Theses and Dissertations

2015

The use of reflective practices by psychology interns

Rachel Fried

Pepperdine University

Graduate School of Education and Psychology

THE USE OF REFLECTIVE PRACTICES BY PSYCHOLOGY INTERNS

A dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Rachel Fried

August, 2015

Edward Shafranske, Ph.D., ABPP — Dissertation Chairperson

This dissertation, written by

Rachel Fried

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Edward Shafranske, Ph.D., ABPP, Chairperson

Carol Falender, Ph.D.

Aaron Aviera, Ph.D.

TABLE OF CONTENTS

LIST OF TABLES

DEDICATION

To my parents, Leonard and Chana Grunstein, who instilled in me a passion to never stop learning. To Stevie, Jonathan, Eli, and Andy, for letting me follow my passion and for loving and supporting me, always.

ACKNOWLEDGMENTS

VITA

2009 – 2015   **Doctor of Psychology (Psy.D.),** Anticipated Summer 2015
Pepperdine University, Graduate School of Education and Psychology (GSEP), Los Angeles, CA

2006 – 2008   **Master of Arts in Marriage and Family Therapy**, Spring 2008
University of Southern California (USC), Los Angeles, CA

2004-2006   **Master of Arts in Educational Psychology and Technology**, Spring 2006
University of Southern California (USC), Los Angeles, CA

1998-2002   **Bachelor of Arts in Psychology,** Fall 2002
Stern College for Women, New York, NY

CLINICAL EXPERIENCE

2014 – 2015   **Pre-Doctoral Intern, APA-Accredited Doctoral Internship**
Veteran Affairs, Sepulveda Ambulatory Care Center (SACC), North Hills, CA

2012 – 2014   **Practicum Trainee Veteran Affairs**
VA Los Angeles Ambulatory Care Center, Los Angeles, CA

2011-2012   **Pre-doctoral Assessment Extern, Pediatric Neuropsychology**
Kaiser Permanente, Los Angeles, CA

2010-2011   **Practicum Student**
Metropolitan State Hospital, Norwalk, CA

2009-2013   **Pre-doctoral Therapist**
Pepperdine University Psychological and Educational Clinic, Los Angeles, CA

SUPERVISORY EXPERIENCE

2014 – 2015   **Intern Supervisor for Psychology Practicum Student**
Veteran Affairs, Sepulveda Ambulatory Care Center (SACC), North Hills, CA

2011 – 2013   **Peer Supervisor, Doctoral Trainees**
Pepperdine University Psychological and Educational Clinic, Los Angeles, CA

RESEARCH EXPERIENCE

2013-2014   **Data Manager**
Harbor UCLA Medical Center, Torrance CA

2007   **Research Assistant**
University of Southern California (USC), Los Angeles, CA

TEACHING EXPERIENCE

2012   **Teaching Assistant, Doctoral-level Clinical Psychopathology Course**
Pepperdine University, Graduate School of Education and Psychology (GSEP), Los Angeles, CA

ABSTRACT

Despite its importance, little is known about how psychologists are trained to reflect on their

conduct of psychotherapy. These abilities are collectively known as reflective practice, which is

considered a core competence within the field of psychology. This study examined the use of

reflective practice by clinical, counseling, and school psychology interns and looked at how

reflective practice is being facilitated by supervisors. The study examined the use of reflective

practice in different clinical situations and obtained opinions about which reflective practices are

believed to most impact clinical effectiveness. The study also examined barriers that may

impede engagement in reflective practice. A mixed-method approach, including quantitative and

qualitative analyses, was used to examine study questions in a sample of 69 pre-doctoral

psychology interns. Results of this study indicated that for clinical cases in which the therapeutic

work was "going well," psychology interns engaged in reflective practice slightly more than

once per month. However, for challenging cases (whether the "work was going well or not")

reflective practice was reported to increase, on average, to more than once per month, but less

than once a week. There was no significant difference in frequency of reflective practices used

between "challenging cases going well" and "challenging cases not going well." This study

found that supervisors facilitated an average of slightly over half of the total reflective practices

measured. Further, the number of practices facilitated by supervisor was significantly correlated

with the frequency of reflective practice use among interns. The reflective practices perceived to

have the most impact on clinical effectiveness were (a) reflecting on feelings during session, (b)

examining personal beliefs and values, and (c) reflecting on the quality of the therapeutic

relationship. The most significant barrier to engagement in reflective practice was reported to be

time. In regard to interns' beliefs about how helpful reflective practice is to clinical practice, two

major themes emerged: (a) whether reflective practice was helpful to the therapist (e.g., increased self-awareness) versus (b) if it was helpful to the client (e.g. helped client process their emotions more). Implications for future research and application to clinical practice are discussed.

Introduction

An important characteristic of any field of professional practice is the ability to observe and reflect on one's actions in a thoughtful and critical way (Schön, 1983, 1987). Within the field of psychology, this approach has been identified as a core competence and is known as reflective practice (Fouad et al., 2009). While references to notions of reflective practice appear frequently in the psychology literature, little is known about the actual use of reflective practice in clinical practice (Fouad et al., 2009). This dissertation has as its main aim the assessment of the use of reflective practice by clinical, counseling, and school psychology doctoral interns.

Within the field of psychology increased attention has been placed on reflective practice, particularly in the context of clinical training. It is an integral component of the competencies movement aimed towards defining and assessing specific professional competencies for psychologists and is considered to be one of the foundational competencies for psychologists in training. This competency-based approach to training stands in stark contrast to the more traditional approach in which competence was seen as the outcome following the accumulation of knowledge in particular content areas; the acquisition of knowledge was viewed as a measure and means of reaching professional competency (Peterson, Abrams, Peterson, & Stricker, 1997, 2006). The competency-based approach was the focus of a succession of conferences (The Committee of Accreditation of the American Psychological Association, 1996; The Competencies Conference, 2002; The National Council for Schools and Programs of Professional Psychology, 1986), over the last two decades, which established competencies for professional psychologists for the purpose of evaluating clinical skills (Epstein & Hundert, 2002; Fouad et al., 2009; Kaslow et al., 2007; Rodolfa et. al., 2005). Currently, the competency model, also known as the Cube Model (Fouad et al., 2009) has gained acceptance across a number of

psychology training programs. The model identifies 15 professional competencies. These include both foundational competencies (i.e., the values, knowledge, skills and attitudes that are the foundational characteristics of a psychologist) and functional competencies (encompassing the major functions performed by a psychologist), across three stages of professional development (i.e. practicum, internship, entry into practice). The foundational competency of reflective practice is currently defined as, "Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care" (Fouad et al., 2009 p. S10).

Reflective practice as a distinct competency has evolved over time to embrace a broader construct. It includes a focus on developing one's self-awareness as a way to enhance clinical practice (i.e. reflective practice), the ability to self-assess across all domains of clinical practice (i.e. self-assessment), the ability to understand how to properly care for oneself in the context of clinical practice (i.e. self-care), and the ability to actively engage in the supervision process (i.e. participation in the supervision process). What seems to be shared across these four domains is the expectation that one can develop the ability to become increasingly self-aware in two important areas of clinical training (particularly in respect to psychological treatment): (a) an understanding of how to appropriately apply therapeutic approaches and interventions and (b) an understanding of the practitioner's personal identity and characteristics (often referred to as *use of the self*) and how this interacts with the practitioner's clinical work.

This dissertation utilizes the term reflective practice as an umbrella term to include self-assessment, self-care, and participation in the supervision process. What follows is a brief overview of the history of reflective practice. A more detailed discussion on the competency movement and reflective practice is set forth in Appendix A.

Background

  Historically, Dewey (1933) is credited with initiating the discussion of reflective practice. Although his theory is grounded in educational theory and critical thinking, it has broad application to professional practice, generally. According to Dewey, reflective practice is the process by which, "the ground or basis for a belief is deliberately sought and its adequacy to support the belief examined" (p. 9). The process that stimulates reflective practice, according to Dewey, is having thoughts that result in beliefs, which have a level of importance attached to them by the practitioner. Thus, reflective thought usually follows, as the mind engages in conscious inquiry into the nature, conditions, and bearings of beliefs and then examines the logical consequences of those thoughts on behavior. The act of reflective practice usually involves a state of perplexity or doubt that cannot be addressed through formal logic alone. Dewey proposes that certain thoughts are not automatically questioned, but rather they are accepted as true, whether because of tradition, instruction, or imitation. This kind of visceral thought process appears to disrupt the process of reflection. It is suggested that personal contexts, often greatly influence what thoughts are unconsciously accepted. Therefore, according to Dewey, reflective practice must be a conscious and dedicated process for it to yield a fruitful understanding of professional practice and for the process to enhance professional competency.

  Schön's (1983, 1987) work, based on Dewey's (1933) ideas of reflective practice, is the basis of the contemporary discussion of reflective practice in many areas of professional practice, including psychology (Fouad et al., 2009). His views have also impacted education, medicine, nursing, and sports psychology, among other disciplines (Copeland, Birmingham, DeMeulle, D'Emidio-Caston, & Natal, 1994; Knowles, Gilbourne, Tomlinson, & Anderson, 2007; Mamede,

Schmidt, & Penaforte, 2008; Teekman, 2005). Schön's (1983) unique contribution to the world

of the practitioner is that he questioned the dominant approach to practice. He called this

approach "technical rationality," (p. 21) or the strict application of research to practice. He

argued that while scientific theory is necessary to inform practice, it is not adequate in addressing

the complexity of practice. Schön (1983) proposed that practice must be "reflection-in-action"

(p. 49). This is because the science of the laboratory, under ideal conditions, does not take into

account the vague nature of how problems are expressed in clinical situations. What is

necessary, according to Schön (1983), is the ability to reflect on what has occurred, in practice,

and what is occurring while a practitioner is engaged in practice. He distinguished the two by

calling one, "reflection-on-action" (p. 49) and the other, "reflection-in-action," (p. 49)

respectively. Both are important to practice, and, according to Schön (1983), the ability to

reflect when in action (i.e. critically evaluate, question, and shift while engaged in practice)

arises out of repeated reflection on action. Schön (1983) asserted that engagement in reflection

produces a tacit way of knowing, emblematic of a very skilled practitioner. It is important to

note, Schön's (1983) notions of "reflection-on-action" (p. 49) and "reflection-in-action" (p. 49)

have been integrated into how the competency of reflective practice has been conceptualized for

training psychologists. These notions inspired the proposed behavioral anchors at each level of

professional development for the Reflective Practice competency (for a more detailed

description, see Fouad et al., 2009 in Appendix A).

A widely cited definition of competence (drawn from medicine) is "the habitual and

judicious use of communication, knowledge, technical skills, clinical reasoning, emotions,

values, and reflection in daily practice for the benefit of the individual and community being

served" [which depends on] habits of mind, including attentiveness, critical curiosity,

self-awareness, and presence" (Epstein & Hundert, 2002, p. 227). At the center of the definition is the need for reflective practice. Kaslow et al. (2007) explicitly identified reflective practice and self-assessment as the guiding principles to achieve competence. Further, Rubin et al. (2007) suggest that training should focus on developing the trainee's capacity for self-reflection and self-assessment because this is at the heart of lifelong competent practice across all competency domains. Interestingly, the definition of competence is borrowed from the medical profession, where it originated (Epstein & Hundert, 2002). This appropriation is consistent with the fact that clinical psychology is also a health care profession. Also the definition remedies a gap in the psychology literature, since psychology had not until recently dedicated effort to apply an explicit competency model (Falender & Shafranske, 2004) nor to examine and to validate definitions of competence (Fouad et al., 2009). What follows is a brief overview of the limited literature on reflective practice within the field of clinical psychology.

Reflective Practice Within the Field of Psychology

Within the field of clinical psychology, reflective practice has been defined as using focused inquiry to increase personal and professional self-awareness. The goal is to attain a comprehensive understanding of one's professional work and to increase competency in practice (Fouad et. al., 2009; Nelson & Neufeldt-Allsetter, 1998; Skovholt, Ronnestad, & Jennings, 1997). Reflective practice is believed to be a metacognitive skill that brings focus to observations, interpretations, and evaluations of one's own thoughts, emotions, feelings and actions, within the context of one's professional work (Bennett-Levy et al., 2001; Hoshmand, 1994; Ward & House, 1998).

In practice, reflection can have two broad applications. It refers to the personal use of self-awareness, which is an examination of the clinician's life experiences, cultural contexts, and

previous relationships as well as how these personal factors influence the therapeutic process. This is the subjective and experiential aspect of therapy. Reflection also refers to practice-based learning. Thus, the professional forms a procedural knowledge base over time through continued engaged reflection, and self-assessment, which is what guides a professional's moment-to-moment actions in the professional realm (Lavender, 2003; Schön, 1987).

Although there is no empirical research on the benefits of reflective practice or how it relates to clinical effectiveness, there is some literature on the proposed benefits (Bernard & Goodyear, 2004). According to Skovholt et al. (1997), reflective practice is believed to be what allows the practitioner to continue to develop and grow, avoiding stagnation and burnout. It is also suggested that reflective practice can enhance clinical effectiveness (Schön, 1987). This is because reflection is believed to engender a process whereby the practitioner develops increasing personal self-awareness. It is postulated that this in turn contributes to a greater understanding of how most effectively to approach the client and a determination of what personal biases may hinder effective treatment (Hoshmand, 1994; Lavender, 2003). Additionally, engagement in self-reflection is believed to lead to a self-assessment process, whereby the learner develops the ability to monitor his or her own progress, validly assess his or her strengths and what areas are in need of improvement. The process helps identify whether standards for practice have been met and what needs to be done when professional limits are reached (Belar et al., 2001; Kaslow et al., 2007). Insights are thereby provided as to what is needed to pursue the most effective and ethical clinical practice (Rosin, 2015; Schön, 1987). According to Gillmer and Marckus (2003), in essence reflective practice addresses the gap between theory and the moment-to-moment decision points in therapy. This is what characterizes skilled practice. Furthermore, from a cross-cultural therapy perspective, reflective practice is believed to engender the supervisee's

ability to genuinely identity him/herself, the client and any cultural influence on the therapeutic process (Collins, Arthur, & Wong-Wylie, 2010).

There has been some discussion of the deleterious effects of a lack of engagement in reflective practice. Skovholt and Ronnestad (1992) found through their studies on counselor development that counselors tended to become more rigid and externally oriented as they advanced in their training. They suggest that more critical engagement in reflective practice, as it relates to personal experiences and biases, may be the ingredient in developing a more open attitude towards training and practice. Further, it has also been proposed that lacking the capacity to self-assess is equivalent to failing to attain a level of professionalism necessary to be a psychologist. This is because it interferes with being able to self-correct behavior (Belar et al., 2001).

It is clear that being able to engage in reflective practice necessitates several unique personal characteristics (Rosin, 2015), including:

- Openness and curiosity (Falender, Shafranske, & Falicov, 2014; Fouad et al., 2009; Kaslow et al., 2007; Neufeldt, Karno, & Nelson, 1996);

- The ability to be mindful and bring awareness to thoughts, feelings, and sensations (Dallos & Stedmon, 2010; Falender et al., 2014);

- The ability to bring awareness to the impact of one's self on others and how one is experienced by others (Fouad et al., 2009; Wong-Wylie, 2010);

- The ability to monitor what is and what is not known (i.e. metacompetence; Falender et al., 2014; Fouad et. al., 2009); and

- The ability to engage in critical thought (Fouad et. al., 2009; Rosin, 2015).

As evident from the definitions of reflective practice and the characteristics required, this construct is related to many areas, such as critical thinking and judgment, experiential learning theory, cultural awareness and competence, self-awareness, and moment-to-moment awareness in the clinical realm (or mindfulness; Collins et al., 2010; Eraut, 2000; Gambrill, 2005; Gambrill & Gibbs, 2009; Nut-Williams, 2010; Owen & Lindley, 2009). (For a more detailed review of these related areas, please see Appendix A).

Reflective Practice Within Supervision

Much of the discussion on reflective practice within the field of psychology occurs within the context of clinical supervision (Moffet, 2009; Neufeldt et al., 1996; Orchowski, Evangelista, & Probst, 2010; Ward & House, 1999). Supervision is where habits of practice are developed and thus it is the most advantageous context to foster reflective practice (Neufeldt et al., 1996). Furthermore, self-assessment and self-appraisal are central to the ability to self-reflect in practice (Fouad et al., 2009). However, when initially done without the benefit of supervision, it is fraught with challenges to accuracy (Bollich, Johannet, & Vazire, 2011; Caputo & Dunning, 2005; Carter & Dunning, 2008; Kaslow et al., 2007; Krueger & Muller, 2002; Wise et al., 2010). Nevertheless, the role of reflectivity in clinical supervision and supervisee development has received very limited attention in both theoretical and empirical work within the field of psychology (Orchowski et al., 2010). A brief summary of the extant literature on reflective practice within clinical supervision is set forth below.

The literature on reflective practice, within supervision, addresses how to help supervisees reflect on their practice in a systematic way. Engaging in reflectivity is construed as a sequential process within supervision. The process usually evolves from a clinical stuck-point, confusion or surprise. The therapist's own personal qualities are considered in the process of

reflection, as is the institutional and supervisory environment (Neufeldt et al., 1996; Orchowski et al., 2010; Ward & House, 1998). Most of the literature focuses the reflective process on attention to therapist actions, emotions, and thoughts, as well as to the interaction between the therapist and client, as sources of understanding. Simultaneously, and of equal import, is the focus on knowledge of theory and, concomitantly, on self-assessment of knowledge and skill. Often times this occurs through the use of journal writing, watching videos or listening to audios (Fouad et al., 2009; Moffet, 2009; Orchowski et al., 2010). The goal of this process, within supervision, is for reflectivity to lead to changes in perception, action or attitude and an increased understanding of oneself and clinical practice, in general. "When modeling reflective practice, the supervisor aims to confront puzzling interpersonal or affective events, explore the dynamics behind the event, and work toward resolving the puzzling event so that they can apply the new knowledge in future practice situations" (Neufeldt et al., 1996, p. 5). From this stance of heightened, affective awareness, the supervisees can apply analytic thinking skills to examine the dynamics underlying their sense of uncertainty. Then, a plan of action can be developed that is grounded in their sense of self, as well as, their knowledge of theory and clinical practice. (For a more detailed discussion of each of these articles on reflective practice and supervision, see Appendix A).

