological therapy; the majority also during their studies (90%, n = 11).

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Interview Guide and Data Analysis

For this study, we developed a semistructured, in-depth interview guide to include issues that have been relatively unexplored. We designed the questions to allow the participants to share their story openly as social work students with a psychiatric difficulty. For example, the students were asked about situations in which they felt good about themselves and about times at which they had faced conflicts during their studies.

Data analysis was performed using the immersion/crystallization method. This analysis method includes immersion and crystallization in the collected narratives by reading and rereading, and identifying and interpreting the main patterns that emerge (Crabtree & Miller, 1992; Karnieli-Miller et al., 2011; Meitar, Karnieli-Miller, & Eidelman, 2009).

The analysis included several readings of the narratives to allow thorough familiarity with each of the participants and their stories (Meitar et al., 2009). At the initial stage of the analysis, the first author divided the narratives into broad categories (Shkedi, 2009). In the next stage, she broke down the categories into smaller units of meaning and focused on their interrelationships, providing a general map of the categories. At this stage, the third author conceptualized the categories found by the first author. In the third and final stage, the first and third authors focused the various categories around the central theme that emerged—the transition from patient to therapist (therapists who are also patients; in this case therapists coping with psychiatric difficulties)—by finding an explanation for the phenomenon under study.

This central theme best reflects the participants’ stories (Shkedi, 2004). During this process, to enrich the trustworthiness of the study, several steps were taken:

1. After each interview was analyzed by the first author, the third author read the interview and the analysis. After all of the interviews had been analyzed, the second author viewed the categories and offered an additional point of view on the evolving theme. This use of multiple lenses added to the trustworthiness of the qualitative research.
2. The first researcher is a social worker with psychiatric difficulties. We therefore focused on her reflective process to identify points at which her personal experiences might either affect or be useful to the research data and analysis, as well as to bracket her experiences. This process continued throughout the entire study, including ongoing discussion and reflection facilitated by the third author to identify her motives, difficulties, and agendas. This included reflecting on the first author’s personal experiences throughout her social work education using the research interview (which was not included in the study because its sole purpose was to increase the trustworthiness of the research). Close supervision of the analysis was accompanied by this continuous reflective process, to help identify and give voice to participants’ stories that sometimes differed from those of the researcher and to allow the different voices and experiences to surface.

Results

It was clear from the narratives that, throughout their studies, the participants were paying great attention to their experiences as patients and how those related to their expectation to become a therapist. They were preoccupied with thoughts and experiences of the transition from the personal to the professional, from weakness to strength, and from illness to health:

I think that throughout my degree, I was inside this situation, this tension, patient-therapist, and what this exceptional creature is; a patient who is also a therapist. I asked myself if it is even possible. Is it fair to my patients that I am their therapist while a patient myself? This question was constantly in my mind because most of the time I was in some treatment or another. I mean, when you’re sitting in the classroom, it is very clear which chair you’re in; the patient’s chair or the therapist’s chair. There are two chairs, you can’t sit in both, make up your mind, and I was sitting in both of them, even at the same time…. That was an exceptional creature that no one spoke about, not in the lab, not in class, nowhere.

This ongoing internal discourse stood out against the silence throughout the students’ education. The distinction between the patient’s chair and the therapist’s chair was clear; the existence of a chair that could contain a person who was both a therapist and a patient was never acknowledged. In practice, the students were continuously revising their own position regarding the combination of both parts, trying to figure out what this meant—whether it was possible to sit in both chairs, whether a chair existed that could contain both roles, and whether this was fair to their own patients.

The Transition From Patient to Therapatient

During the interviews, it became clear that the aforementioned questions were part of the students’ personal and professional development process. It included four stages, and some of the students were still in the second or third stage. The first stage began with the students’ introduction to the world of health care and psychiatric difficulties from the other side of the table. From there followed their
decision to enroll in social work studies, in which they found themselves preoccupied with doubts about their therapeutic capability (as illustrated in the quote above). They then wondered about on which “chair” they could and should be sitting: that of the patient or that of the therapist. In the next stage, they focused mainly on accepting the idea of a therapist who is a patient, and concentrated on their abilities as a therapist, giving little attention to their personal experience as a patient.