As this brief introduction to reflective practice suggests, despite its identification as an essential competence, significant gaps exist in understanding the nature, development and actual conduct of reflective practice in professional psychology. Nevertheless, the theory underlying the construct of reflective practice, as described in the theoretical literature, suggests several behavioral practices, listed below:

- Examining personal beliefs (Dewey, 1933; Fouad et al., 2009; Hoshmand, 1994; Scaife, 2010);

- Examining one's cultural background and diversity characteristics (Collins et al., 2010; Dewey, 1933; Fouad et al., 2009; Peterson et al., 2006; Scaife, 2010; Wong-Wylie, 2010);

- Examining thoughts, feelings, and physical sensations (Dallos & Stedmon, 2010; Neufeldt et al., 1996; Rosin, 2015);

- Self-assessing one's clinical competence (Belar et al., 2001; Fouad et al., 2009; Kaslow et al., 2007);

- Self-assessing the need for self-care (Fouad et al., 2009);

- Thinking critically about the application of theory and research to clinical practice and how to be clinically effective (Dallos & Stedmon, 2010; Neufeldt et al., 1996; Scaife, 2010);

- Thinking about one's impact on others and the quality of the therapeutic relationship (Fouad et al., 2009);

- Reflecting on what is needed in supervision (Fouad et al., 2009; Scaife, 2010);

- Learning to reflect-in-action through reflection-on-action (Dallos & Stedmon, 2010; Fouad et al., 2009; Schön, 1987);

- Keeping a journal of clinical experiences (Griffith & Frieden, 2000; Moffet, 2009; Orchowski et al., 2010; Sutton, Townend, & Wright, 2007);

- Viewing videos or listening to audios of sessions (Fouad et al., 2009; Orchowski et al., 2010).

Challenges to Engaging in Reflective Practice

There have been several challenges identified to the promulgation of reflective practice within the field of psychology (Boud & Walker, 1998; Nelson & Neufeldt-Allsetter, 1998; Orchowski et al., 2010; Roberts, Christiansen, Borden, & Lopez, 2005; Scaife, 2010). First, there are difficulties inherent in even defining a concept that appears to be so theoretical and intangible in nature (Dallos & Stedmon, 2010). Since reflection is an internal process, it is difficult to measure objectively and bring under experimental control. It is also multi-dimensional, making it difficult to capture and measure. For example, reflection can be on the past, present, future, oneself, others, the world, personal experiences and so on and so forth, which leads to challenges in specifying and comparing experiences of reflection, let alone assessing competence in reflective practice (Bennet-Levy, 2001). Another significant roadblock is the lack of appropriate evaluation strategies of the competencies within the field of psychology, necessary to guide reflective practice. This lack of evaluative tools is one of the major reasons for the delays that often occur in professions between the initiation of a competency-based movement and the adoption of a culture of competence (Rubin et al., 2007).

Challenges to training in reflective practice in supervision. Lack of time is reported to be a common barrier to engagement in reflectivity (Vasquez, 1992). Other barriers to reflective practice were identified in a small qualitative study of five counseling students and included: experiencing mistrusting/unsafe relationships (among students, supervisors, and professors), interacting with non-reflective students, receiving unsupportive jarring feedback from supervisors, facing an unsafe educational landscape (i.e. assigning standard grades for reflective exercises, supervisors playing dual roles), and interacting with unsupportive academic personnel (Wong-Wylie, 2007).

Additionally it is suggested that students in training may resist reflective practice. This is because, by its very nature, reflective practice involves the motivation and openness of an individual to look at all aspects of his or her self and practice. This can be an overwhelming and anxiety provoking experience. Fears of appearing incompetent and the discomfort associated with looking at personal vulnerabilities can be an impediment to engaging in reflective practice (Orchowski et al., 2010; Scaife, 2010). Furthermore, a sizable body of research demonstrates that supervisees often fail to disclose information to their supervisors or choose to discuss topics that produce only positive impressions of their work, as opposed to negative ones (Coburn, 1997; Ladany, Hill, Corbett, & Nutt, 1996; Mehr, Ladany, & Caskie, 2010). This would limit the potential of engaging in effective reflective practice within the context of supervision. Thus, it is suggested that a supervisee's approach to reflectivity critically determines whether they ultimately adopt a reflective stance. For example, supervisees who are confident, self-aware, self-efficacious, open to feeling vulnerable and comfortable with uncertainty are believed to be more likely readily to integrate reflective practice into supervision. By contrast, a student who fears evaluation or engages in a high degree of impression management may respond defensively at the request to display vulnerability and engage in reflective practice. Ultimately, this interferes with the student's ability to learn (Orchowski et al., 2010).

Limitations and Gaps in the Reflective Practice Literature

As noted above, the literature includes several definitions of reflective practice, practices that may develop and encourage reflective practice, and proposed benefits. However at this point, the literature remains largely theoretical. What is missing is an empirically-derived understanding of the ways in which trainees engage in reflective practice and the extent to which (e.g., frequency) they engage in such practices. Also, largely absent from the literature is an

understanding of how supervisors encourage the use of reflective practice within supervision. Further, it is not known which reflective practices increase clinical effectiveness and how reflective practices are viewed from the trainee's perspective. Finally, the barriers to the use of reflective practice have not been empirically studied. The development of an empirically-informed understanding of the use of reflective practice and factors influencing its development in supervision is essential to advance reflective practice as a competence.

Purpose of the Study

The purpose of this study is to describe: (a) the use of reflective practices by doctoral interns in clinical, counseling and school psychology; (b) the reflective practices that are being facilitated by supervisors in clinical supervision; (c) opinions of supervisees about the reflective practices that contribute to clinical effectiveness; (d) opinions of supervisees about perceived benefits of reflective practice; and (e) opinions of supervisees about perceived barriers to reflective practice. The aim of this study is to obtain an empirical snapshot of current practices and attitudes to lay the groundwork for the development of a detailed functional model of reflective practice.

Method

Research Approach and Design

This study utilized a survey approach to obtain both qualitative and quantitative data regarding the use of reflective practices and opinions regarding benefits and barriers to reflective practice. The use of an Internet-based self-report instrument was employed because of its ability to reach a large number of participants and because of its ease of use (Hoonakker & Carayon, 2009).

Participants

Participants recruited for this study were interns from clinical, counseling, school, and combined psychology doctoral programs. Given that the internship year represents a significant milestone in the transition from student into professional psychologist and is the formal culmination of organized clinical training for many students, interns can provide an important snapshot into the extent to which reflective practices have been developed over the course of their education and training.

Instrumentation

The instrument developed for this study included a demographics section and a reflective practices section (see Appendices A and B). We turn first to a description of the demographics section.

Demographic section. The demographics section was developed to obtain demographic information on study participants (e.g. age, gender, ethnicity, program type, degree type, and theoretical orientation). It included forced-choice items, with the option to select *other* and fill-in other answers to the response items. Data from this section allowed for comparison of the study participants and the population of interns, based on the APPIC Match Survey (2014-2015)

of internship placed applicants and provided the means to examine the adequacy of the sample to generalize from the findings.

Reflective practices section. The examination of the use of reflective practices was conducted considering the clinical conditions that might influence motivation for reflection, such as the degree of challenge and whether or not the conduct of the case was going well. This required participants to first reflect on all their cases over the past month in which they provided psychological treatment (i.e. individual psychotherapy or couple's psychotherapy) and to select three different cases that best fit the following categories: (a) A case in which the therapeutic work was going well (b) a clinically challenging case in which the therapeutic work was going well; and (c) a clinically challenging case in which the therapeutic work was not going well and in which the participant felt ineffective. Participants were also instructed that if they could only identify cases in two of the categories, they should complete the survey on those cases. Following their selection of cases, participants indicated their use of 20 reflective practices, (e.g. "I devote time to examine my personal beliefs and values;" "I devote time to the self-assessment of my clinical competence") for each of their three identified clinical cases. An open-ended item was also included to identify other reflective practices. Items on this portion of the survey were selected based on the reflective practices addressed in the existing literature, within psychology, on reflective practice. In addition, items were formulated, in consultation with the chair and committee members of the present dissertation, who have contributed to the literature on clinical supervision in clinical psychology.

The second part of the survey asked participants about the reflective practices that were facilitated within their supervision during the first half of their internship year. Finally, the

survey asked participants to identify up to three reflective practices that they believed to have had the greatest impact on their clinical effectiveness as psychotherapists.

The third part of the survey has a qualitative component. It was intended to gather more detailed and in-depth information about the interns' beliefs about reflective practice, which was not easily captured through the reflective practice survey items. Participants were asked about their beliefs about how reflective practice is helpful to clinical practice and the perceived barriers towards engagement in reflective practice. The Reflective Practice Survey can be found in Appendix B.

Survey development. The Reflective Practice Survey was developed in three primary stages. First, a critical review of the literature on reflective practice within psychology was undertaken. This was done in order to identify the behavioral practices that psychology discusses as being central to reflective practice. In the second stage, an expert panel reviewed the initial survey of behavioral practices to determine the validity of the survey (i.e. face, content, and construct validity). In the third stage a small pilot study was done with 12 third year Pepperdine doctoral students, in a psychology practicum course, to ensure that the survey items were clear and understandable. Based on feedback from students, further consultation with the expert panel, and consultation with an expert on survey development (S. Harrell, personal communication, December 4, 2014) items that were considered to be vague or unclear were removed from the survey. In addition, it was decided that the respondents be asked to consider their engagement in reflective practice within the circumscribed time frame of one month. It was believed that this would provide a more accurate report of their performance of reflective practices based on research that suggests that retrospective memory is less likely to be biased when a specific time-frame for retrospection is imposed (Pearson, Ross, & Dawes, 1992). The

survey was also expanded to consider engagement in reflective practice under varying conditions (i.e. typical cases, clinically challenging cases where the therapeutic work is going well, and clinically challenging cases not going well where the supervisee feels ineffective). This change was made, as the extant literature suggests that the starting point for reflective practice is understood to be when a challenge is encountered, such as a therapeutic stuck point, uncertainty, or confusion (Neufeldt et al., 1996; Orchowski et al., 2010; Ward & House, 1998). However, there is also much discussion, in the literature, on how fears of vulnerability and feeling incompetent may impede supervisee engagement in reflective (Neufeldt et al., 1996; Orchowski et al., 2010; Scaife, 2010; Ward & House, 1999). Comparing use of reflective practices in three clinical conditions provides a means to examine the impact of fears of vulnerability on meta-competence and self-reflection.

Procedures

This section presents the procedures that were employed in this study, including the means of recruitment, human research subjects' protection, data collection and data analysis. These procedures were approved by the Pepperdine University Graduate and Professional Schools Institutional Review Board (IRB).

Recruitment

Recruitment for study participants began following approval by Pepperdine University's Institutional Review Board (IRB) on February 19, 2015. Recruitment was open for a period of three months (e.g. February, 2015-April, 2015). Participants were recruited from internship sites with membership in the Association of Psychology Postdoctoral and Internship Centers (APPIC). The training directors at these sites were contacted via email, through the email list set forth in the APPIC directory. Following the initial request to forward invitations to participate in the current study a follow-up reminder was sent one month later. A cover letter noting that this study pertains to interns' engagement in reflective practice, the extent to which supervision facilitates reflective practice, and the reflective practices that are believed to contribute to clinical effectiveness, was included in the email. Training directors were asked to forward to their current interns a link to the web-based instrument. These announcements also asked recipients to forward the invitation to any pre-doctoral interns who meet eligibility for the study. It is important to note that this *snowballing* approach to participant recruitment resulted in participation from interns who were not from APPIC internship sites. However, this data could be separated out, as participants were asked to answer whether they were at an APPIC or APA accredited internship site.

APPIC (2015) reports that 3,569 students matched through the Phase I and Phase II match process in the 2014-2015 training year. However, there is no way to determine how many potential study participants actually received the web-based instrument. Therefore an exact number of desired participants could not be determined. Furthermore, given that the current study is not based on any prior research, it was difficult to establish an aspirational quantity for the number of participants for this study.

Human Research Subjects Protection

The procedures employed in this study were deemed acceptable and approved by Pepperdine University's Graduate and Professionals School IRB. To ensure their protection, the participants were informed of the study's purpose and procedures, the estimated completion time, protection of confidentiality, potential risks and benefits in participation, the voluntary nature of participation, and the right to discontinue participation at any time. In order to incentivize participation, research participants were given the opportunity to enter a drawing to receive one of three, twenty-five dollar Amazon, gift cards for their participation (Hoonakker & Carayon, 2009). Sixteen participants submitted their emails to participate in the drawing.

Consent. Because this study was determined to pose no greater than minimal risk, formal documentation of informed consent was not required. Instead, the consent to participate was included in the opening section of the Internet-based survey and consent was obtained prior to the participant beginning the survey. The informed consent form included a description of the study, the study's purpose and procedures, the rights of human research subjects and the potential risks and benefits to participation.

Potential risks and benefits. This study was presumed to pose no greater than minimal risk to study participants. The risks included: inconvenience due to time spent in participation

(approximately 15-20 minutes), fatigue, and possible distressing reactions when reflecting on challenging cases that were not going well and/or related to feelings of disappointment or incompetency for not being exposed to the idea of reflective practice or using reflective skills in practice. Potential risks were minimized by making the study as user-friendly and convenient as possible, not asking for any identifying information, and suggesting that in the event of a distressful reaction to the study, participants should seek assistance to deal with the distress. Participants were given the name and contact information of the researcher and the study advisor to obtain assistance to obtain a referral to a clinician if they experience distress as a result of their participation in the study.

Participants receive no direct benefit from the current study; however, it is believed that participation in the study could provide information about some means to enhance their reflective practice, which is a foundational clinical competency (Fouad et al., 2009). Also, participants may experience satisfaction in having contributed to the profession and its literature through their participation.

Data Collection

Data was collected through an Internet-based survey administered by SurveyMonkey, a Internet-based survey development company. Information about the IP addresses of the participants accessing the survey website was not obtained in order to protect participant anonymity. The use of an Internet-based survey is both beneficial to the researcher and study participants. It minimizes cost, provides for convenient access from any Internet-enabled computer, protects participant confidentiality, and produces better response quality, as compared to mail-based surveys (Hoonakker & Carayon, 2009).

For the purposes of data entry and analysis, Internet-based surveys provide several benefits. They minimize cost and time associated with data entry and also significantly reduce the rate of error associated with manual data entry. The use of an online survey service also allows for easy conversion of the data into a database for statistical analysis. The data for this study was stored on a password protected external drive and will be destroyed, by the investigator, five years after the completion of this study. To ensure that participants did not complete the study multiple times due to receiving the invitation to participate more than once, the Internet-program housing survey only allowed each computer IP address to access the survey once. IP addresses were not recorded in order to protect participant anonymity.

Participant demographics. Sixty-nine participants (59.46%) completed the survey sufficiently to be included in the final analyses. Participants ranged in age from 26 to 66 years (*Mean age* = 31.62, *SD* = 6.67). Of the 69 participants, 60 (87%) were female and 9 (13%) were male. In regards to racial/ethnic identification, 75.4% of participants identified as White (non-Hispanic), 2.9% as Asian/Pacific Islander, 5.8% as Hispanic/Latino, 8.7% as African American/Black, 4.3% as Bi-racial/Multi-racial, and 1.4% identified as Other. In terms of program type, 78.3% were in clinical programs, 14.5% in counseling programs, 5.8% in school psychology programs, and 1.4% in combined programs. For their degrees sought, 47.8% were pursuing a Psy.D. and 51.5% were pursuing a Ph.D. For theoretical orientation, 50% described their orientation as cognitive behavioral, 27.9% as psychodynamic, 13.2% as humanistic/existential, 7.4% as Other (e.g., interpersonal, feminist), and 1.5% as family systems. Finally, 25 participants (21.01%) stated they were in their own personal therapy. Descriptive statistics of demographic variables for the final participant sample appear in Table 1.

It was not possible to compare these participant characteristics to the data available for

current APPIC pre-doctoral interns because the results of the 2014-2015 Match Survey were not

yet posted. However, APPIC match statistics were available from 2011. These are reported

below. Although these demographic statistics do not reflect the current sample, it is still

noteworthy information as it can provide a general idea of demographic characteristics of APPIC

predoctoral interns. Of 2,731 participants who completed the 2011 survey, 79% were in clinical

psychology programs, 13% were in counseling programs, 5% were in school counseling

programs, 3% were in combined programs, and 1% endorsed other. In regard to degree sought,

54% were in Ph.D. programs and 45% were in Psy.D. programs. Ages ranged from 23-64, with

a mean age of 30.1 (SD=5.5). In regard to gender, 79% of the sample was female, while 21%

was male. In regard to ethnicity, 6% were African American, 1% was American Indian/Alaskan

Native, 7% was Asian/Pacific Islander, 8% was Hispanic/Latino, 75% were White (Non-

Hispanic), 4% were Bi-racial/Multi-racial, and 3% identified as other.

Data Analysis

The data analyses incorporated a mixed-methodological approach including quantitative

and qualitative analyses. The quantitative analysis portion utilized descriptive statistics to

characterize participant demographics, behavioral practices of reflective practice being utilized,

and the overall frequency of engagement in these practices. Next, independent sample t-tests and

one-way analysis of variances (ANOVAs) were performed to examine possible group

differences in their frequency of reflective practice use based on gender, race, type of degree,

type of program, primary therapeutic orientation, and participation in own therapy. Pearson

correlations further evaluated the linear relationship between frequency of reflective practices

and participant age. A paired-samples t-test was conducted to compare the mean frequency of

reflective practices between the three types of clients (i.e., case going well, challenging case going well, and challenging case not going well). To examine the role of supervision, descriptive statistics identified the reflective practices currently being encouraged in supervision. Correlational analyses then examined whether the number of reflective practices encouraged by participants' primary supervisor was related to the frequency of supervisee engagement in reflective practices. Finally, descriptive statistics identified the reflective practices, which were viewed as most effective in enhancing clinical effectiveness.