In the last stage, students not only acknowledged the possibility of being a therapist who also copes with a psychiatric difficulty, but even began to understand the advantages of their unique position as a therapist. These included the ability to empathize with their patients’ psychiatric difficulties and to use the knowledge acquired through their own experiences. The following sections include an elaboration of this process.

**Slowly Approaching the Health Care World**

The first stage of the process occurred prior to the students’ enrolment in social work education. At this stage, the potential students slowly approached the world of health care and psychiatric difficulties from the other side of the table. They did so without initially committing themselves to the new role, through a process of exploration of how this world looked and felt:

It actually started from a long period in which I was volunteering in a mental health community club. It was after my hospitalization and I had come to the conclusion that, to pull myself out of this reclusiveness, I needed contact with other people, to speak to other people, and that’s how I got to the community club. It was my first contact ever with people diagnosed with mental difficulties. Until then, that whole world was unknown to me.

This student’s initial decision to volunteer was based on the need to cope better and to overcome his internal psychiatric experience. He achieved this through making a separation between the “me” and the “them.” Even though he had just been released from psychiatric hospitalization, he referred to the experience in the community center as his first encounter with people diagnosed with mental difficulties. The reason for volunteering, at this stage, was mainly to move forward from his own experiences:

I see it as a bit more natural…. Things happened really fast for me, I mean, and also the fact that I had always been on the receiving side, and this hadn’t happened before. And then there was this natural process of, okay, I’ve grown out of being only on the receiving side; I need to do more things now. Very slowly, at first, I did something smaller. I went to volunteer somewhere, worked with children, and then went to study. During my studies I worked in supported housing and stuff like that, and then it seemed very natural to me. I mean, I can’t point to one specific thing that led to that.

The desire and need to move toward the side of giving from the side of only receiving help is reflected here. This stage is characterized by dichotomous thinking; there are those who receive help and those who provide help: “I was on the receiving end and slowly, I am now beginning to give.” Within this stage, the role of being a patient was not thoroughly discussed, but was experienced as a passing phase. In the next stage, the split no longer existed when the students began to acknowledge that the patient part of them would not disappear.

**Does a Patient Have the Ability to be a Therapist?**

The next stage occurred while entering social work studies and its accompanying field work. During this process, students were expected to “sit on the therapist’s chair” and take part in therapeutic or semitherapeutic situations. These situations gave rise to their doubts and questions about themselves both as patients and as professionals:

I think that my hospitalizations were very unsettling during my studies…and I think that being a patient, and not only a patient but also being hospitalized, and being a student of a therapeutic profession was very, very difficult. It really made me ask myself what I was doing and whether I could really study this profession. Is it acceptable? I felt very guilty, detached, and alone….And I think that my main feeling during my hospitalizations was that I was playacting, wearing the mask of a student of a helping profession. And who am I kidding? I’m the patient, I’m not the therapist. I mean, the question of which side I’m on kept coming up; on which chair I’m sitting. And I felt really guilty that I’m also studying social work. I felt small and apologetic.

The transition between the weak and vulnerable experience and the strong and learning position led to a sense of doubt and lack of authenticity. At this stage, these two parts were experienced as contradictory, eliciting feelings of confusion and deception. Difficult emotions of shame, guilt, and a need to apologize seemed to represent the perception that it was improper to study and pretend to be a helping professional while the student was simultaneously a patient in need of help.

In addition to these difficult feelings, this stage was characterized by concerns that accompanied the encounter between the therapist and patient parts of the student. At this stage, students characterized the image of the therapist as an ideal, which added to their self-doubt:

So I said, wait, I am not suited to this profession, where all boundaries are permeable. Very permeable boundaries. Who
is the patient, who is the therapist, and is it okay that the therapist will also be a bit of a patient, even a little crazy, or someone with difficulties? Is it okay that he has difficulties, or does the perfect therapist have to be healthy...completely clean and flawless? That was my professional image.

The student raised doubts about his suitability as a therapist. He experienced the profession as disturbing where the personal and the professional parts met, and perhaps clashed. The therapist was idealized as “perfect” and “flawless,” whereas the patient was characterized by various levels of difficulty, from “a bit of a patient” to “crazy,” the extreme lay term for someone with mental illness. The meeting point of the “perfect” and the “crazy” undermined his image of the professional. In this stage, the “crazy” parts, difficulties and weaknesses, were experienced and emphasized:

In this profession, you really bring from within yourself and then suddenly, in the midst of the crisis, bringing from within yourself is not really an option because you want to make people believe in change and instill motivation, and I was saying [to myself], “But I can’t do the change myself, so what am I—some kind of hypocrite? What strengths am I talking about? I don’t have any strength.” I had a crisis during my field work. I felt as if I couldn’t speak to them; I didn’t have the tiniest bit of enthusiasm.

The professional task of believing and instilling hope and encouragement in the other becomes too difficult and inauthentic when one has no hope in one’s own life. This experience leads to feelings of falsity and hypocrisy, and of disempowerment to perform this task.

When students treated patients with a story similar to their own, the blurring of the boundaries might have been more prominent:

In my second year of field work, which I stopped after two months, I worked with a patient who told me that she had been to a psychiatrist and had received medication. At that moment, my empathy level shot up. Suddenly, she became the patient whom I hugged the most, not physically, of course, my Number One patient. Suddenly, I wanted to break the [therapeutic] setting. I wanted to reach out and help her, to be more than a regular social worker. It came out of good will, but this was one of my confusing experiences.

The similarity between their experiences and the sense of connection led to the wish to break down the regular work boundaries, to “hug” the patient emotionally and provide different services of help. The student described the figurative outreach of hands, leading to a breaking of the ethical boundaries by saying that he “hugged” her. The good intentions behind this behavior created difficulties.

At this stage, in addition to the wish to reach out beyond the accepted treatment, some students identified with the patient’s story to such an extent that they experienced it through their own perspective. Hence, they made inappropriate use of their own experience to make decisions about the patient’s care:

I was in therapy that was designed to flood the emotions and the traumatic experience, and in this therapy, I think that I totally collapsed. I didn’t have the strength to deal with this experience of emotional flooding. When the time came for me to provide treatment, I didn’t set the goal of flooding people with their difficulties as the goal. I was very careful about that, maybe because of my own experience that flooding can cause someone to collapse. I had someone [a patient] with a traumatic experience. I really tried to avoid that place [of returning and reconstructing the experience]. And that was again out of my experience of when they tried to flood me and make me reconnect and reconstruct, when it was very difficult for me.

The difficulty of differentiating between the self and the other is represented in this quote. The personal experience appeared confusing and was interpreted as the truth. This interpretation and personal experience created a situation in which the student did not focus on the patients’ needs (“I didn’t set the goal of flooding”). This was emphasized by the move back and forth from her own difficult experience to the patients’ situation, focusing on her own experience as the main reason for avoiding this type of therapy. In this stage, the students had great difficulty differentiating between their own and the patients’ needs and goals. This stage was characterized by a personal focus on their needs, difficulties, and lack of capabilities.

A Patient Can Be a Therapist

Not all students interviewed reached this stage, but they might have the potential to reach it in the future. This stage of development occurred when the students stepped back from their own personal story and experienced and were able to “see” the patient in front of them. The students began to identify their existing strengths alongside their weaknesses and vulnerability. This stage was characterized by their ability to “get out of their own skin” and see the needs of the person they were treating:

I’m slowly and gradually building my professional identity. I mean, if once, it was just connecting to the kids [children], trying to help them, without boundaries, behaving with them as if they were my friends in some way….I mean, I didn’t know what it meant to see the needs of the patient. I had no awareness of that at all. I would do a lot of things out of, say, bring them presents, so I wouldn’t feel guilty. Say, if someone would tell a sad story that would get to me in all sorts of places and I wasn’t aware of that, so I would have all sorts of counter reactions, in an unprofessional way. Now I
am more aware of what is done and why it is done, and I want to succeed in helping in a professional way that will give them the strength to cope with their lives, even when I won’t be with them. You know, help them in a professional way…give them tools.

The gradual distancing from the personal story was viewed here through the transition from helping others for one’s own sake to the desire to help others for the others’ sake; from being a hero and acting in place of the other to helping others identify their own way of doing things. This newfound ability to discern the patient’s needs enabled acquisition of a professional identity and professional tools.