Qualitative analysis was used in order to better understand interns' beliefs about how reflective practice was helpful to their clinical practice as well as the barriers to engagement in reflective practice. The qualitative data for this study was analyzed based on a thematic analysis approach to qualitative data (Braun & Clarke, 2006; Smith, 2003). First, the responses to the two open-ended questions were carefully reviewed, noting any patterns in the data. A semantic approach was employed to search for patterns in the responses. This revealed themes within data items that were prevalent across the data set. Initial codes were generated in a systematic fashion based on the responses to particular research questions. The data relevant to each code was then collated and analyzed using an inductive approach driven by the data. The results were then summarized and interpreted to reveal their broader meaning and implications in light of the theories postulated in this thesis. Further analysis was then done to refine the specifics of each theme and to establish clear definitions and names for each theme.

Results

The survey yielded quantitative and qualitative data regarding the use of reflective

practices in three clinical conditions as well as attitudes concerning the use and effectiveness of

reflective practices as well as barriers to their use. We turn first to a description of the use of

reflective practices.

The Use of Reflective Practices

Descriptive statistics (means and standard deviations) of the average frequency of

reflective practices used in the past month across the three types of clients appear in Table 2. On

a scale of 1-4 (1 = never, 4 = every week), the most frequently used practices for cases in which

therapeutic work was going well, were "I pay attention to the thoughts I am having during

session with this client" (*Mean frequency* = 3.69), "I devote time to think about the quality of the

therapeutic alliance/relationship with this client" (*Mean* = 3.53), and "I pay attention to the

feelings I am having during session" (*Mean* = 3.52). The least used practices for cases going

well were, "I maintain a journal about my conduct of psychological treatment with this client"

(*Mean* = 1.49), "I review recordings of my conduct of psychological treatment with this client"

(*Mean* = 1.54), and "Reviewing the relevant scientific literature applicable to this case" (*Mean* =

2.17; see Table 3).

For challenging cases going well, the most frequently used reflective practices (on a scale

of 1-4) were, "I pay attention the feelings I am having during session" (*Mean* = 3.80), "I pay

attention to the thoughts I am having during session with this client" (*Mean* = 3.77), and "I

reflect on my interventions while conducting therapy with this client" (*Mean* = 3.70). The three

least used practices for challenging clients going well were "I maintain a journal about my

conduct of psychological treatment with this client" (*Mean* = 1.46), "I review recordings of my

conduct of psychological treatment with this client" (*Mean* = 1.64), and "Reviewing the relevant scientific literature applicable to this case" (*Mean* = 2.35; see Table 4).

Finally, for challenging cases not going well, in which therapists feel ineffective, the most frequently used practices (on a 1-4 scale) were, "I pay attention to the feelings I am having during session" (*Mean* = 3.84), "I pay attention to the thoughts I am having during session with this client" (*Mean* = 3.82), and "I reflect on my interventions while conducting therapy with this client" (*Mean* = 3.63). The least used practices for challenging clients not going well were "I maintain a journal about my conduct of psychological treatment with this client" (*Mean* = 1.51), "I review recordings of my conduct of psychological treatment with this client" (*Mean* = 1.60), and "Reviewing the relevant scientific literature applicable to this case" (*Mean* = 2.53; see Table 5).

Demographic differences. Independent sample t-tests revealed that females used reflective practices (*Mean* = 3.10, *SD* = .45) significantly more frequently than males (*Mean* = 2.70, *SD* = .19; $t[53] = -2.17, p = .03$). However, no other differences between groups was found. Analyses of variance (*ANOVA*) did not indicate differences in frequency of use of reflective practices based on race-ethnicity ($F[6] = .30, p = .16$), between PhD interns (*Mean* = 2.97, *SD* = .46) and PsyD interns (*Mean* = 3.14, *SD* = .43; $t[52] = -1.50, p = .14$) nor between interns participating in their own therapy (*Mean* = 2.94, *SD* = .45) versus those not in their own therapy (*Mean* = 3.08, *SD* = .45; $t[53] = .90, p = .37$). Further, the average frequency of reflective practices used in the past month was not significantly different based on type of program ($F[3] = 1.67, p = .19$), primary therapeutic orientation ($F[4] = 1.48, p = .22$) or age ($r = -.23, p = .09$).

Impact of clinical condition. Results of the paired samples t-test comparing the mean frequency of reflective practices between the three types of clinical conditions or cases (i.e., case going well, challenging case going well, and challenging case not going well) appear in Table 6. The frequency of reflective practices used in the past month for the challenging case going well (*Mean*=3.13, *SD*=.45) was significantly higher than the frequency of reflective practices used for the case going well (*Mean*=2.89, *SD*=.53; *t*[60]=-5.32, *p* < .01). The frequency of reflective practices used for the challenging case not going well (*Mean*=3.14, *SD*=.52) was also significantly higher than the frequency of reflective practices used for the case going well (*Mean*=2.85, *SD*=.54; *t*[57]= -5.16, *p* < .01). However, the difference in frequency of reflective practices between the challenging case going well (*Mean*=3.13, *SD*=.45) versus the challenging case not going well (*Mean*=3.16, *SD*=.51) was not significant (*t*[57]= -.87, *p* =.39).

Encouraging Reflective Practice in Clinical Supervision

The mean number of reflective practices encouraged by supervisors was 7.88 (*SD* = 4.17) out of 15 total practices (see Table 7). The most frequently supported practices by primary supervisors were "reflecting on the interventions I use while conducting therapy" (84.51%), "reflecting on the feelings I had during session (e.g., anger, frustration, sadness)" (81.69%), "reflecting on the thoughts I had during session" (77.46%), and "reflecting on the quality of the therapeutic alliance/relationship" (77.46%). The least supported practices by supervisors were "reviewing recordings of my conduct of psychological treatment" (32.39%), "reflecting on bodily sensations I had during session (e.g., tension)" (40.85%), and "reflecting on how I apply research to clinical practice" (49.30%). The total number of reflective practices supported by the primary supervisor was significantly positively correlated with frequency of reflective practice

use ($r = .39$, $p < .01$), such that increased practices supported by a supervisor was associated with greater frequency of reflective practice use.

Impact of Reflective Practices on Clinical Effectiveness

The participants were also asked to identify the reflective practices that had the largest impact on their clinical effectiveness (see Table 8). The participants reported that the following reflective practices contributed most to their clinical effectiveness: "reflecting on the feelings I had during session (e.g., anger, frustration, sadness)" (46.48%), "examining my personal beliefs and values" (26.76%), and "reflecting on the quality of my therapeutic relationship" (26.76%). The practices which they opined contributed the least to their clinical effectiveness were: "maintaining a journal about my conduct of psychological treatment (0%), "reflecting on what is needed from supervision or consultation" (2.82%), and "reflecting on self-care" (4.23%).

Qualitative data. In regard to question one, "How has your engagement in reflective practice been helpful to your clinical practice?", sixty-one responses were recorded and analyzed. Five respondents stated that reflective practice is integral to their practice and necessary, but no reasons were supplied in regard to how or why. In addition, three responses indicated just "yes." Finally, one respondent stated that they did not have a consistent measure of client outcome alongside engagement in reflective practice, so they were unable to determine whether reflective practice had been helpful. Thirty-six participants explained that reflective practice was helpful to them as practitioners, while ten respondents focused on the helpfulness of reflective practice in relationship to the patient. Themes that emerged in terms of how reflective practice is helpful to the practitioner included, increased self-awareness (e.g. "Enables me to be more self-aware and mindful"), increased understanding of countertransference (e.g. "It helps me to identify countertransference issues and manage these") and increased clinical effectiveness

(e.g. "Thinking back I have much more effective therapy sessions when I have time between each client to reflect, but this is often not the case"). Responses about how reflective practice is helpful to the patient included themes about reflective practice helping drive better treatment planning, case conceptualization, and the patient's emotional processing (e.g. "I often find that my case conceptualization of a case is improved after searching the literature some, and reflecting on treatment session goals/planning between sessions. Getting a better handle on conceptualization helps me better target/tailor interventions to the individual client and psychosocial environment"). The final theme that emerged was in regard to the impact of engagement in reflective practice on considering the therapeutic relationship and improving the alliance. Six respondents discussed this theme (e.g. "It helped me to consider each therapeutic relationship as separate entities from one to the next, each is unique and I am not necessarily the same person to each client").

In regard to question two, "Do you experience barriers to engaging in reflective practice?", sixty participants provided answers, with eleven stating that they do not experience barriers to engagement in reflective practice. Time was overwhelmingly brought up as a barrier to engagement in reflective practice, with 30 respondents (61%) discussing this theme (e.g. "Yes, the work-load and unrealistic schedule of internship. We are so busy running groups, doing didactics, supervision, individual sessions, and doing paperwork that it leaves little time to reflect"). Other themes that emerged related to supervisors not being experienced in facilitating reflective practice. This was the subject of responses of four participants (e.g. "Lack of supervisors who know how to use reflective practice"). Others noted the difficulty of reflecting in the face of vulnerable feelings, overwhelming feelings, uncertainty, or challenging clinical

28

cases. For example, this theme was brought up in the 15 remaining respondents as reflected in the following statements:

- "Yes, in the business of internship year, that interferes with self-care, causing me to be fatigued and push through clients rather than reflect. This is especially true on emotionally challenging clients;"

- "Being stressed out with the amount of clinical work/administrative responsibilities that I have. It is more difficult to be present with patients and myself when my stress is high;"

- "Certain emotions are more difficult so that is why I have my own therapist;" and

- "Frustration with how a case is going. Feeling stuck interferes with the quality of the reflection."

Discussion

This study examined the use of reflective practices by psychology interns, obtained data regarding the extent to which reflective practices were facilitated and encouraged by supervisors in supervision, and obtained opinions about which of the reflective practices most impact clinical effectiveness. The study also obtained qualitative data about how reflective practice has been helpful to the participants in their clinical work and identified barriers that in their opinion impede engagement in reflective practice.

In regard to frequency of engagement in reflective practice, results of this study demonstrated the following:

- In cases in which the therapeutic work was going well, over the course of one month, on average, psychology interns engaged in reflective practice slightly more than once per month. The reflective practices that interns most frequently endorsed using for cases that were going well were, "I pay attention to the thoughts I am having during session with this client," "I devote time to think about the quality of the therapeutic alliance/relationship with this client," and "I pay attention to the feelings I am having during session."

- In challenging cases where the work was going well, or where the work was not going well and the therapist felt ineffective, psychology interns reported engaging in reflective practice, on average, more than once per month, but less than once a week. The most frequently engaged in practices, for both these cases, were: "I pay attention the feelings I am having during session," "I pay attention to the thoughts I am having during session with this client," and "I reflect on my interventions while conducting therapy with this client."

Overall, the results suggest that psychology interns are engaging in reflective practice at a low frequency and therefore not on a regular or consistent basis. The results indicated that in-session reflective practices (e.g. paying attention to thoughts, feelings, physical sensations, and interventions while in session) are engaged in more frequently compared to out-of-session reflective practices (e.g. devoting time to reflect on personal beliefs or diversity characteristics of oneself or patient etc.). Taken together, the mode across all three cases being indicated weekly engagement in reflective practice. The low frequency in which reflective practices are performed as well as the disparity between in-session and out-of-session reflective practice requires further consideration.

Schön (1983) and Fouad et al. (2009) stress the importance of consistent engagement in reflective practice required to enhance competency in practice. The findings of this study are notable (if not alarming) that reflective practice may not be occurring among trainees. While the consequences of regular engagement in reflective practice on clinical outcome have not been empirically tested, it is theoretically logical to conclude that reflection plays a significant role in the conduct of psychological treatment. Unfortunately, there is a dearth of literature in this area to guide practice (Fouad et al., 2009; Moffet, 2009; Neufeldt et al., 1996; Orchowski et al., 2010), particularly in respect to impact on therapeutic and supervisory effectiveness. Future studies may want to study the actual impact of regular engagement in reflective practice as well the ideal frequency of engagement across different reflective practices and identification of the most effective practices.

Of note, two of the three most frequently endorsed practices were the same across all three clinical conditions (i.e., case going well, challenging case going well, and challenging case not going well). These in-session practices were paying attention to thoughts and feelings. The

31

third most frequently endorsed practice for both categories of challenging cases was "reflecting on interventions while conducting therapy." These practices represent what Schön (1983, 1987) refers to as reflection-in-action (i.e., thinking about practice while actually engaged in practice). According to the benchmarks document (Fouad et al., 2009), elements of reflection-in-action should be evident at the point of readiness for internship and reflection-in-action should be the main mode by which practitioner reflects on his or her practice at the point of entry into practice. While the frequency of reflective practices, particularly outside-of-session are low, the survey results of in-session reflection practices appear to be consistent with these competency expectations.

The quantitative data and qualitative data suggest low frequencies of out-of-session (i.e., reflection-on-action) reflective practice. The qualitative data provides a glimpse into some of the factors that influence performance. The majority of respondents indicated that time is the major barrier to engagement in reflective practice. Given that reflection-in-action does not take any additional time, it is not surprising that these were the most frequently endorsed practices. Further, the least frequently endorsed reflective practices were consistent across all three client cases and these were the following: maintaining a journal about one's conduct of psychological treatment, reviewing recordings of one's conduct of psychological treatment, and reviewing the relevant scientific literature applicable to clients. Not surprisingly, these practices are the most time consuming and given that time is reported to be such a significant barrier to engagement in reflective practice, these results are not unsurprising. Of import, reviewing recordings is delineated in the competency benchmarks document as one of the behavioral anchors for reflective practice (Fouad et al., 2009). It is also explicitly endorsed by, arguably, one of the most seminal works on reflective practice within psychology, along with journal writing

(Orchowski et al., 2010). Further, reviewing the relevant scientific literature is, perhaps, what is most central to reflective practice according to Schön (1983) and others (Hoshmand, 1994; Scaife, 2010; Treiweiler & Stricker, 1997). They view the task of reflective practice as a means of artfully translating scientific knowledge into professional practice. These results suggest that more focus should be given to how to, realistically, create the time for interns to engage in these important reflective practices. Given the dearth of literature, it may be that relatively little attention is paid in graduate education and training to the specifics of reflective practice and its importance.

In regard to differences in frequency of engagement across the three client cases, results indicated that the frequency of reflective practices used in the past month for challenging cases going well as well as challenging cases not going well, were both significantly higher than the frequency of reflective practices used for cases going well. However, there was no significant difference in the frequency of reflective practices used between challenging cases going well and challenging cases not going well. This finding is consistent with what would be expected, based on the theoretical literature. According to the vast majority of literature on the subject of what stimulates reflective practice, confusion, a clinical stuck point, and uncertainty, seem to be the major starting points for engagement in reflective practice (Neufeldt et al., 1996; Orchowski et al., 2010; Ward & House, 1998). Thus, the finding of the present study, in which reflective practice seems to be significantly more engaged in, in relation to challenging cases than in cases going well, fits the literature well. Further, the fact that there was no statistically significant difference in engagement in reflective practice between challenging cases going well or not is highly encouraging. The theoretical data suggests that feelings and thoughts of ineffectiveness may be hinder reflectivity (Neufeldt et al., 1996; Orchowski et al., 2010; Scaife, 2010; Ward &

House, 1999), but this was not supported in the quantitative section of the study. Interestingly, when examined qualitatively, 13 respondents out of 60 discussed that challenging cases may be a barrier to engagement in reflective practice. These respondents discussed themes related to the difficulty of reflecting in the face of vulnerable feelings, overwhelming feelings, uncertainty, or challenging clinical cases. This seeming discrepancy between quantitative and qualitative results should be explored in future research to examine the extent to which beliefs about reflective practice versus actual use of reflective practice may differ. In addition, it may be fruitful to look at how engagement in reflective practice, in the face of challenging clients and feelings of ineffectiveness, may differ based on the context. The current study only looked at engagement in self-reflective practice with challenging cases that are not going well, where feelings of ineffectiveness are present. It did not examine the context of supervision with these same cases. This may have yielded different results. This would be a worthwhile area to address in future studies, especially given the important research on non-disclosure in supervision in the face of feelings of vulnerability and incompetency (Coburn, 1997; Ladany et al., 1996; Mehr et al., 2010). It would be also important to study the impact of reflective practice on treatment outcome.

Supervision

The study found that supervisors facilitated an average of a little over half of the total reflective practices measured in this study (7.88 out of 15 total practices within supervision). The most frequently supported practices were, "reflecting on the interventions I use while conducting therapy," "reflecting on the feelings I had during session (e.g., anger, frustration, sadness)," "reflecting on the thoughts I had during session," and "reflecting on the quality of the therapeutic alliance/relationship." The least supported practices by supervisors were "reviewing

recordings of my conduct of psychological treatment," "reflecting on bodily sensations I had during session (e.g., tension)," and "reflecting on how I apply research to clinical practice." These results seem to suggest that, with regard to reflective practice, supervisors frequently focus their facilitation more narrowly on what occurs in the therapy room and what is directly relevant to the therapeutic process (i.e. the therapeutic alliance). They appear to focus less on more global reflective practices such as thinking about the trainees' cultural characteristics and that of their clients. Several reasons may account for this finding. There is an immediate need in supervision to focus on specifics of sessions in order to understand what occurred and what needs to be done (Orchowski et al., 2010). This study did not elucidate what the purpose and outcome were of this supervisory focus. Perhaps, this narrow approach arises out of the practical need to understand and then follow with consequential action (Ward & House, 1999). Perhaps, though, it reflects the lack of efficacy of supervisory practices that only facilitate a re-telling of session material, with no intended purpose or meaningful outcome. This would be an important area for future study. These results also suggest that perhaps a greater focus needs to be put on how supervision can serve as the conduit to helping supervisees engage in critical global reflection, such as on themselves and their clients. Further, these results seem to suggest that there are perceived barriers to facilitating reflection as it applies to (a) how to apply research to clinical practice within supervision and (b) watching videos or listening to audios. These need to be better understood, as both are important tools of reflective practice (Fouad et al., 2009; Orchowski et al., 2010). The American Psychological Association (APA) Standards of Accreditation in Health Service Psychology, which were approved in February of 2015, clearly state that supervisors are responsible for reviewing the relevant scientific and empirical bases for the professional services delivered by the interns. Further, the standards delineate that programs

primary training method must be experiential and include sufficient observation and supervision by psychologists to facilitate interns' readiness to enter into the general practice of psychology on training completion (APA, 2015).