Unlike the previous stage in which the students asked questions about the feasibility of the phenomenon of a therapist who also has patient parts, at this stage, they accepted themselves as containing both parts and discussed the concerns related to the existence of both parts and the relationship between them:

I was afraid of sitting in front of someone and passing over to him what I was going through. I mean, I don’t want to ruin someone. That really scares me, being someone’s therapist and ruining them. I know I won’t ruin, I mean, you know, from the point of view of how I will behave, whether it will have a bad effect on him because of what I’m coping with? I don’t think I can wipe out a part of my personality, which is coping with this illness. I mean, this is something that I’m going to be dealing with all the time…and I don’t want to screw up someone’s life because I’m coping with this illness.

The fear of ruining the other because of the patient part in themselves existed, but did not paralyze them. They had an apparent realization that “this” part would always be a part of the self and could not be removed. They took their professional responsibility seriously and were committed to not allowing the situation to have a negative effect on the patient. During this stage, the students developed the capacity to accept their strengths alongside their weaknesses. For this to happen, they began to view the complexity of the parts within them:

I presented a case study in an honest and authentic way. I expressed the dilemmas and difficulties that arose, together with personal content. I did not disclose my past, but there was no need. I felt as if I was bringing my whole self; the weak and powerless parts together with the strong parts in an integrative way. I brought conflicts, wishes, difficulties, as well as capabilities and a passionate desire to be a part of this profession. I felt that I brought myself from within in an especially meaningful way because I did not sense the need for “headlines” from my past or about my illness to express those conflicted parts.

The ability to express strengths alongside weaknesses created a sense of completeness. At this stage, the student applied an authentic expression of difficulties and capabilities, which was considered part of her professional development, and was not necessarily derived from the fact that she was a patient. Her disclosure of the dilemmas experienced as her professional self without the need to disclose her personal story of mental illness was an authentic, important step for her. Among the students, this process contributed to the ability to accept both the patient and the therapist parts:

The understanding that I can be a therapist and that I can even enjoy it; I mean, the anxiety of sitting in the office and of someone coming in to speak to me. Who am I? What am I? Until now, I was only a patient. What has this to do with me? Switching the chairs is also very difficult. Suddenly, I understood that I really can be there for someone and that my eyes aren’t only asking for help but can also be comforting and provide help.

After a period of deliberation, this student acknowledged his ability to sit in both chairs. He was not only a patient in need of treatment, but rather a person who was capable of treating and helping others. His self-identity broadened to include the therapist parts.

To allow this process to occur, the students stressed the need to acknowledge, know, and accept both of these parts. This process included acceptance of the difficulties and pitfalls that arose because they were patients, as well as the benefits, strengths, and capabilities they acquired from these experiences. Another student expressed why this process was important, but did not necessarily occur at this stage:

It was very important for me to learn, and I am still in the process of learning…how to use knowledge—my knowledge—to help others. The knowledge that I have accumulated as a mental health consumer to help others. I don’t, I think that during my studies, it happened less; that side was less prominent. What developed was something that wasn’t exactly me, wasn’t really my narrative somehow. It seems that a professional student developed alongside a student with his own narrative—someone who lost so much in life, two little dwarfs within one person.

Although he wished to use knowledge and personal experiences to help others, he also understood that learning this skill needed time (and would happen in the next stage). During his social work studies, the two parts developed, side by side (“two little dwarfs”), and despite the wish to merge them, this was not an easy task. The student understood that experiences derived from pain could contribute to future professional development. In the next and final stage, the students succeeded in integrating the parts of the patient and the therapist within them.
**Being a Therapatient**

During this stage, the students felt able and willing to use their personal experiences to enrich their professional knowledge. They used their knowledge derived from experience both for others and for themselves. Sometimes, they used self-disclosure throughout the process and at other times, they used their experiences indirectly, without disclosure. For some of the students, their knowledge derived from experience became part of their professional tool box:

I feel and know how these things [personal experience as a patient] have helped me specifically as a professional, to see and understand all sorts of things. I feel this in many situations in which I can understand all sorts of things or see things from angles that come less naturally to, first of all, being one of them, I mean being a patient in a psychiatric hospital, being treated in wards that are more, being one of them, has really helped me. I mean, after all, they are people just like us… Depression issues aside, I learned so much from myself.