The qualitative data suggests that, generally, the barrier to the abovementioned is lack of time. Of import, as well, were the responses of four of the participants, discussing that a barrier to their engagement in reflective practice was the lack of supervisors able to facilitate this skill. Understanding more about what supervisors are doing from their own perspective in regard to facilitating reflective practice and how they develop reflectivity in their supervisees would be a very important next step in this research (Neufeldt et al., 1996).

Although the current study suggests that reflective practice may not be occurring in a systematic way and that important areas of practice may not be getting sufficient attention in clinical supervision, these results are not surprising, nor are they discouraging. The recognition of supervision as a distinct competency, with its own set of guidelines, has only gained momentum over the course of the last decade, commensurate with the competency-based approach to education and training (Fouad et al., 2009). Further, the idea that training in supervision is necessary has been slow to happen (APA, 2015). It has only been in the last few months that specific guidelines that promote the provision of competency-based supervision have been published by the APA (2015). Relevant to the current study, are the following guidelines: Diversity, guideline 1, states that supervisors understand that they serve an important function as role models to supervisees on how to explore and reflect on how biases impact clinical work. This provides a safe environment for supervisees to do the same. The guideline of Assessment/Evaluation and Feedback is also highly relevant, with Guideline 2 having direct bearing on the current study, given that reviewing audio/video was one of the practices least

endorsed in the context of supervision. Per guideline 2, supervisors should use live observation or audio or video review techniques, whenever possible, as these are associated with enhanced supervisee and client patient outcomes. Finally, Guideline 4 states that supervisors recognize the value and support supervisees in developing the skill to self-assess competence, which is also highly relevant to this dissertation.

A promising result in regard to supervision was the finding that the total number of reflective practices supported by the primary supervisor was significantly positively correlated with frequency of reflective practice use, such that increased practices supported by a supervisor was associated with greater frequency of reflective practice use. Given that supervision is the place where reflective practice should be taught and developed, according to the literature (Neufeldt et al., 1996; Orchowski et al., 2010), this result is extremely positive.

Clinical Effectiveness

The participants opined that reflective practices such as reflecting on feelings during session, examining personal beliefs and values and reflecting on the quality of the therapeutic relationship, had the greatest impact on clinical effectiveness. Reflecting on the therapeutic alliance was endorsed as one of the most frequently engaged in practices only in relation to cases in which the therapeutic work was going well. Interestingly, examining personal beliefs was not one of the practices endorsed as being engaged in most frequently across any of the client cases.

It is important to note that the qualitative results of this study support the finding that reflecting on the therapeutic alliance is an important element in reflective practice. Several respondents discussed that reflective practice is helpful because it leads to an enhanced understanding of the therapeutic alliance, which presumably contributes to better clinical work.

There is limited research identifying the myriad of factors that contribute to positive outcomes in psychotherapy. However, there is substantive research which evidences that the therapeutic alliance accounts for a significant portion of the variance in positive therapeutic outcomes (Norcross & Wampold, 2011). This is consistent with results of the current study. While, less empirical research has been done on how examining personal beliefs leads to clinical effectiveness, the theoretical research postulates that it does (Sue, 1998). Nevertheless, the impact of therapists' attending to their own feelings in session and how this affects their clinical effectiveness has not been studied. The current study noted that attending to feelings was opined to be an important factor in reaching clinical effectiveness. It would be interesting to see if this is substantiated in future research.

The reflective practices that interns thought contributed the least to their clinical effectiveness were (a) maintaining a journal about the conduct of psychological treatment, (b) reflecting on what is needed from supervision or consultation and (c) reflecting on self-care. In regard to journal writing and reflecting on self-care, these results were not surprising. Indeed, despite advocacy in the literature concerning journal writing being an important reflective practice (Griffith & Frieden, 2000; Orchowski et al., 2010; Sutton et al., 2007), results from the current study suggest that this is not actually happening in practice. This may be attributable in part to the lack of standardization around journal writing, within the field of psychology, or a clear understanding of how journal writing is helpful for effective practice. As to self-care, interestingly, Ronnestad and Skovholt (2001, 2003) talk about the importance of continued reflective practice during the practitioner's career, as a defense against professional stagnation and burnout. Yet, respondents viewed reflecting on self-care, as being among the least significant contributors to their clinical effectiveness. Perhaps, at the stage of internship, burnout

is not a strong consideration, as working full time has just begun. Therefore self-care may not be considered regularly or thought of in strong connection to clinical effectiveness.

The finding that "reflecting on what is needed from supervision or consultation" was considered one of the least impactful reflective practices was somewhat surprising. At the stage of internship, supervision is still considered a necessary support and critical to helping the supervisee practice effectively (APA, 2015; Falender & Shafrankse, 2004; Fouad et al., 2009). Future research needs to understand how supervisees see the utility or purpose of supervision and what makes for good use of supervision.

Limitations

This study carries several methodological limitations. Firstly, this study employed self-report instruments, exclusively, which may result in self-report biases. In regard to the sample, it was not possible to calculate the actual response rate since it is not known how many training directors received the invitations and forwarded it on to their interns. Additionally, the current results must be interpreted with caution in mind because of threats to validity. External validity may be threatened due to small sample size. Furthermore, study participants were self-selecting and it is not possible to know whether participants who chose to complete this study, versus those who never even started the study are significantly different. It is feasible that people willing to participate in this study were more reflective, as the survey itself requires reflectivity. This could have skewed the results. Despite these limitations in validity, the present study demonstrated several meaningful findings with implications for future research.

Recommendations for Future Research

Because this is the first known study to examine psychology interns' engagement in reflective practice, how supervisors are facilitating reflective practice within supervision, and

beliefs about the reflective practices that relate to clinical effectiveness, replication studies are needed to corroborate the present findings. Future research may aim to replicate the findings of this study, attain a sample size that is larger and more representative of the intern population, establish its psychometric properties, and further examine the construct validity of the instrument by measuring it against variables known to be important to reflective practice. This includes self-awareness, mindfulness, critical thinking, and cultural competence. Additionally, future studies may want to more closely examine the nature and content of supervisees' engagement in reflective practice and how this impacts clinical practice. Given, that clinical effectiveness is the overarching goal of engagement in reflective practice, future studies should examine if, in fact, reflective practice directly relates to clinical effectiveness. The specific mechanisms that may account for this relationship should also be examined. Finally, the current study focused on reflective practice from the perspective of psychology interns. Future studies should focus on supervisors as well as practicum students. This would provide the field of psychology with a fuller view of reflective practice, within the context of training. It could also help inform the development of a model of reflective practice for psychologists in training.

Conclusions

This study examined: (a) the use of reflective practices by psychology interns, (b) how reflective practice is being facilitated by supervisors in supervision, the (c) reflective practices believed to most impact clinical effectiveness, (d) interns' beliefs about how reflective practice is helpful to clinical practice and (e) barriers to the use of reflective practice. To the best of the investigators knowledge, no prior investigation has attempted to study reflective practice among psychology interns. Sixty-nine predoctoral interns provided complete responses to study instruments. The literature base on reflective practice within psychology remains largely

theoretical and, therefore, it is hoped that this study will be a useful addition to the literature. Reflective practice has important implications for the training of future clinicians and for the attainment of clinical competence. It is an important variable for future research.

REFERENCES

American Psychological Association. (2015). Guidelines for clinical supervision in health

    service psychology. *American Psychologist, 70*(1), 33–46. doi:10.1037/a0038112

Belar, C., Brown, R. A., Hersch, L. E., Hornyak, L. M., Rozensky, R. H., Sheridan, E. P., . . .

    Reed, G. W. (2001). Self-assessment in clinical psychology: A model for ethical

    expansion of practice. Professional Psychology: Research and Practice, 32(2), 135–141.

    doi:10.1037//0735-7028.32.2.135

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value

    of self-practice of cognitive therapy techniques and self-reflection in the training of

    cognitive therapists. *Behavioral and Cognitive Psychotherapy, 29*(2), 203–220.

    doi:10.1017/S1352465801002077

Bernard, J., & Goodyear, B. (2004). *Fundamentals of clinical supervision*. Needham Heights,

    MA: Alyn & Bacon.

Bollich, K. L., Johannet, P. M., & Vazire, S. (2011). In search of our true selves: Feedback as a

    path to self-knowledge. *Frontiers in Psychology, 2*, article 312.

    doi:10.3389/fpsyg.2011.00312

Boud, D., & Walker, D. (1998). Promoting reflection in professional courses: The challenge of

    context. *Studies in Higher Education, 23*(2), 191–206. doi:0307-5079/98/020191-16

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in*

    Psychology, 3, 77–101. doi:10.1191/1478088706qp063oa

Caputo, D., & Dunning, D. (2005). What you don't know: The role played by errors of omission

    in imperfect self-assessments. *Journal of Experimental Social Psychology, 41,* 488–505.

    doi:10.1016/j.jesp.2004.09.006

Carter, T. J., & Dunning, D. (2008). Faulty self-assessment: Why evaluating one's confidence is

    an intrinsically difficult task. *Social and Personality Psychology Compass, 2*(1), 346–

    360. doi:10.1111/j.1751-9004.2007.00031.x

Coburn, W. J. (1997). The vision in supervision: Transference-countertransference dynamics and

    disclosure in the supervision relationship. *Bulletin of the Meninger Clinic, 61*(4),

    481-494. doi:00259284/19970901

Collins, S., Arthur, N., & Wong-Wylie, G. (2010). Enhancing reflective practice in multicultural

    counseling through cultural auditing. *Journal of Counseling and Development, 88*(3),

    340–347. doi:10.1002/j.1556-6678.2010.tb00031.x

Copeland, W. D., Birmingham, C., DeMeulee, L., D'Emidio-Caston, M., & Natal, D. (1994).

    Making meaning in classrooms: An investigation of cognitive processes in aspiring

    teachers, experienced teachers, and their peers. *American Educational Research Journal,*

    31(1), 166–196. doi:10.2307/1163271

Dallos, R., & Stedmon, J. (2010). *Reflective practice in psychotherapy and counseling*. New

    York, NY: McGraw Hill.

Dewey, J. (1933). *How We Think*. Stilwell, KS: Renaissance Classics.

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *The*

    Journal of the American Medical Association, 287(2), 226–235.

    doi:10.1001/jama.287.2.226

Eraut, M. (2000). Non-formal learning and tacit knowledge in professional work. *British Journal*

    of Educational Psychology, 70, 1–13. doi:10.1348/000709900158001

Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Falender, C. A., Shafranske, E. P., & Falicov, C. (2014). Reflective practice: Culture in self and other. In C. A. Falender, E. P. Shafranske, & C. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach* (pp. 273-281). Washington, DC: American Psychological Association.

Fouad, N. A., Hatcher, R. L., Hutchings, P. S., Collins, F.L., Jr., Grus, C. L., Kaslow, N. J., . . . Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology, 3*(4)*, S5–S26. doi:10.1037/a0015832

Gambrill, E. (2005). *Critical thinking, evidence-based practice, and mental health*. New York, NY: Columbia University Press.

Gambrill, E., & Gibbs, L. (2009). *Critical thinking for helping professional: A skills-based workbook* (3rd ed.). New York, NY: Oxford University Press.

Gillmer, B. & Marckus, R. (2003). Personal professional development in clinical psychology training: Surveying reflective practice. *Clinical Psychology*, *27*, 20-23. doi:10.1002/cpp.660

Griffith, B., & Frieden, G. (2000). Facilitating reflective thinking in counselor education. *Counselor Education and Supervision, 40*(2), 82–94. doi:10.1002/j.1556-6978.2000.tb01240.x

Hoonakker, P., & Carayon, P. (2009). Questionnaire survey nonresponse: A comparison of postal mail and Internet surveys. *International Journal of Human-Computer Interaction*, *25*(5), 348–373. doi:10.1080/10447310902864951

Hoshmand, L. T. (1994). *Orientation to inquiry in a reflective professional psychology*. Albany, NY: State University of New York Press

Kaslow, N. J., Bebeau, M. J., Lichtenberg, J. W., Portnoy, S. M., Rubin, N. J., Leigh, I.W., . . . Smith, I. L. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice, 38*(5), 441–451. doi:10.1037/0735-7028.38.5.441

Knowles, Z., Gilbourne, D., Tomlinson, V., & Anderson, A. G. (2007). Reflections on the application of reflective practice for supervision in applied sport psychology. *The Sport Psychologist, 27,* 109–122.

Krueger, J., & Muller, R. A. (2002). Unskilled, unaware, or both? The better-than-average heuristic and statistical regression predict errors in estimates of own performance. *Journal of Personality and Social Psychology, 80*(2), 180–188. doi:10.1037//0022-3514.82.2.180

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. E. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*(1), 10–24. doi:10.1037/0022-0167.43.1.10

Lavender, J. (2003). Redressing the balance: The place, history, and future of reflective practice in clinical training. *Clinical Psychology, 27,* 11–15. doi:10.1037/0022-0167.43.1.10

Mamede, S., Schmidt, H. G., & Penaforte, J. (2008). Effects of reflective practice on the diagnoses of medical illnesses. *Medical Education, 43*(5), 468–475. doi:10.1111/j.13652923.2008.03030.x

Mehr, K. E., Ladany, N., & Caskie, G. I. L. (2010). Trainee nondisclosure in supervision: What

    are they not telling you? *Counseling and Psychotherapy Research, 10*(2), 103–114.

    doi:10.1080/14733141003712301

Moffet, L. A. (2009). Directed self-reflection protocols in supervision. *Training and Education

    in Professional Psychology, 3*(2), 78–83. doi:10.1037/a0014384

Nelson, M. L., & Neufeldt-Allsetter, S. A. (1998). The pedagogy of counseling: A critical

    examination. *Journal of Counselor Education and Supervision, 38*(2), 1–31.

    doi:10.1002/j.1556-6978.1998.tb00560.x

Neufeldt, S. A., Karno, M. P., & Nelson, M. L. (1996). A qualitative study of experts'

    conceptualization of supervisee reflectivity. *Journal of Counseling Psychology, 43*(1),

    3-9. doi:10.1037/0022-0167.43.1.3

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships. *Research

    Conclusions and Clinical Practice, 48*(1), 98–102. doi:10.1037/a0022161

Nut Williams, E. (2010). A psychotherapy researcher's perspective on therapist self-awareness

    and self-focused attention after a decade of research. *Psychotherapy Research, 18*(2),

    139–146. doi:10.1037/1931-3918.S.1.17

Orchowski, L., Evangelista, N. M., & Probst, D. R. (2010). Enhancing supervisee reflectivity in

    clinical supervision: A case study illustration. *Psychotherapy Theory, Research, Practice,

    and Training, 47*(1), 51–67. doi:10.1037/a0018844

Owen, J., & Lindley, L. D. (2009). Therapists' cognitive complexity: Review of theoretical

    models and development of an integrated approach to training. *Training and Education in

    Professional Psychology, 4*(2), 128–137. doi:10.1037/a0017697

Pearson, R. W., Ross, M. & Dawes, R. M. (1992). Personal recall and the limits of retrospective

 questions in surveys. In J.M. Tanur, J.M. (Ed.), *Questions about questions: Inquiries into*

 the cognitive bases of surveys. New York, NY: Russell Sage Foundation. Retrieved from

 https://books.google.com/books?hl=en&lr=&id=8FEiM0gA_wwC&oi=fnd&pg=PA65&

 dq=survey+design+and+retrospective+memory&ots=sLkUOZLecL&sig=sO6SSA3cxlS6

 qoJ0Iud28lbcd9w#v=onepage&q=survey%20design%20and%20retrospective%20memor

 y&f=false

Peterson, R. L, Abrams, J. C., Peterson, D. R., & Stricker, G. (1997). The national council of

 school and programs of professional psychology educational model. *Professional*

 Psychology: Research and Practice, 28(4), 373–386. doi:10.1037/0735-7028.28.4.373

Peterson, R. L., Abrams, J. C., Peterson, D. R., & Stricker, G. (2006). The national council of

 school and programs of professional psychology educational model. *Training and*

 Education in Professional Psychology, 8(1), 17–36. doi:10.1037/1931-3918.S.1.17

Roberts, M. C., Christiansen, M. D., Borden, K. A., & Lopez, S. J. (2005). Fostering a culture

 shift: Assessment of competence in the education and careers of professional

 psychologists. *Professional Psychology: Research and Practice, 36*(4), 355–361.

 doi:10.1037/0735-7028.36.4.355

Rodolfa, E., Eisman, E., Rehm, L., Bent, R., Nelson, P., & Ritchie, P. (2005). A cube model for

 competency development: Implications for psychology educators and regulators.

 Professional Psychology: Research and Practice, 36(4), 347–354.

 doi:10.1037/0735-7028.36.4.347

Ronnestad, M. H., & Skovholt, T. M. (2001). Learning arenas for professional development: Retrospective accounts of senior psychotherapists. *Professional Psychology: Research and Practice, 32*(4), 181–187. doi:10.1037//0735-7028.32.2.181

Ronnestad, M. H., & Skovholt, T. M. (2003). The journey of counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*(1), 5–44. doi:10.1023/A:1025173508081

Rosin, J. (2015). The necessity of counselor individuation for fostering reflective practice. *Journal of Counseling and Development, 93*, 88–95. doi:10.1002/j.1556-6676.2015.00184.x

Rubin, N., Leigh, I. W., Nelson, P. D., Smith, I. L., Bebeau, M., Lichtenberg, J. W., . . . Kaslow, N. J. (2007). The competency movement within psychology: A historical perspective. *Professional Psychology: Research and Practice, 38*(5), 452–462. doi:10.1037/0735-7028.38.5.452

Scaife, J. (2010). *Supervising the reflective practitioner: An essential guide to theory and practice*. New York, NY: Routledge.

Schön, D. A. (1983). *The reflective practitioner: How professional think in action*. New York, NY: Basic Books.

Schön, D. A. (1987). *Educating the reflective practitioner: Toward a new design of teaching and learning in the professions*. San Francisco, CA: Josey-Bass.