The transitions in this student’s speech between “them” (the mental health consumers) and “us” (the professionals), and simultaneously talking about his personal experience, highlighted his identification with the professional population while recognizing his ability to continue to be a mental health consumer. The patient part of him had not disappeared but was observing from the outside, from the professional’s point of view. Within this process, he developed the understanding and recognition that his personal experience was advantageous and meaningful, allowing him to see the patients as people, and using this knowledge and understanding to help others from a professional standpoint. Sometimes, the use of personal knowledge involved personal disclosure:

And then, in the first staff meeting and in the meeting with the residents, I disclosed myself. It was very difficult, but when I had done this, I suddenly understood how important it was because it became a tool in my work as a counselor. When a resident comes and says, “I’m depressed,” I can say, “I understand you.” And when I say, “I understand you,” it has more value than when any other counselor says, “I understand you.”

This student expressed his belief in the significant advantage of the personal experience and the use of disclosure. He conveyed the sense of increased empathy and sensitivity, and even a slight criticism toward those who had never been in the situation.

Personal experience can be used in different ways, not necessarily by self-disclosure:

In my third year [of my studies] I worked in a mental health clinic. That was where I felt closest to the patients; I felt that I had the most to give them. I received very positive feedback. So for me, it was the most meaningful year of my studies. That’s why I chose to work with this population again. I think that I had more emotional ability genuinely to understand their experiences because I had been through something similar. I think I could be of more help, and feel good about myself and about what I’m doing. Here, I have confidence in the work I do.

The insider experience as a mental health consumer allowed this student a feeling of closeness and understanding of these patients and of what they were going through. A gradual understanding developed that the personal experience has reciprocal benefits—for the people treated by the students and for the students themselves in their personal and professional development and confidence. Integration of both parts allowed the students to identify, accept, and become a therapatient—a therapist who is also a patient:

The feeling was that, somehow, here, I am beginning to live. I am starting to come out into the light in a way, because for a very long time I was, I was in some kind of monotonous existence, and suddenly, I can express other sides of myself—not only my weird and difficulties sides, but also strengths.

The expression “starting to come out into the light” might symbolize the ability to live and act as a professional who is also a patient, as a therapatient. This process included a balanced appreciation and expression of the student’s capabilities and difficulties. His integration and acceptance of both parts led him to acknowledge, accept, and even appreciate the meaning of being a patient who is also a therapist.

**Discussion**

The students’ significant dilemmas, challenges, and developmental transition from being mental health patients to mental health providers weaves through the interviews. This developmental process consists of four stages that social work students with psychiatric difficulties undergo. Not everyone reaches the end of the process or passes through all of the stages, but the ability to undergo this process is crucial for developing the ability to integrate both the therapist and the patients parts and become a therapatient.

The first stage of this process usually occurs prior to the students’ enrolment in social work education. At this stage, the potential students gradually develop an interest in the helping profession. They express a desire to provide treatment and help others, and not only to receive help and treatment. Parts of this stage are analogous to the model of recovery among individuals with psychiatric
difficulties. The first stage in the recovery process is the discovery that there is more to them than their illness (Anthony, 1993; Davidson, O’Connell, Tondora, Lawless, & Evans, 2005). This allows them to begin to develop an identity that is not only associated with their illness. In the present study, it led the students to initiate a transition toward enrolling to social work studies.

The second stage occurs once the students begin their education. At this stage, they experience doubts regarding their ability to be therapists because they are patients. They experience difficult feelings of confusion, doubt, and inauthenticity. In accordance with the literature, these feelings are not unique to social work students with psychiatric difficulties, but are common also among other health care students without psychiatric difficulties (Rønnestad & Skovholt, 2003). These feelings are common especially in the beginning and middle stages of the students’ education.

Nevertheless, the source of these feelings is different among the various student groups. Among students without psychiatric difficulties, the origin of the doubt and confusion lies in their doubts as to whether they have the personal characteristics needed to work in a health care profession and whether they have the needed competencies and skills (Rønnestad & Skovholt, 2003). In contrast, the students in this study asked an additional question regarding the ability of an individual who is a patient to be a therapist, a question that has been raised previously in the professional literature (Reamer, 1992; Sherman, 1996; Tinius, 1988). What remains unclear is whether students coping with psychiatric difficulties focus and spend time also on contemplating about the first two issues, regarding their own competencies and the suitability of their personal characteristics. Dealing with these issues is important because they are a part of the development of a self-aware and mindful health care provider.