Skovholt, T. M., & Ronnestad, M. H. (1992). Themes in therapist and counselor development. *Journal of Counseling and Development, 70,* 505–515. doi:10.1002/j.1556-6676.1992.tb01646.x

Skovholt, T. M., Ronnestad, M. H., & Jennings, L. (1997). Searching for expertise in counseling,

    psychotherapy, and professional psychology. *Educational Psychology Review, 9*(4),

    361-371. doi:1040-726x/97/1200-0361

Smith, J. A. (2003). *Qualitative psychology: A practical guide to research methods*. Thousand

    Oaks, CA: Sage Publications.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American*

    Psychologist, 53(4). 440–448. doi:10.1037/0003-066x.53.4.440

Sutton, S., Townend, M., & Wright, J. (2007). The experience of reflective learning journals by

    cognitive behavioral psychotherapy students. *Reflective Practice: International and*

    Multidisciplinary Perspective, 8(3), 387–404. doi:10.1080/14623940701425048

Teekman, B. (2005). Exploring reflective thinking in nursing practice. *Journal of Advanced*

    Nursing, 31(5), 1125–11 5. doi:10.1037/a0018844

Trieweiler, S., & Stricker, G. (1997). *The scientific practice of professional psychology*. New

    York, NY: Plenum.

Vasquez, M. (1992). Psychologist as clinical supervisor: Promoting ethical practice. *Professional*

    Psychology: Research and Practice, 23(3), 196–202. doi:10.1037/0735-7028.23.3.196

Ward, C. C., & House, R. M. (1998). Counseling supervision: A reflective model. *Counselor*

    Education and Supervision, 38(1), 23–34. doi:10.1002/j.1556-6978.1998.tb00554.x

Wise, E. H., Nutt, R. L., Schaffer, J. B., Sturm, C. A., Rodolfa, E., & Webb, C. (2010). Life-long

    learning for psychologists: Current status and a vision for the future. *Professional*

    Psychology: Research and Practice, 41(4), 288–297. doi:10.1037/a0020424

Wong-Wylie, G. (2007). Barriers and facilitators of reflective practice in counselor education:

Critical incidents from doctoral candidates. *Canadian Journal of Counseling Education,*

41(2), 59–76.

Retrieved from http://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/viewArticle/325

TABLES

Table 1

Descriptive Statistics for Demographic Characteristics of Sample

Variable	n	%
Type of program		
Clinical Psychology	54	78.3%
Counseling Psychology	10	14.5%
School Psychology	4	5.8%
Combined	1	1.4%
Degree		
Ph.D.	35	51.5%
Psy.D.	33	47.8%
Primary Theoretical Orientation		
Cognitive-Behavioral Therapy	34	50%
Existential/Humanistic	9	13.2%
Family Systems	1	1.5%
Psychodynamic	19	27.9%
Other	5	7.4%
Gender		
Female	60	87%
Male	9	13%
Race-Ethnicity		
African-American/Black	6	8.7%
American Indian/Alaskan Native	1	1.4%
Asian/Pacific Islander	2	2.9%
Hispanic/Latino	4	5.8%
White (non-Hispanic)	52	75.4%
Biracial/Multiracial	3	4.3%
Other	1	1.4%
Own Personal Therapy	25	21.01%
Age in Years	*Mean* = 31.62	*SD* = 6.67
	Median = 30	
	Mode = 28	
	Range = 26-66	

Table 2

Descriptive Statistics for Frequency of Reflective Practices Used in the Past Month

	Case going well		Clinically challenging case going well		Clinically challenging case not going well	
	Mean (SD)	*Mode*	*Mean (SD)*	*Mode*	*Mean (SD)*	*Mode*
Reflective practices overall	2.87 (.54)	2.89	3.13 (.46)	3.00	3.13 (.53)	3.21
In-session reflective practices	3.47 (.61)	4.00	3.69 (.49)	4.00	3.70 (.50)	4.00
Outside session reflective practices	2.71 (.57)	3.07	2.98 (.51)	2.93	2.98 (.61)	3.20

Table 3

Percentage of Reflective Practices Used in the Past Month for Case Going Well

	% Never	% Once per month	% More than once per month	% Every week	Rating Average (1-4)
I devote time to examine my personal beliefs and values.	4.00	17.33	29.33	49.33	3.24
I devote time to reflect on the influence of my cultural background and diversity characteristics.	8.00	17.33	40.00	34.67	3.01
I pay attention to bodily sensations I am having during session (e.g., tension) with this client.	8.00	13.33	25.33	53.33	3.24
I pay attention to the thoughts I am having during session with this client.	0.00	2.67	25.33	72.00	3.69
I pay attention to the feelings I am having during session (e.g. anger, frustration, sadness) with this client.	2.67	9.33	21.33	66.67	3.52
I devote time to the self-assessment of my clinical skills.	4.00	21.33	34.67	40.00	3.11
I devote time to reflect on how to increase my clinical effectiveness with this client.	4.05	8.11	41.89	45.95	3.30
I devote time to reflect on how to apply theory to clinical practice with this client.	4.05	18.92	29.73	47.30	3.20
I devote time to think about the quality of the therapeutic alliance/relationship with this client.	1.33	5.33	32.00	61.33	3.53
I reflect on my interventions while conducting therapy with this client.	1.33	6.67	32.00	60.00	3.51
I devote time to reflect on the influence of my client's multicultural identities.	10.67	21.33	30.67	37.33	2.95
I devote time to reflect on supervisor feedback on this client.	5.41	17.57	29.73	47.30	3.19
I maintain a journal about my conduct of psychological treatment with this client.	80.00	4.00	2.67	13.33	1.49
I review recordings of my conduct of psychological treatment with this client.	67.57	17.57	8.11	6.76	1.54
I devote time to reflect after a therapy session with this client, in addition to writing a therapy note.	13.33	26.67	24.00	36.00	2.83
I devote time to reflect on what I need supervision in or consultation on with this client.	2.67	26.67	28.00	42.67	3.11
I devote time to reflect on my self-care with this client.	29.73	32.43	22.97	14.86	2.23
Over the course of the past month, how many times have you reviewed the relevant scientific literature applicable to this case?	28.00	36.00	26.67	9.33	2.17
Over the past month how often did you intentionally seek time with a peer to discuss your work with this client?	33.33	20.00	32.00	14.67	2.28

Table 4

Percentage of Reflective Practices Used in the Past Month for Challenging Case Going Well

	% Never	% Once per month	% More than once per month	% Every week	Rating Average (1-4)
I devote time to examine my personal beliefs and values.	4.23	16.90	26.76	52.11	3.27
I devote time to reflect on the influence of my cultural background and diversity characteristics.	5.63	16.90	29.58	47.89	3.20
I pay attention to bodily sensations I am having during session (e.g., tension) with this client.	2.86	7.14	21.43	68.57	3.56
I pay attention to the thoughts I am having during session with this client.	0.00	4.29	14.29	81.43	3.77
I pay attention to the feelings I am having during session (e.g. anger, frustration, sadness) with this client.	0.00	4.29	11.43	84.29	3.80
I devote time to the self-assessment of my clinical skills.	1.43	10.00	28.57	60.00	3.47
I devote time to reflect on how to increase my clinical effectiveness with this client.	0.00	4.29	24.29	71.43	3.67
I devote time to reflect on how to apply theory to clinical practice with this client.	1.43	12.86	30.00	55.71	3.40
I devote time to think about the quality of the therapeutic alliance/relationship with this client.	0.00	4.29	22.86	72.86	3.69
I reflect on my interventions while conducting therapy with this client.	0.00	4.29	21.43	74.29	3.70
I devote time to reflect on the influence of my client's multicultural identities.	8.70	18.84	21.74	50.72	3.14
I devote time to reflect on supervisor feedback on this client.	4.29	10.00	27.14	58.57	3.40
I maintain a journal about my conduct of psychological treatment with this client.	78.57	7.14	4.29	10.00	1.46
I review recordings of my conduct of psychological treatment with this client.	68.57	11.43	7.14	12.86	1.64
I devote time to reflect after a therapy session with this client, in addition to writing a therapy note.	7.14	20.00	27.14	45.71	3.11
I devote time to reflect on what I need supervision in or consultation on with this client.	0.00	12.86	31.43	55.71	3.43
I devote time to reflect on my self-care with this client.	15.94	28.99	27.54	27.54	2.67
Over the course of the past month, how many times have you reviewed the relevant scientific literature applicable to this case?	22.54	35.21	26.76	15.49	2.35
Over the past month how often did you intentionally seek time with a peer to discuss your work with this client?	18.31	25.35	26.76	29.58	2.68

Table 5

Percentage of Reflective Practices Used in the Past Month for Challenging Case Not Going Well

	% Never	% Once per month	% More than once per month	% Every week	Rating Average (1-4)
I devote time to examine my personal beliefs and values.	4.23	16.90	26.76	52.11	3.27
I devote time to reflect on the influence of my cultural background and diversity characteristics.	5.63	16.90	29.58	47.89	3.20
I pay attention to bodily sensations I am having during session (e.g., tension) with this client.	2.86	7.14	21.43	68.57	3.56
I pay attention to the thoughts I am having during session with this client.	0.00	4.29	14.29	81.43	3.77
I pay attention to the feelings I am having during session (e.g. anger, frustration, sadness) with this client.	0.00	4.29	11.43	84.29	3.80
I devote time to the self-assessment of my clinical skills.	1.43	10.00	28.57	60.00	3.47
I devote time to reflect on how to increase my clinical effectiveness with this client.	0.00	4.29	24.29	71.43	3.67
I devote time to reflect on how to apply theory to clinical practice with this client.	1.43	12.86	30.00	55.71	3.40
I devote time to think about the quality of the therapeutic alliance/relationship with this client.	0.00	4.29	22.86	72.86	3.69
I reflect on my interventions while conducting therapy with this client.	0.00	4.29	21.43	74.29	3.70
I devote time to reflect on the influence of my client's multicultural identities.	8.70	18.84	21.74	50.72	3.14
I devote time to reflect on supervisor feedback on this client.	4.29	10.00	27.14	58.57	3.40
I maintain a journal about my conduct of psychological treatment with this client.	78.57	7.14	4.29	10.00	1.46
I review recordings of my conduct of psychological treatment with this client.	68.57	11.43	7.14	12.86	1.64
I devote time to reflect after a therapy session with this client, in addition to writing a therapy note.	7.14	20.00	27.14	45.71	3.11
I devote time to reflect on what I need supervision in or consultation on with this client.	0.00	12.86	31.43	55.71	3.43
I devote time to reflect on my self-care with this client.	15.94	28.99	27.54	27.54	2.67
Over the course of the past month, how many times have you reviewed the relevant scientific literature applicable to this case?	22.54	35.21	26.76	15.49	2.35
Over the past month how often did you intentionally seek time with a peer to discuss your work with this client?	18.31	25.35	26.76	29.58	2.68

Table 6

Paired Samples t-test Comparing the Mean Frequency of Reflective Practices Between Clients

		Mean	SD	SEM	95% CI Lower	95% CI Upper	*t*	df	*p*
Pair 1	Going Well Challenging Going Well	-.24	.35	.05	-.33	-.15	-5.32	60	<.01
Pair 2	Going Well Challenging Not Well	-.29	.43	.06	-.41	-.18	-5.16	57	<.01
Pair 3	Challenging Going Well Challenging Not Well	-.03	.30	.04	-.11	.04	-.87	57	.39

Table 7

Percentages of Primary Supervisors Facilitating Each Reflective Practice

	Percentage of Supervisors
Examining my personal beliefs and values.	70.4%
Reflecting on the influence of my cultural background and diversity characteristics.	50.7%
Reflecting on bodily sensations I had during session (e.g. tension).	40.8%
Reflecting on the thoughts I had during session.	77.5%
Reflecting on the feelings I had during session (e.g. anger, frustration, sadness).	81.7%
Engaging in self-assessment of my clinical effectiveness.	62.0%
Identifying ways to increase my clinical effectiveness.	76.1%
Reflecting on how I apply theory to clinical practice.	71.8%
Reflecting on how I apply research to clinical practice.	49.3%
Reflecting on the quality of the therapeutic alliance/relationship.	77.5%
Reflecting on the interventions I use while conducting therapy.	84.5%
Reflecting on the influence of my clients' multicultural identities.	59.2%
Reviewing recordings of my conduct of psychological treatment.	32.4%
Reflecting on what is needed from supervision or consultation.	62.0%
Reflecting on self-care.	53.5%
None of the above practices were facilitated in supervision.	2.8%
Other	1.4%

Table 8

Percentage of Participants Endorsing Reflective Practice as One of Their Top Three Practices Contributing to Clinical Effectiveness

	Percentage of Participants
Examining my personal beliefs and values.	26.8%
Reflecting on the influence of my cultural background and diversity characteristics.	14.1%
Reflecting on the bodily sensations I had during session (e.g. tension).	16.9%
Reflecting on the thoughts I had during session.	22.5%
Reflecting on the feelings I had during session (e.g. anger, frustration, sadness).	46.5%
Engaging in self-assessment of my clinical effectiveness.	9.9%
Identifying ways to increase my clinical effectiveness.	22.5%
Reflecting on how I apply theory to clinical practice.	19.7%
Reflecting on how I apply research to clinical practice.	11.3%
Reflecting on the quality of the therapeutic alliance/relationship.	26.8%
Reflecting on the interventions I use while conducting therapy.	23.9%
Reflecting on supervisor feedback.	16.9%
Reflecting on the influence of my clients' multicultural identities.	12.7%
Maintaining a journal about my conduct of psychological treatment.	0.0%
Reviewing recordings of my conduct of psychological treatment.	8.5%
Reflecting after each therapy session in addition to writing a therapy note.	8.5%
Reflecting on what is needed from supervision or consultation.	2.8%
Reflecting on self-care.	4.2%
I have not engaged in any of the above practices.	0.0%
Other	0.0%

APPENDIX A

Literature Table

Reflective Practice and Psychology: Definitions and Benefits

Authors	Year	Abbreviated Title	Summary
Gillmer & Marckus	2003	Personal Professional Development in clinical psychology training: surveying reflective practice	This article is part of a special journal issue devoted to reflective practice. The articles in the issue were presented at a day-long conference on reflective practice within clinical psychology in the U.K. The article begins with a discussion about the importance of personal and professional development within clinical training and the difficulty in establishing this as a competency given the vulnerable aspects of this process. The authors then describe a study they did which surveyed several programs to understand their focus on PPD within their courses. The author notes that the core competency aimed at in PPD is self-reflection in professional and academic life.
Griffith & Frieden	2000	Facilitating Reflective Thinking in Counselor Education	This article provides four educational strategies that may facilitate the development of reflective thinking in counselors. The authors state that educational experiences that engage students' different learning styles, encourage critical thinking about assumptions that guide practice, and allow for opportunities to provide feedback and encourage reflection. The authors state that Socratic questioning, journal writing, Interpersonal Process Recall (IPR), and reflecting teams (a reflecting team is a group of counseling professionals or students that observe a "stuck system", such as a family and their therapist. The reflecting team discuss their observation with the therapist and client mid-therapy, and then the client and therapist discuss the observations of the reflecting team-this can be used in group counseling classes that are experiential) meet these criteria. Examples of how to use each of these are described in detail through the article as well as advisement to be cautionary about these processes, which can induce anxiety and difficult self-disclosure on the part of the supervisee.
Hoshmand	1994	Reflective Professional Psychology	Hoshmand's orientation is mostly towards developing a reflective stance in our approach to inquiry, i.e. in research, however she does address how individual therapists should engage in a reflective practice to bridge what they know from research into effective clinical practice. She speaks about counselors being in the position of ""knowing subjects and objects to be known"" (p.6). Thus, she states that the task of the counselor is to engage in the process of reflexivity, or stepping outside of the system that we are a part of in order to closely examine our involvement and influence. Thus, according to Hoshmand, professional training should provide opportunities for self-inquiry in order to allow for this 'stepping out' process to occur. According to Hoshmand, reflective thought includes ""scanning the situation, sorting and conceptualizing the problem, looking for inner coherence to the various aspects of the solution, testing it in action, and looping back to earlier steps" (p. 50). Further, reflection should be directed not only at one's cognitive processes and problem solving but also at the contribution of one's personal ways of being to the inquiry process" (p.151). According to Hoshmand, it is important to figure out how we know when there is nothing that can reliably guide our knowing according to Hoshmand. Reflective practice brings to consciousness this awareness. The process "enables us to place in perspective the respective roles and contributions of our academic theoretical knowledge, our experiential learning, and our practice-tested knowledge" (p.13). Reflective practice is also termed meta-learning and metacognition and may be facilitated by the use of Socratic questioning and interactive dialogue. Hoshmand suggests that reflective practice helps us analyze whether we judge things pre-maturely because we have automated perceptions or schemas. This process results in the counselor being able to hear the unique experiences of each of his or her clients. Reflection on practice helps us revise our patterned thinking, monitor our thought processes and assumptions and ultimately leads to 'mature ways of knowing' (p.150).
Lavender	2003	Redressing the balance: the place, history, and future of reflective practice in clinical psychology	This article is part of a special journal issue devoted to reflective practice. The articles in the issue were presented at a day-long conference on reflective practice within clinical psychology in the U.K. The author states that reflective practice is very important because it allows the practitioner to approach the uncertainties and complexities of clinical practice. The author also discusses why clinical psychology has neglected reflective practice, specifically in the UK where there was a heavy emphasis on research and empirical study. The author identifies 4 processes of reflective practice-have overlap but for clarification author separates them: 1. reflection in action. This is precipitated by confrontation with the unexpected or when the action that flows from theory hits its limits. The practitioner reflects on their cognitions and emotions and what to do next. It is a rapid analysis. It is similar to metacognition. To enhance this, the author advocates for real world workshops and simulated workshops. 2. reflection on action/ This occurs after an event. It can happen with others in supervision. In these

situations, using Kolb's learning cycle can be helpful to think about the reflective process. It can happen alone when listening to tapes, thinking, writing, or drawing. 3. reflection about impact on others. Feedback from others about our impact on them is helpful for this process. This can be done systematically such as with 360 degree feedback, group tasks with observers providing feedback, team assessment tasks, outdoor development exercises, completing personality measures, and using video observations. 4. reflection about self (awareness and development). This is important, as the author points out that none of us are immune from vulnerability from our past and psychological problems. Having an understanding of this deepens our respect and understanding of clients. To enhance this, therapy is suggested, and the reflection methods previously mentioned in the article. Also mentioned is the development of relationships with partners, families, and friends. These are awareness enhancing experiences that can lead to change and development.

Nelson & Neufeldt-Allsetter	1998	The Pedagogy of Counseling: A Critical Examination	The purpose of this article is to offer a critique of counselor education practices and to offer an alternative method based on constructivist theory. According to the authors one of the most difficult things to teach is how to develop a creative approach to problem solving. This requires professional reflection and thinking outside the lines. To do this the authors suggest that training must go beyond teaching specific counseling techniques. Fostering students to develop self-awareness of their own humanness is extremely important according to this article. The authors suggests that a constructivist approach can help develop this sense of awareness in that its purpose is to help the learner become an active participant in socially co-constructing, questioning, evaluating, and inventing information. In this way, students will learn how to continuously reflect on the information they encounter. This is especially important in the field of counseling as the application of science to practice is not a simple formula. Being able to apply techniques under ideal conditions takes expertise. According to Ronnestad and Skovholt (1992) the most important factor to facilitate counselor development was continuous professional reflection. It takes several years to develop expertise (10-15 years), and therefore the authors posit that training students to be able to engage in reflective practice while in training is essential. This education process involves providing the space, permission, and encouragement to reflect and the knowledge of how to inform one's reflective process, and a safe relational environment to do this in. This would involve helping trainees go into their sense of clinical doubt, analyze the theories they are using to understand the challenge, and staying aware of their own personal biases and thinking patterns in terms of how they are impacting the process.
Ronnestad & Skovholt	2001	Learning Arenas for Professional Development: Retrospective Accounts of Senior Psychotherapists	Twelve senior practitioners were re-interviewed 11 years after an initial study looking at counselor development among a sample of 100 practitioners. The purpose of the present study was to look at what senior practitioners could offer in terms of how they developed and grew. From the data, four themes emerged (labeled primary learning arena). 1. the profound impact of early life experience 2. the profound cumulative influence of professional experience 3. the profound influence of professional elders 4. the profound personal experiences in adult life. The authors discuss three implications of their study: 1. professional growth is impacted by experiences in one's personal and professional life 2. the processing and reflecting on experiences, both personal and professional, leads to enhanced wisdom and optimal practice. The authors emphasize that supervisors and supervisees should be open to discussing life experience and their impact on the interchange in therapy. They further state that training programs should supplement course work, supervision, and personal therapy with seminars focused on how personal and professional development interact 3. the profession of psychotherapy is viable for psychologists in the senior years.
Ronnestad & Skovholt	1993	Supervision of Beginning and Advanced Graduate Students of Counseling and Psychotherapy	This article provides a summary of research on developmental considerations and approaches to supervision. The authors also summarize their own research on supervision. The article then addresses approaches to supervision with beginning students and then advanced students. Relevant to this dissertation, they state that their research demonstrates that counselors tend to become more rigid and assume an external orientation throughout training. Authors suggest that if graduate programs focus more on personally based and integrative processes, which are fostered through reflection, this might not have occurred.
Ronnestad & Skovholt	2003	The Journey of the Counselor Therapist	This article summarizes a reformulation of an earlier study performed by the authors, which looked at counselor development among a sample of counselors and therapists at various levels in the field of psychology. The study was a cross-sectional and longitudinal qualitative study. This paper summarizes a reformulation of the original study, with results presented as a phase model and as a formulation of 14 themes of counselor/therapist development. Initially 8 stages were developed. This article reformulated the 8 stages into 6 phases. Phase 1: The Lay Helper Phase: the lay helper quickly identifies the problem; provides strong emotional support; gives advice based on their own experience; is guided by common sense; boundary problems are present at this phase-strong identification and unexamined quality of how to best assist can lead to over-involvement and impede reflection characteristic of effective helping; advice

giving is common Phase 2: the Beginning Student Phase: This phase is challenging as students move from the known world of the lay helper to the unknown world of professional; professors and supervisors have a great impact; criticism, direct or subtle, actual, or perceived can be detrimental; easily applied models are lifesaving at this phase; students search for strong models; an attitude of openness to new learning and a willingness to recognize the complexity of professional work is very important to enhance competence. Phase 3: The Advanced Student Phase: the basic task is to function at a basic professional level; students feel the pressure to excel and do things perfectly, leading to a cautious approach; there is still a lot of external dependency; conflicts in supervision may peak at this stage; modeling is still important but the advanced student is critically assessing and evaluating the models; there is a frustration by the lack of opportunity to observe senior practitioners. Phase 4: The Novice Professional Phase: this phase encompasses the first years after graduation. First there is a period of trying to confirm the validity of training then a period of disillusionment when converted with challenges that are not adequately mastered, third there is a period of exploration into self and professional environment; strong recognition of inadequacy and gaps in training at this stage; more attention focused on understanding and mastering relationship issues, defining roles, and regulating boundaries. Phase 5: The Experienced Professional Phase: At this stage the counselor has been practicing for several years and has varied experience. Central developmental task is to create a cohesive personal and professional self; increased flexibility in role and working style is expressed; boundaries are clear and practitioner is better at regulating their involvement; experienced professionals report that much learning comes from their experience with client and personal life; learning primarily happens through practitioners; sense of intellectual apathy and boredom due to repetitive tasks; general sense, though, of self-satisfaction and self-acceptance; sense of competence but also modesty. The next part of the article details themes of therapist/counselor development. Theme 1: Professional Development Involves an increasing higher order integration of the professional self and the personal self. Theme 2: the focus of functioning shifts dramatically over time from internal to external to internal. These parallel the training phases. Theme 3: Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience. This guards against professional stagnation. A supportive environment allows for personal reflection. Theme 4: An intense commitment to learn propels the developmental process. Theme 5: the cognitive map changes: beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise. Theme 6: professional development is a long, slow, continuous process that can also be erratic. Development can be conceptualizes as repeated cycles of enthusiasm/experienced hardship, self-doubt, anxiety, dejection, exploration/processing, and integration (mastery). Theme 7: professional development is a life-long process. Theme 8: many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most. Theme 9: clients serve as a major source of influence and serve as primary teachers. Theme 10: personal life influences professional functioning and development throughout the professional life span. Theme 11: Interpersonal sources of influence propel professional development more than impersonal sources of influence. Theme 12: New members of the field view professional elders and graduate training with strong affective reactions. Theme 13: Extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability. Theme 14: for the practitioner there is a realignment from self as hero to client as hero. The article concludes with further elaboration on theme 3. continuous reflection as a prerequisite for optimal learning and professional development at all levels of experience. The ability to reflect on all experience and challenges and difficulties in particular are prerequisites for optimal development. Reflection is defined here as "a continuous and focused search fore a more comprehensive, nuanced and in-depth understanding of oneself and others, and of the processes and phenomena that the practitioner meets in his/her work" pg. 34. The authors believe that stagnation or negative development comes from not reflecting. The counselor must possess cognitive reflective capacity and affective competence in order to positively impact the client.

Skovholt & Ronnestad	1992	Themes in Therapist and Counselor Development	The goal of this study was to consider themes in counselor development, as well as to look at the dimension of development versus professional stagnation. The study was conducted over 5 years with 100 therapists and counselors from the first year of graduate school to 40 plus years beyond graduation, split up into 5 groups of 20. Following interviews, the research team met to intensely analyze the results of the interviews, followed by several rounds of review by others and a re-interviewing of 60 of the 100 participants to check-in on the categories and accuracy of the analysis. The following themes emerged. Under Primary Characteristic Themes-Theme 1: professional development is growth toward professional individuation. Theme 2: an external and rigidity orientation in role, working style, and conceptualizing issues increases throughout training and then declines continuously. Theme 3: as the professional matures, continuous professional reflection constitutes the central

developmental process. This is the major method of professional development across all stages and there are three parts: intense professional and personal experience are essential to development as is an open and supportive work environment (values diversity, high standards of performance and a searching process,(not just total acceptance of pre-ordained set of principles), and reflective stance. This means that the individual is giving time, intentionally, to processing alone and with others, significant experiences. An active, exploratory, and open attitude is crucial. In the early years of training, in more structured environments it is important for the individual to define themselves not only through the views of others. Later, when the counselor is beyond the structure and control of others, it is crucial for the individual to seek out stimulation and feedback continuously. This is how stagnation can occur. Theme 4: Beginning practitioners rely on external expertise; senior practitioners rely on internal expertise. Theme 5: Conceptual system and role, and working style become increasingly congruent with one's personality and cognitive schema. Theme 6: there is movement from received knowledge to contracted knowledge. Process Descriptor Themes: theme 7: Development is influenced by multiple sources that are experienced in both common and unique ways (i.e. professional elders, peers and colleagues, clients, theories, research, one's own personal life, social and cultural environment, on a micro and macro level. These sources uniquely impact because of timing, intensity, and pace dimensions (i.e. theoretical orientation of supervisor). Theme 8: optimal professional development is a long, slow, and erratic process. The use of professional reflection goes on year after year and expands and is individualized. New counselors need to understand the difficulty of this process and the slowness of the development of professional expertise. Theme 9: Post-training years are critical for optimal development. Theme 10: as the professional develops, there is a decline of pervasive anxiety. Sources of Influence Themes: Theme 11: Interpersonal encounters are more influential than are impersonal data (e.g. theories and research). Theme 12: personal life strongly influences professional functioning. Theme 13: clients are a continuous major source of influence and serve as primary teachers. Theme 14: Newer members of the field view professional elders and graduate training with strong affective reactions. Theme 15: External support is most important at the beginning of one's career and at transition points. Theme 16: Professional isolation becomes an important issue with increased experience and age. Theme 17: Modeling/imitation is a powerful and preferred early, but not later, learning method. Theme 19: for the practitioner there is a realignment from a narcissistic position to a therapeutic position. Theme 20: extensive experience with suffering produces heightened tolerance and acceptance of human variability. In summary, these themes suggest that development involves a movement from reliance in external reality to internal authority through the individual interaction with many sources over time. Sources of influence seem to have greater or equal power even beyond graduate training, and may be a central element in professional development versus stagnation and impairment.

Skovholt, Ronnestad, & Jennings	1992	Searching For Expertise in Counseling Psychotherapy and Professional Psychology	This article discusses the nature of expertise within the field of applied psychology. The issues in measuring expertise are discussed. Importantly, the authors write about how a key component of expertise is the ability to engage in continuous professional reflection. This is similar to deliberate practice and appears to produce domain-specific growth rather than stagnation. Stagnation occurs when the individual is closed to grappling with the complexity in the world of practice, finding comfort in predictability and routine.
Trieweiler & Stricker	1997	The Scientific Practice of Professional Psychology	Trierweiler and Stricker (2003), based on Schön's theory of "technical rationality" posit, the determination of the relevancy of the theory to a problem is based on a careful "local assessment" (page 262). Thus Trierweiler and Stricker argue that psychologists, generally, do not operate from theories, which would involve precise predictions about phenomenon. Conceptual frameworks might be a more appropriate way of describing how psychologist approach clinical situations. A framework, according to Trierweiler and Stricker is " A set or a system of ideas that draw attention to particular phenomena and to particular aspects of a phenomena in the local clinical situation." Thus, a framework has heuristic value in that it helps the practitioner examine his or practice in an analytical way, allowing the practitioner to identify what is, and what is not known, in the clinical situation. This is part of the process of reflection. What is key to this theory of reflective practice is the outcome of this reflective practice: According to Trierweiler and Stricker approaching practice from this reflective stance "can lead the therapist to choice points wherein new questions are framed, leading to modification of approach or to continuation along the existing path, but with eyes open to alternative interpretations of the case" (page 271).
Bollich, Johannet, & Vazire	2011	In Search of Our True Selves: Feedback as a Path to Self-knowledge	This article addresses how one accurately develops self-knowledge. The article reviews literature on the tendency of human beings to have faulty self-assessments about personality traits and behavior. The article discusses two sources of self-knowledge; intrapersonal approaches (introspection) and interpersonal approaches (feedback). There is some literature to suggest that introspection leads to a reduced tendency to self-enhance (Sedikides et al., 2007; Hizxon and Swann, 1993), however there is also

literature that suggests that self-reflection does not lead to accurate self-knowledge (Wilson et al., 1995; Wilson, 2002). This article makes the point that evaluations from close others can sometimes be more accurate than self-evaluation, and research is cited to support this point. The authors state that the idea source of external feedback is someone who knows the target well but is distant enough to be objective. Also of import is how the target will receive the feedback. In general, those with higher self-esteem, self-efficacy and an internal locus of control respond more positively to feedback. Also, research supports that individuals tend to learn about less desirable traits from others as compared to introspection, and are also less convinced of information learned from others. Thus, the authors state that there must be time to process both negative and positive feedback for it to be effective and impactful.

Childs	2011	Mindfulness and Clinical Psychology	This article discusses the implications of mindfulness for clinical practice. Relevant to this dissertation is the section on mindfulness and reflective practice. The author discusses the importance of being a reflective practitioner, which consists of being able to consider how theory, skill, values, and context interact and affect treatment. The author states that in practice, reflective practice involves a moving away from personal or cultural insensitivity. This is in contrast to the more open and observational stance of mindfulness. The author argues that in order to get the best of both these forms of reflection, it is necessary to balance mindfulness with more focused critical observation. Mindfulness can help establish the broadest base for reflection. A model of supervision consistent with this idea is briefly described (Jones & Childs, 2002).
Dallos & Stedmon	2010	Reflective Practice in Psychotherapy and Counseling	Dallos and Stedman (2010) provide a more detailed framework on the processes that encompass reflective practice. They assert that, "reflective practice is a successive process of analyzing and reanalyzing important episodes of activity, drawing on multiple levels of representation. This includes propositional, autobiographical, and ethical knowledge, yet does not squeeze out serendipitous and playful potential for learning our very personal experiences" (p. 4). Dallos and Stedman split the process of reflective practice into two components: personal reflection and personal reflexivity. Personal reflection refers to the spontaneous act of reflecting in the moment. Personal reflexivity refers to the act of looking back and reflecting on a prior episode. This is similar to Schön's concepts of 'reflection in action' and 'reflection on action,' respectively (Schön, 1983, 1987). According to Dallos and Stedmon (2010), personal reflection encompasses the awareness of bodily sensations and emotions, cognitions, and evoked memories in the moment of reflective episodes. In contrast, personal reflexivity is a conscious cognitive process, where knowledge is applied to theory in order to make sense of episodes. This knowledge is drawn from the identification of psychological theories applicable to the circumstances, and an understanding of one's own autobiographical account (i.e. from the multiple culture's the practitioner may ascribe to). Dallos and Stedmon's (2010) theory of reflective practice implies a two stage-process. In essence, the first-order episodes of reflection in action (i.e. personal reflection) later become second-order episodes of reflection (i.e. personal reflexivity). The temporal sequencing of these two levels is not always discrete. Sometimes first order and second-order reflections occur indiscriminately and out of sequence in the context of therapy itself.
Moffet	2009	Directed Self-Reflection Protocols in Supervision	The article addresses how to help supervisees prepare for problematic reactions in therapy (i.e. violated expectations, boundary intrusions, narcissistic injuries) that are likely to occur in their clinical work. One of the underlying assumptions of this article is that one of the goals for supervision is for the supervisee to learn how to self-supervise, which is essentially a continuous self-assessing orientation to clinical wok. This distills to being able to anticipate one's readiness for particular clinical tasks, reflecting regularly on clinical work, considering how interventions impact one's clients, recognizing and using one's emotional responses for therapeutic benefit, and being able to flexible apply different clinical interventions when indicated. Moffet created a self-reflection protocol to accomplish the task of helping trainees confront challenging situations. He developed a list of questions that address issues that are frequently problematic for trainees. This is dependent on the particular setting. The supervisee is then asked to reflect on the questions before the second supervision session, and provide honest and uncensored answers. The supervisee is welcomed to discuss these answers, but this is not required. The expectation is that having reflected upon these issues, when they arise in clinical practice, the supervisee is more readily able to identify the challenges and be better prepared to mange them effectively or bring them up in supervision sessions. The questions do not ask about beliefs, values, or past experiences. Rather, they focus on predictions of how supervises would act in hypothetical situations (e.g. What do you do when you believe that you cannot perform a task as well as others expect you to do?", "What do you think, feel, and do when you see someone in distress?', 'What do you think, feel, and do when you are expected to follow rules you do not agree with?") The purpose is to reduce anitherapeutic responses and to promote empathy for unfamiliar patients. Questions are grouped into personal and then professional issues to help trainees clarify their personal style and then their professional roles. This is helpful for the trainee to see the demarcation

before these two become fully integrated. Moffet provides an example of how to use self-reflection questions with an example protocol designed for working with substance-dependent men in a residential therapeutic community, however many of the questions would be relevant for trainees working with any kind of patient and in most settings.