Students in the second stage often have difficulty distinguishing between their own story and that of their patient. This finding is similar to the first stage mentioned in the professional literature, regarding students of health care professions who are preoccupied with projecting their personal solutions onto others (Rønnestad & Skovholt, 2003). However, what is true for one person is not necessarily true for another (Hayes, 2002). This is a complex stage that the students need to undergo, to allow them the capability to understand the differences and similarities between them and their patients, to be able to focus and help their patients with their own specific needs.

Students who have not yet managed to move beyond the second stage are at risk of becoming what the literature refers to as “impaired professionals.” Impairment is defined as professional dysfunction and the inability to provide proper care as a result of a psychiatric disorder (Laliotis & Grayson, 1985; Reamer, 1992). Impairment can affect both the patient and the student by overidentification, involvement, and enmeshment (Johnston et al., 2005; Rance et al., 2010), or by students projecting their personal experiences onto their patients (Regehr, Stalker, Jacobs, & Pelech, 2001).

At this stage, the participants in the present research described situations in which the boundaries between the self and their patients were undermined, and they found themselves violating the accepted boundaries of treatment. This study indicates that students who are currently at this stage need assistance in processing these feelings, both for their own sake and for the sake of their patients. In cases of students who are coping with psychiatric difficulties, the need to keep themselves safe is even greater in light of the risk of a withdrawal or relapse of the illness (Johnston et al., 2005), and fear of the effects of this withdrawal on them and on their patients. These risks emphasize the importance of referral to treatment and the provision of additional support. In times of need, they might also require greater supervision, or even a recommendation for taking time out of social work school, to return and be more available for their patients and their profession (Russel, Gill, Coyne, & Woody, 1993).

This second stage introduced a reality whereby a student with a psychiatric difficulty either feels unsuitable or is actually not yet suitable to become a therapist. Nevertheless, the present research has shown that not every professional/student with a psychiatric difficulty is an impaired professional. On the contrary; the idea that a therapist can be also a patient is not new. The concept describing this reality is the “wounded healer” (Groesbeck, 1975; Zerubavel & Wright, 2012), a concept highlighting that despite (or because of) coping with difficulties, pain, and wounds, the therapist can treat the wounds of others. To advance and to develop into a therapist who manages to deal professionally with his or her psychiatric difficulties and then with the patients’ difficulties, the students need to undergo a process that allows them to see the self and the other, and differentiate between the two.

This necessary process occurs during the transition to the third stage. This stage requires acceptance of both the patient and the therapist parts, and the acquisition of a new identity that is separate from the all-encompassing identity of the illness (Davidson et al., 2005). During this stage, the students are able to recognize the coexistence of their strengths alongside their weaknesses and to identify their ability to care for others (Davidson & Strauss, 1995). The fourth and last stage identified here represents a significant leap of not only understanding and accepting that both parts exist, but also acknowledging the benefits and advantages of their unique contribution as therapists who are also patients—therapists.
Students who have reached the fourth stage feel able and willing to make use of the expertise acquired from their own experience to enrich their professional knowledge. The students understand that the personal knowledge complements the professional knowledge acquired during their social work education. This realization is important because the literature indicates that in situations in which students feel comfortable with being both patients and therapists, they are able to make extensive use of their knowledge from experience in a way that contributes to their understanding of and unique attention to their patients (Gilbert & Stickley, 2012).

The present study identified a variety of ways in which these students who reached the fourth stage used their personal knowledge from experience. These included the ability for deep understanding and sensitivity of mental health patients’ pain and distress (Disability Rights Commission, 2007; Rance et al., 2010), expressed in an empathic response to their suffering. Another use of their own experience was through self-disclosure to allow others to acknowledge their journey and understand that they could relate to their experience and that people coping with a mental illness can live a significant, meaningful life. In contrast to previous studies that related to knowledge from experience of people with psychiatric difficulties, as relevant only in the context of self-disclosure (Moran, Russinova, & Gidugu, & Gagne, 2013), this study identified this practice as having only one use and benefit, which is not relevant to all.