Neufeldt, Karno, & Nelson	1996	A Qualitative Study of Experts' Conceptualization of Supervisee Reflectivity	The goal of this qualitative study was to see whether scholar's perceptions of reflectivity, across different disciplines, share common ground and could provide a more unifying theory of this very important construct. Authors spoke about their work hopefully leading to a more comprehensive theory as well as a better understanding of how supervisors can facilitate the development of reflectivity. The focus of this study was only on reflectivity that occurs in supervision. The study aimed to answer the following questions: (1) what are the hypothesized characteristics of reflectivity that counselors in supervision use? (2) How are they thought to be interrelated? (3)What environmental and personal conditions facilitate trainee use of reflectivity? 5 experts were interviewed, Schön, Skovholt, Ronnestad, Holloway, Copeland (education). Respondents interviewed twice, initially and after Neufeldt (researcher) developed categories based on initial interviews. Respondents could critique, agree, or disagree, and or expand on their own and other's comments. Karno and Nelson then coded the interviews independently and consensus resolved any disagreements. Analysis revealed a common set of attributes/categories of reflectivity, with many of the categories having identified dimensions. Firstly, respondents described one property of reflective practice as a sequence that occurs-this was titled the causal condition category. An event in therapy triggers reflection in supervision, which leads to new actions and events in counseling, which then triggers further reflectivity. The single property of this category is the problem, the trainee's feelings of uncertainty or thoughts about a dilemma, surprise, confusion, and stuckness trigger reflectivity. The dimensions of this condition range from uncertain to clear. The second category identified was Intervening conditions, which act to either facilitate or constrain reflective practice. These intervening conditions are trainee personality, cognitive capacity (it appears some supervisees are more equipped than others to reflect), and supervisory environment. The third category is Process: Search for Understanding of Phenomena. The process part of the construct seemed to involve the following: A. Locus of attention along two dimensions, (1) attention directed to the therapist's actions, emotions, and thoughts in the counseling session (2) attention is directed to the interaction between the client and therapist. B. Stance, which refers to a patterns of viewing the phenomena of the counseling session. Four dimensions characterize a reflective stance, 1. intention versus lack of purpose, active inquiry vs. lack of questioning, openness to understanding vs. search for verification, vulnerability vs. defensive self-protection. C. sources of understanding (theory vs. random observation, personal and professional experience vs. reliance on others, and self-experience vs. reliance on client. D. Depth (reflective practice can be profound vs. superficial; meaningful vs. meaningless). Fourth category/attribute is Consequences. The results of the reflection are integral. it goes beyond just thinking-it results in change (perceptual vs. no change in perception; behavioral change in therapy vs. no change in behavior in therapy) and long-term growth (increased capacity to make meaning vs. diminished or unchanged capacity to make meaning).
Orchowski et al.	2010	Enhancing Supervisee Reflectivity	The goal of this article was to demonstrate how a supervisor can promote self-reflection in their supervisees through a case report. There has not been any empirical study on this topic, to date. The article discussed process and interventions that can be used, barriers to fostering self-reflection, and limitations in the current literature and future directions. Processes discussed were the following: 1. Supervisors must engage in their own self-reflective process at the start of the supervisory relationship in order to provide mentorship to others on cultivating reflectivity (e.g. developing awareness of cultural background of self, supervisee and client). Supervisors can review tapes of supervision sessions to gauge how they are inculcating reflectivity into their supervision, and to make it explicit how and why reflectivity will be central to the supervision process. 2. Supervisors need to model reflective dialogue (e.g. reflecting on his or her own cognitions or emotional experiences within supervision. This mimics Schön's (1983, 1987) reflection-in action; processing what you are doing while you are doing it, and reflection-on action; processing events after they occur). This modeling may allow supervisees to garner a greater understanding of how to react moment-to-moment in therapeutic interactions through being present to thoughts and feelings they are experiencing. 3. Communication strategies can be used to develop reflectivity (e.g. open-ended non judgmental questions to cultivate a deeper understanding of one's affective response in session, Socratic questioning which fosters inductive reasoning). As important as what the supervisor asks is how the supervisor responds to supervisee's reflective comments (respect, genuineness, authenticity, trust, and openness must be demonstrated). 4. Utilizing Reflectivity In and Out of Session: vital to provide time for

reflection before, during, and after supervision sessions to encourage the development of reflective practice). Outside session activities include, reflecting on a dilemma through structured questions (Carrol and Holloway, 1999; Neufeldt, 1999), structured journal writing, supervisees utilizing a self-supervision check-list when reviewing tapes before supervision to discuss, and taking self-assessment measures that can promote reflectivity (e.g. Self-awareness and Management Strategy Scale). In session activities include: using Interpersonal Process Recall(IPR; Kagan, 1980). The article also discusses overcoming barriers to promoting self-reflection. These include: understanding the power differential in the relationship and the potential for a dual relationship and how this can create a threatening environment. Must clarify roles and minimize dual roles when possible. The environment must also be warm and supportive so that supervises are comfortable self-disclosing, even supervisees who carry personal characteristics such as fear of evaluation. Limitations in the current literature on reflective practice are significant. There is no data on what reflective practices are meaningful, how theoretical orientation shapes supervisor engagement in promoting reflective practice, there is little understanding of the factors that comprise meaningful reflection, and what types of self-reflection are most useful for supervisees' development, and how engaging in reflective practice promotes supervisory development. There is a lack of assessment measures to gauge the quality and engagement in reflective practice. Also, there is no understanding of the most effective time to implement reflective practice (i.e. inside or outside of supervision), and what activities supervisors can use to effectively implement and encourage reflectivity, and which strategies are best suited for specific supervisees.

Scaife	2010	Reflective practice and Supervision	Scaife provides a comprehensive definition of the components of reflective practice. She asserts that reflective practice is the process of thinking deeply as well as paying attention to concomitant feelings both when engaged in practice and, then again, when thinking about it later from an observer's perspective. Thoughts about the value-laden context and ourselves get taken into account, which may lead to changes in practice. According to Scaife, reflective practice is characterized by the following: (1) It is an active process with purposeful intention. (2) It goes beyond just a description of an experience. There is no pre-determined end to the practice. (3) It involves reflecting on questions from self and others on experiences. (4) It involves critically thinking about and evaluating experiences, creating explanations for experiences, while staying open to alternative explanations. An observer perspective is required wherein the reflector reflects on him or herself and the wider socio-cultural context. It necessarily involves practice, which may mean gaining a better understanding of practice or making changes to practice. It involves linking current and prior experiences, theories, literature, and research. It is personal and involves things that are meaningful to the reflector. It is an experience that needs to happen independent from considerations of others. It may lead to more awareness of 'tacit' knowledge (p.7). It can include reflections on behavior, thoughts, feelings, values, attitudes, skills, and the social and cultural context.
Belar	2009	Advancing a Culture of Competence	The purpose of this article is to highlight several issues related to advancing a culture of competency. The first issue addressed is the risk of 'stove-piping competencies," which is the failure to appreciate that many of the components of competencies are interrelated, and thus discrete assessments may not give a full picture of how a trainee will function in real-life situations. The second issue is the need for trainees to perform accurate self-assessments. This is important to both quality improvement efforts, life-long learning and the maintenance of competency across the life-span, but the literature on this area in psychology is lacking. The third issue presented is the ethical issue of mentors serving the dual function of being a gatekeeper and the need to have non-biased reviews of students. The fourth issue presented is the need to assess the process of clinical decision-making in trainees and to ensure that this is being taught and measured well in training. The fifth issue presented is the need to allocate resources for professional development in order for faculty to be able to promote and teach what is necessary to develop competency within their students. The sixth issue presented is a question of the model of short-term training within psychology and whether students miss out on opportunities to get in depth experience to learn about the complexity of human behavior.
Belar et al.	2001	Self-Assessment in Clinical Health Psychology: A Model for Ethical Expansion of Practice	The purpose of this article is to offer a model of self-assessment that practitioners can use to assess their readiness to work patients with physical health problems. Psychologists are expanding their practice into areas they were not trained well in graduate school, and therefore it is critical they are able to self-assess their readiness to work with these populations. In addition to providing the 13 question self-assessment protocol, the authors also provide guidelines for developing a template to self-assess and achieve readiness. A template for assessing one's readiness to work with breast cancer patients is provided as an example as well.
Fouad et al.	2009	Competency Benchmarks	This article identifies core professional competencies and benchmarks for these competencies across three professional levels (i.e. readiness for practicum, readiness for internship, readiness for entry into practice). The article describes the history the competency movement, the process of how the benchmarks document was developed,

and ends with a description of the benchmarks. The National Council of Schools and Programs of Professional Psychology (NCSSP) is one of the first widely acknowledged models of competency. Established in 1986, the model identified 6 core competency areas. Program curricula were designed to meet the standards of these 6 competencies. In 1996, the Committee of Accreditation (CoA) of the APA, revised its guidelines for accreditation. Programs would have to specify their education and training in terms of professional competencies expected of their graduates. The next step was at the 2002 Competencies Conference: Future Directions in Education and Credentialing. The conference addressed core competencies expected of graduates of psychology training programs (identification of the competencies, education and training, and assessment of competencies). The Cube Model was one of the outcomes-this model has gained acceptances across psychology training programs. It proposes 12 competencies, on a three dimensional model, conceptualized as either foundational (refers to the knowledge, skills, attitudes, and values that serve as the foundation for what the psychologist is expected to perform and is on the x-axis) or functional (encompasses the functions of a psychologist and is on the y-axis). The z-axis represents the stages of professional development. The competencies conference also put forth that identification of competencies would be a continuing agenda item for the Council of Chairs of Training Councils (CCTC). The APA Board of Educational Affairs convened a task force in 2003 to begin measuring the competencies, a step beyond defining them. A more recent step was the creation of the Assessment of Competency Benchmarks Work Group-an outcome from the CCTC and APA Board of Educational Affairs. The group met to identify levels of competency appropriate for different stages of professional development. The document identified benchmarks for the 15 competency areas delineated in the Cube Model. The intent of the workgroup was to advance discussion on how to measure and implement a competency-based approach to education and training. Each competency was operationally defined, broken down into its essential components, and given behavioral anchors for each level of training. The core foundational competencies include: professionalism, reflective practice, scientific knowledge and methods, relationships, individual and cultural diversity, ethical and legal standards and policy, and interdisciplinary systems. The functional competencies include: assessment, intervention, consultation, research and evaluation, supervision, teaching, administration, and advocacy (note: teaching and advocacy were additions from the original cube model). According to Fouad et al., the essential component of reflective practice at the readiness for practicum level is "basic mindfulness and self-awareness; basic reflectivity regarding professional practice (reflection-on-action). The behavioral anchor displays for this are: Problem solving skills, critical thinking, organized reasoning, and intellectual curiosity and flexibility. At the readiness of internship level, the essential component of reflective practice is defined as "Broadened self-awareness; self-monitoring; reflectivity regarding professional practice (reflection-on-action); use of resources to enhance reflectivity; elements of reflection-in-action. The behavior anchor displays are as follows: articulates attitudes, values, and beliefs toward diverse others, recognizes impact of self on others, self-identifies multiple individual and cultural identities, describes how others experience him/her and identifies roles one might play within a group, responsively utilizes supervision to enhance reflectivity, systematically and effectively reviews own professional performance via videotape or other technology with supervisors, and initial indicators of monitoring and adjusting professional performance in action as situation requires. Finally, at the readiness for entry into practice level, the essential component of reflective practice is defined as: "reflectivity in context of professional practice (reflection-in-action), reflection acted upon, self used as therapeutic tool." The behavioral anchors for this are the following: "demonstrates frequent congruence between own and other's assessment and seeks to resolve incongruities, models self-care, monitors and evaluates attitudes, values, and beliefs towards diverse others, systematically and effectively monitors and adjusts professional performance in action as situation requires, consistently recognizes and addresses own problems, minimizing interference with competent professional functioning." As far as the self-assessment clinical competency, at the readiness for practicum level the essential component of this competency is defined as "knowledge of core competencies; emerging self-assessment re: competencies." The behavioral anchor displays for this are: "demonstrate awareness of clinical competencies for professional training, develops initial competency goals for early training (with input from faculty). Self-assessment at the readiness of internship level is defined as "broadly accurate self-assessment of competence; consistent monitoring and evaluation of practice activities." The behavioral anchor displays are: self-assessment comes close to congruence with assessment by peers and supervisors, identifies areas requiring further professional growth, writes a personal statement of professional goals, identifies learning objective for training plan, systematically and effectively reviews own professional performance via videotape or other technology." Finally, at the readiness for entrance to practice, the essential component of self-assessment is defined as "accurate self-assessment of competence in all competency

64

domains; integration of self-assessment in practice." The behavioral anchors are: "accurately identifies level of competence across all competency domains, accurately assesses own strengths and weaknesses and seeks to prevent of ameliorate impact on professional functioning, recognizes when new/improved competencies are required for effective practice. Finally, self-care (attention to personal health and well-being to assure effective professional functioning) is defined at the readiness for practicum level as understanding of the importance of self-care in effective practice; knowledge of self-care methods; attention to self-care." The behavioral anchor is: "demonstrates basic awareness and attention to self-care." At the readiness to internship level, the essential component to self-care is "monitoring issues related to self-care with supervisor; understanding of the central role of self-care to effective practice." The behavioral anchor displays are: "Works with supervisor to monitor issues related to self-care, and takes action recommended by supervisor for self-care to ensure effective training." Finally, at the readiness for entrance to practice, self-care is defined as "self-monitoring of issues related to self-care and prompt intervention when disruptions occur." The behavioral anchor displays re: "Anticipates and self-identifies disruptions in functioning and intervenes at an early stage with minimal support from supervisors, and models self-care."

Kalsow et al.	2007	Recognizing, Assessing, and Intervening with Problems of Professional Competence	This article discusses ways to handle competence problems through a series of proposals. Relevant to this dissertation is proposal 3: self-assessment. The article suggests that when assessing competence problems, evaluating self-assessment capacity is central. When necessary bolstering self-assessment capacity may be a way to prevent competence problems. Self-assessment is a foundational competency and includes self-awareness, self-reflection, self-understanding, and self-evaluation. The authors note that this must be taught and encouraged, but methods to evaluate this construct are limited as are correlations between self-assessment and external measures of performance and observable measures of competence. Thus strategies to enhance one's ability to accurately self-assess must be used (i.e. guided self-assessment, and self-evaluation exercises early in training). The authors also discuss that as the profession recognizes the value of self-assessment, questions around definition, criteria, measurement, and how to teach this will arise. Also, given that self-assessment interacts with other variables, such as personality style, life circumstances, and one's developing professional identity over time, assessment measures must be multifaceted and implemented at various stages. According to Belar, lacking the skill to self-assess is equivalent to failing to attain professionalism, and lacking the skill to think like a psychologist. The authors suggest that psychology must establish a culture that genuinely values self-assessment and reflective practice, from the beginning of training and is supported by feedback from others and multiple sources (faculty, supervisors, peers). Training should emphasize the development of a capacity to examine difficult and uncomfortable material as a way to achieve mastery and reduce the negative performance impact. This is supported by an atmosphere of empathy, concern, and respect, which engenders trust in the evaluation.
Kaslow et al.	2007	Guiding Principles for the Assessment of Competence	This article presents guiding principles for the assessment of competence as the authors assert that the assessment of competence is highly important for several reasons: it fosters learning, advances the field, protects the public, and determines effectiveness. There are adequate methods for assessing knowledge within the field, however what is lacking is methodologies for evaluating clinical skills and other attributes of competence. This article borrows from and extends on the principles developed by the Assessment of Competence Workgroup from the competencies conference. Principle 1: A culture shift is required for competence assessment to be integrated into the education, training, credentialing, and post credentialing of professional psychologists. For example, grade inflation must be acknowledged and altered, and valid and reliable assessments must be encouraged and valued. Buy-in is necessary across the board. Principle 2: Competencies must be conceptualized as generic, holistic, and developmental abilities. That is, knowledge, skills, dispositions, self-perceptions, motives, beliefs, and attitudes are all dimensions of holistic abilities, not just separate measures of performance. It is easier to assess knowledge than skills and attitudes, and therefore more meaningful assessments must be developed. An example is problem-based learning methodologies, such as case vignettes. Principle 3: meaningful assessment of competence is developmental in nature and attends to overall competence within and between competencies across all stages of professional development. Principle 4: Effective assessment approaches integrate formative and summative evaluations. Principle 5: There must be collaboration and coherence between the educational programs and their implementation of competency assessment, and credentialing regulators. Principle 6: Assessment methods must be reliable, valid, flexible, feasible, practical and timely. Principle 7: Generic competency assessment bolstered by assessment of specialty competencies will serve to strengthen the assessment of competence. Principle 8: Assessment of competence is multidomain (relates to assessment of all competency domains), multi-method (refers to using more than one methodology such as paper and pencil measures, oral exams, supervisor

ratings), multi-informant (multiple sources report on an individual's competence). Principle 9: Self-reflection and self-assessment are key components of competence and must be taught and encouraged. It is difficult to measure this construct due to the lack of measurement tools and consensus on how to represent self-awareness. A 360-degree evaluation is suggested as good tool to foster reliable and valid self-assessment. The article acknowledges that training in self-assessment has been minimal as compared to education. The College of Psychologists of Ontario developed a tool to aid psychologists in self-exploration related to their psychotherapy practice. This self-assessment guide is competed biannually by all psychologists in the jurisdiction. The document assists members in self-assessing about their competence in legislation, standards and guidelines, service to clients, teaching and training, research, supervisory activities, current areas of practice, and anticipated areas of future practice. Members create professional development plans to address discrepancies between current and desired competence and at 2-year interval members reflect and modify the plan. Self-assessment can be taught and encouraged and should be integrated into training from the beginning. It can be enhanced through monitoring and feedback from external sources. Training must emphasize self-assessment as an ongoing imperative. There is a dearth of self-assessment models within psychology. Reliable methods must be developed. Principle 10: Competence assessment must focus on interpersonal functioning and professional development. Principle 11: Competence assessment must be sensitive to individual and cultural diversity. Principle 12: Assessment of ethics is very important and is beneficial if it incorporates ethical integrity across all aspects of training (course, experiential placements, research, comprehensive exams, and dissertations). Principle 13: Assessing capability in addition to competence is important. Capability is the extent to which individuals can adapt their skills to new contexts and situations, generate new knowledge, and continue to develop and improve their performance. Principle 14: It is important to have remediation and management policies in place when competency problems are identified. Principle 15: Training should be offered to educators, supervisors, and credentials in effective methodologies for ongoing assessment. Attention to common biases in performance ratings and challenges should be given. The article concludes with recommendations for the implementation of strategies to enhance the assessment of competence including the recommendation for a culture shift towards a high level of value placed on competency assessment, the recommendation that workgroups be formed to further define competencies, especially for core, generic, competencies, research should be conducted on the development of psychometrically sound and comprehensive assessment methodologies.