We must be cautious and emphasize that the process presented here is dynamic, and the transition between the different stages is not static. The students might move between the different stages in the process during different times and experiences in their professional and personal development, and in relation to their mental health state. This puts even greater emphasis on the need to recognize this process as part of professional development and to encourage an open discourse about it and about the possibilities as well as the challenges that arise. Discussing these issues openly during professional supervision can help the conflicts and dilemmas “come out of the closet,” to be spoken of, and resolved.

However, discussing these issues seems challenging because of the self and public stigma the students face (Corrigan, 2002; Holmes & River, 1998). It seems that despite advocacy and expanding the range of opportunities for disadvantaged populations being assimilated at the base of social work education, the profession has so far refrained from acting against the stigma and discrimination of psychiatric difficulties (Scheyett, 2005). One step toward this process is to publicly acknowledge and appreciate the existence of the “chair” that includes a therapist who is also a mental health patient, and to help educators understand the complexity as well as the possibilities when these students become therapists and manage to use their personal experience, as well as the other competencies they have acquired, to help others.

**Limitations, and Implications for Future Research**

Despite the uniqueness of our study, it contains several limitations. First, although the relatively small sample enabled a deeper understanding and more meaningful learning about the study participants’ experiences, it limits generalizability. This is especially true because the sample included self-selected participants; therefore, those who chose to participate might have been somehow different from those who chose not to participate (e.g., might have experienced less social stigma and self-stigma compared to others). Second, out of all of the health care professions, our study focused only on social work students. Therefore, we recommend continuing to explore this phenomenon among other health care professionals to examine the differences and similarities of each profession during students’ transition from patients to therapists.

Third, some of the participants’ responses in interviews might have been influenced by their prior knowledge of the first author’s background as a social worker with psychiatric difficulties. Moreover, because this goes beyond the scope of the present study, we did not compare study participants who had prior knowledge with those who did not. This study is merely the beginning of a new learning process intended to expand the understanding of the developmental process of health care professionals with psychiatric difficulties. We recommend that future studies explore structural and environmental forces that allow or inhibit professional development, as well as those that elicit shame, self-doubt, self-stigma, and the tendency for nondisclosure of these experiences. Understanding these mechanisms might well provide a better environment to help these students maximize their professional potential.

**Conclusions**

Our study identified a process, a journey that students with psychiatric difficulties underwent to become therapists. The journey began with the initial exploration of themselves as potential help providers and not merely as receivers. Following this, at the beginning of their studies, and especially during role plays, field work, and personal crises, they underwent the most difficult part of this journey—when the therapist image was idealized as flawless and when no chair appeared to fit a person who was both a therapist and a patient. During this stage, they were focused on their weaknesses and their difficulties in dealing with the professional requirements; they were frightened of hurting their patients, and felt dishonest.
To move through this stage, they had to acknowledge their strength and ability to be a therapist, as well as the ability to take a step back and observe themselves from the outside and see the patient and their experience as unique and potentially different than their own. Only then could they acknowledge the possibility of becoming therapists. The next and last stage was realizing, understanding, and acknowledging the meaning of being a therapist, and even understanding its advantages. During this stage, they developed the ability to use their personal experience in a way that could benefit their patients in an authentic manner.

This in-depth exploration showed that students with a psychiatric difficulty had to deal with additional dilemmas and challenges within their professional developmental process. They were preoccupied and concerned about the possibility of the phenomenon of a therapist who was also a patient. Unfortunately, they felt as if they needed to undergo this process alone, silently, and with no guidance. It remains unknown whether this process still leaves room for the “main” professional identity developmental task that includes asking themselves questions regarding their professional competence that are unrelated to the mental issues with which they are dealing.

This study is only the beginning of an examination of a subject that still requires investigation. However, it sheds light on the need for further exploration of this process, as well as for supervision and guidance for students during their studies, to create and discuss the “nonexistent” chair of a therapist who also copes with a psychiatric difficulty. This process should acknowledge their existence, the dilemmas they experience, and the ways to integrate both parts to achieve care both for the self and for the other. This process can enable them to maximize their potential in their health care profession, particularly within the mental health system (Cain, 2000).

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