Leigh et al.	2007	Competency Assessment Models	This article addresses the different qualities of assessment measures (i.e. validity, reliability, fidelity, feasibility and practical considerations), and details different methods for assessing different things (i.e. multiple choice or essay to measure knowledge, oral examination, written case vignettes, images, videotape, audiotape, live patient/client situations to measure decision making, assessments of performance and personal attributes can also be done through rating forms, portfolios, 360 degree evaluations. Integrated assessment of skills can be done through role-plays, the medical model Objective Structured Clinical Examination (OSCE), computer simulations, or standardized patient encounters (SP). The article mentions that no single assessment model can evaluate all competencies and many competencies can be measured by more than one model. The plan would need to identify multiple assessment models and taking into account different stages in professional development. This article also briefly reviewed assessment practices in nursing, dentistry, and medicine.
Lichtenberg et al.	2007	Challenges to the Assessment of Competence and Competencies	This article lists several challenges to the assessment of competencies within psychology. 1. Psychology has had problems defining its competencies in precise enough terms to be measurable. 2. Lack of consensus in the field of the core foundational and functional competencies within the 'Cube Model,' and the key elements of each competency domain (Rodolfa et al., 2005), and fundamental differences among the applied specialties in professional psychology. 3. Very difficult to assess attitudes, and very few established methods at all, and there are none that assess the integration of knowledge, skills, and attitudes in the performance of professional functions that comprise competence (e.g. relationship skills, team work, reflective-practice 'self-awareness etc.). Of relevance, many measures lack fidelity; paper and pencil measures often lack depth in assessing complex factors such as the integration of knowledge, skills, and attitudes. However, high fidelity measures can raise complications (e.g. Time, money, labor intensive, lower generalizability from one setting to another, for some constructs). There is also the problem of not having an agreed upon understanding of what constitutes incompetence and how to manage this. 4.discipline wide shift toward a culture of competency and comprehensive assessment is very challenging and costly, especially because we don't have base rates/prevalence of professional incompetence. There are implementation challenges with competency assessment, post licensure. Also, there may be value clashes; training programs favor having a distinctive approach to training, while licensing boards and credentialing

			bodies favor may value consistency in training.
Peterson, Peterson, Abrams, Stricker	1995	The Reflective Educator	In this article, the author strongly asserts that there is a need to evaluate professional educational programs more thoroughly than has been in the past. The author cites research that shows that trained practitioners are not seen to be more effective than university practitioners, opening the question about whether training in psychology is adequate. The author, one of the founders of the NCSSP, speaks about the approach that the NCSSP takes to training, which is based on Schön's notion of reflective practice. That is that practice is not just a simple application of science. Problems in psychology do not have fixed solutions; they are more complex than that. Therefore what is needed to solve these challenging, unique problems is the ability to reflect-in-action. This allows the practitioner to be a researcher, in essence, in the world of practice. Reflection on action is not just an intuitive approach to practice that lacks scientific rigor. It draws on past research, theory whenever available, but often goes beyond to inventive study. In summary, the author argues that the profession of psychology needs a revision so that it is not viewed as a science, as an art, but as a profession in itself. Disciplined Inquiry is the term the author uses for Schön's term reflective practice.
Peterson, Peterson, Abrams, Stricker	2006	That National Council of Schools and Programs of Professional Psychology Educational Model	Over the past 20 years the National Council of Schools and Programs of Professional Psychology (NCSSP) has devoted itself to examining standards for the education of professional psychologists through a series of annual conferences. This article begins with a summary of how the NCSSP developed its model and core tenets through each conference. The second portion of the article focuses on the NCSSP's education and training model. First described is the educational model. From the perspective of the NCSSP, rigorous professional activity is not just a simple application of scientific knowledge to human problems. It is about starting first with the needs of each individual and bringing the best available research, theoretical concepts, along with the individual and collective experience. This process of professional work is Schön's idea of reflection-in-action (1983, 1987) and Peterson's (1991, 1995, 1996) idea of "disciplined inquiry". The role of the practitioner is that of the "local clinical scientist: (Stricker & Trierweiler, 1995). This approach has impacted the educational programs of professional psychologists, specifically with how dissertations are carried out. Dissertations have become exercises in disciplined inquiry in additional to being traditional. Most emphasize an applied focus. From the perspective of the professional as a local clinical scientist, research training in professional psychology is viewed as essential for developing critical thinking. In supervision, the two critical questions are how do you know? and does it apply? These emphasize the tension between aggregate findings and individual exemplars. The article also emphasizes that a competency-based approach to training is more important than a content-based approach. The educational process must be an experience that allows the personal and professional self to grow. This is consistent with Schön's ideas of reflective practice and must be taught and evaluated by professional training programs. The article concludes with a section on the importance of attending to diversity, within training, and this being a strong component of the NCSSP mission statement.
Roberts et al.	2005	Fostering a Culture Shift: Assessment of Competence in the Education and Careers of Professional Psychologists	This article synthesizes the discussions and conclusions of the Assessment of Competence Workgroup (which met during the Competencies Conference in 2002). The workgroup was charged to generate a plan to assess the attainment and overall competence in professional psychology. This article discusses how a culture shift will be necessary in order for the assessment of competency to become routine and systematic. The authors propose two cultural shifts: a shift to an emphasis on the acquisition and maintenance of competency as a primary objective and a shift to assessing all levels of competence over time. For this to happen, the professional community needs to agree on values and habit that reflect good professional practice. The authors then describe basic principles of the assessment of competence that can guide the assessment process: 1. A developmental perspective should underlie the assessment of all competencies. 2. cultural aspects of competency assessment and the assessment of cultural competence should be taken into account. 3.Formative and summative feedback is both needed. 4. procedures for the assessment of competence should involve self-assessment procedures, and this should begin early in training alongside external assessments. This is what may ensure career long continuity in these practices, as psychologists wont begin practicing this at the point of graduation or credentialing. 5. Career-long assessment of competence is necessary. To achieve this, methods taught during training should represent how professionals should continue assessment of their competence throughout their careers. 6. Assessment of competence should include multidimensional, multi-method input, and multisource feedback. 7. Dual roles in the assessment of competence must be considered and adaptations made to ensure the process is fair and effective.
Rubin et al.	2007	The Competency Movement within Psychology: A Historical Perspective	This article provides a historical context to the competency movement. It highlights that central to the establishment of a culture of competency is the APA ethics guide on competence in the Ethics Code in 2002, accreditation models in North America, efforts to establish competency based training programs across the different training stages, and competency based credentialing bodies. The Competency Conference (2002) has

played a major role in furthering a culture of competence within psychology, and in particular the work on the assessment of competence that emerged from the conference. Authors state that it could be argued that the Boulder Conference, which focused on the knowledge, skills, and attitudes to be, acquired in graduate education in clinical psychology helped set the backdrop for a focus on competencies at the doctoral level. Since then graduate programs have identified competencies for professional practice, with the National Council of Schools and Program of Professional Psychology (NCSPP) being the leader in the field with their early major effort to design and implement a competency-based approach to curriculum. Many areas within psychology have focused on developing competencies for practice including counseling and school psychology programs. Within clinical psychology, attention has been paid to differing standards of competency across practicum, internship, and postdoc. Finally, this article goes through the contribution of credentialing boards both nationally and internationally with a focus on how their work has contributed to the culture of competence. The end of the article highlights the unique contribution of the Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology. Authors focus on how the development of the cube model for competency development was created including a description of foundational competencies (i.e. the building blocks of what psychologists do), which lay the foundation for functional competencies (i.e. the knowledge, skills, and attitudes relevant to the practice of psychology). Two workgroups within the conference focused specifically on competency; The assessment of competence workgroup and benchmarks workgroup, which developed the cube model. The outcome of these two workgroups was the understanding that psychology, as a profession, needs improvement in effective assessment of competence (knowledge, skills, and attitudes, and capability). What is underscored is the need to increase focus on self-assessment, self-monitoring, reflection, and self-awareness, which not only reflect ethical behavior, but are critical to the assessment of competence. In addition to the Competencies Conference, other efforts have contributed to the furthering of a culture of competence. The Education and Leadership Conferences, under the auspices of the Education Directorate of the APA has held several conferences, which have built on and expanded the work of the competencies conference through focusing on specific methodologies for assessment. In 2006, the APA Task Force of Competence in Professional Psychology was completed. This group included individuals representing four APA directorates (Education, Practice, Science, Public Interest) and the Committee for the Advancement of Professional Practice. It also includes two external consultants with expertise in competency assessment. The task force attends to competency assessment models, challenges to the assessment of competence, recommendations for bolstering the competency assessment movement, and guiding principles for competency assessment. The Assessment of Competency Benchmark Workgroup was an event that took place in 2006, which was formed in response to one of the recommendations of the APA Task Force. The group, using the cube model, focused on the developmental progression of the competencies across the stages of doctoral training in professional psychology. The goal of the group was to develop a descriptive, not prescriptive product, to guide training programs development of the assessment of competence. At the end of the article, authors summarize the implications. They state that psychology education and training are on a major brink in terms of paradigm shift to an outcomes-based education and training and competency-based focus. The authors discuss that collaboration across fields and from multiple constituency groups will be important for defining and ascertaining meaningful approaches to the assessment of competence. The challenge will be for the profession to devise, implement, and evaluate the effectiveness of comprehensive, developmentally informed assessments throughout the professional life span.

Wise et al.	2010	Life-Long Learning for Psychologists: Current Status and a Vision for the Future	This article focuses on the importance of enhancing and maintaining one's competence and the challenges psychologist encounter in this process. Relevant to this dissertation is the piece about the challenge that accurate self-assessment presents in maintaining and enhancing one's competence. Several lines of research suggest that people are not effective in determining for themselves what they most need to learn. While this research is not on practicing psychologists, and therefore the implications for professional psychologists is not clear, there still seems to be a suggestion of caution in the assumption of accurate professional self-assessment. The article states that it is unknown whether the gaps in self-assessment increase as the time away from training increases, however it is still suggested that psychologists consider life-long learning to be a fundamental professional value, with continuing education being one area to implement this value. Other recommendations are provided at the end of the article including using self-assessment prototypes as seen in Belar et al. (2001).
Gambrill	2005	Critical Thinking in Clinical Practice	This book is intended for clinicians and any professionals who offer service to clients. The purpose of the book is to give decision-making tools to practitioners to improve the accuracy of clinical judgment. A benefit of this book, in its recent edition, is that evidence based practice is incorporated into the clinical decision making approach that is presented. In the book the idea of metacognitive levels of thought are introduced.

Metacognitive thought is defined as, "awareness of and influence on our reasoning processes" The levels presented are (1) Tacit: thinking without thinking about it. (2) Aware: thinking and being aware of the thinking (3) Strategic: organizing our thinking through using strategies to enhance its efficacy. (4) Reflective: reflecting on our thinking--pondering how to proceed and improve it. This book offers a comprehensive practical guide to building the skill to approach clinical practice with critical thought. The book focuses on both stimulating thought over personal factors that help or hinder critical thought (i.e. overcoming obstacles to critical thinking, understanding influences on how one reasons) balanced with providing practical and skills-based approaches to developing critical thinking capabilities (i.e. how to pose questions and search for answers, appraising research critically, making decisions about data collection). While critical thinking and reflective practice are not synonymous and have not been compared or contrasted within any critical sources, it is clear that they are similar constructs. More research is needed to clarify this.

Gambrill & Gibbs	2009	Critical Thinking for Helping Professionals: A Skills-based Workbook	This book is a skills-based workbook aimed at developing the critical thinking skills of those in the helping profession. According to the authors, critical thinking "involves the careful examination and evaluation of beliefs and actions. It requires paying attention to the process of reasoning, not just the product....It requires evaluating evidence, considering alternate views, and being genuinely fair-minded in accurately presenting opposing views" (p. 4). Furthermore, the authors state that critical thinking involves the use of standards such as clarity, accuracy, relevance and completeness. The following characteristics of critical thinking are listed (p. 5): 1. It is purposeful 2. It is responsive to and guided by intellectual standards (relevance, accuracy, precision, clarity, depth, and breadth). It supports the development of intellectual traits of humility, integrity, perseverance, empathy, and self-discipline. 4. The thinker can identify the elements of thought present in thinking about a problem and routinely asks the following questions: What is the purpose of my thinking (goal/objective)? What precise question (problem) am I trying to answer? Within what point of view am I thinking? What concepts or ideas are central to my thinking? What am I taking for granted, what assumptions am I making? What information am I using? How am I interpreting that information? What conclusions am I coming to? If I accept the conclusions, what are the implications- What would the consequence be if I put my thoughts into action? 5. Is it self-assessing and self-improving. 6. There is an integrity to the whole system (the thinker examines his/her thoughts as a whole as well as in parts. The thinker is committed to intellectual humility, persevering, courageous, fair and just and is aware of how ways in which thinking can become distorted, superficial, unfair, or defective. 7. It yields a well-reasoned answer. 8. It is responsive to the social and moral imperative to enthusiastically argue from opposing viewpoints and seek to identify weaknesses and limitations in one's own position. The authors state that critical thinking is a form of creation and contraction with the following thinking styles, attitudes, and strategies associated with creativity: readiness to explore and change, attention to problem finding and problem solving, restructuring and understanding, belief that knowing and understanding are products of one's own intellectual process, withholding of judgment, emphasis in understanding, thinking in terms of opposites, valuing complexity, ambiguity, and uncertainty in conjunction with an interest in finding order, valuing feedback without deferring to social pressures, recognizing multiple perspectives on a topic, deferring closure in the early stages of a creative task. The authors argue that critical thinking in imperative in clinical practice and is what contributes to effective and ethical practice. According to the authors, critical thinking offer the ability to evaluate the accuracy of claims, evaluate arguments, recognize fallacies, and pseudoscience, use language thoughtfully, recognize affective influences that contribute to judgment, minimize cognitive biases, and increase self-awareness. This workbook aims to help professionals develop the skills to think critically and make informed decisions with their clients. The book contains several exercise which help readers apply principles of reasoning, decision making, and evaluation in different clinical and interdisciplinary situations, understand the criteria they use to make decisions and how to develop sound criteria, as well as exercises which help readers develop the skill of identifying errors in reasoning in different sources (i.e. advertisements, journals, books, class lectures). The book also supplies exercises on how to appraise research, how to review decisions, and how to improve educational and practice environments to support engagement in critical thinking. Among other things, this book addresses how critical thinking can interact with evidenced based practice, and the ways in which applying critical thinking when thinking about evidenced based practice improves services delivery.
Owen & Lindley	2009	Therapist's Cognitive Complexity: Review of Theoretical Model and Development of An Integrated Approach	This article reviews cognitive complexity models and the measures typically associated with these models. A new model is also introduced called, the Therapist's Cognitive Complexity Model, and implications for training are discussed. The article begins by addressing that reflectivity and critical thinking skills are an important goal of counselor education, but there is limited research on how to develop student's cognitive complexity. Authors define cognitive complexity as (a) the ability to identify and

differentiate between therapeutic constructs (e.g. between psychodynamic and CBT techniques) (b) the awareness of cognitive processes (reflecting on cognition when making clinical decisions) (c)the ability to reason about real-life dilemmas (e.g. what therapeutic approach is mist appropriate at this time?). The authors note that there is some research to support that teaching systematic counseling and assessment skills can increase cognitive complexity, however it appears that there is no research indicating that counselors are being adequately taught to think in a complex way. Furthermore, there are no adequate measures. Another issues pointed out is that there is some evidence that cognitive complexity and therapist development go hand in hand and have been taught as such. But there is also evidence that supports that these are separate domains that should be addressed differently in therapist training. The integrated models that have been used (i.e. Kelly, 1995; Hunt, 1970, Perry, 1968) are not comprehensive enough to address the full gamut of reflective thinking needed for counselors. The article also discusses some epistemological models to understand therapist cognitive complexity, and state that these models might be more viable options to understand therapist's cognitive complexity, but are still limited due to the lack of focus on deductive or inductive logic skills, and the amount of knowledge required to make critical decisions with uncertain information. In addition, there are several measurement issues in relation to cognitive complexity (i.e. they tend to be domain general and may not relate at all to therapist training and tasks; measurement of cognitive complexity only measures the ability to differentiate and not integrate, which is a piece of cognitive complexity. The authors introduce their own model of cognitive complexity, which is relevant and domain specific to therapist training and tasks they perform. The model is called the Therapist's Cognitive Complexity Model (TCCM). TCCM has three aspects of cognitive complexity: 1. session thoughts, which are micro clinical judgments such as observations of client behaviors, interactions, hypothesis testing, monitoring interactions after an intervention has been made, and relies on differentiation and integration such as differentiating between session activist and integrating salient versus irrelevant information. Supervisors can help promote this level of cognitive complexity through broad discussions of counseling competencies and more focused discussions on specific therapy interactions. (2) metacognitions is the ability for therapists to monitor their thoughts and reactions while in session and is related to macro clinical judgments such as evaluation of sessions and treatment considerations, overall. According to TCCM, metacognition involves four abilities: (1) Self: self-monitoring of personal thoughts (2) self-other describes the ability to observe one's impact on clients (3) self-other-time involves the ability to observe the impact of the self in relation to clients over time and (4) self-other-time-settings: self-other-time-settings is about monitoring one's abilities and thoughts from setting to setting such as from practicum, clients, and supervisors) the third aspect of TCCm is epistemic cognitions, which is therapist's views about the nature of knowledge and learning, which typically graduate from more dualistic and relativistic to constructivist beliefs about knowledge. These three pieces can form along different trajectories but it believed that they typically converge. Empirical study would be needed to validate this. The article concludes with a section on supervisory and classroom activities to assess and promote cognitive complexity across the three levels.

Authors	Year	Abbreviated Title	Summary
Parsons & Zhang	2014	Counseling Theory: Guiding Reflective Practice	The premise of this text is that in order for counselors to practice competently, they must employ complex mental structures to make meaning of experiences in an integrated and differentiated way. Thus, the authors propose that using theories to guide clinical practice allows counselors to engage in clinical practice from a broader perspective and to flexibly understand and respond to the challenges of clinical practice. The text stresses the importance, of a counselor being able to process the key issues presented and using a strong case conceptualization to drive treatment. Then the text presents an overview of the following theories with more attention given to the practical usages of the theories: Individual Psychotherapy, Existential Counseling and Psychotherapy, Client Centered Therapy, Gestalt Therapy, Cognitive Behavioral Therapy, Behavior Therapy, Reality Therapy, and Solution-Focused Therapy.

Reflective Practice and Self-Awareness

Authors	Year	Abbreviated Title	Summary
Burgess, Rhodes, & Wilson	2013	Trainee In-session reflective capacity: an IPR study	The purpose of this study was to examine the in-session reflective capacity of trainees in order to identify training needs. Through the use of IPR and interview, authors of this study looked at how trainees responded to in-session processes. Results revealed that trainees became distressed when faced with unexpected processes, and described feeling lost, confused, unsure, floundering, unsettled, and having a mental block. Many of the unexpected processes involved interpersonal difficulties. Six out of 10 trainees reported having difficulty making sense out of the complexity of the client's story and integrating these experiences into their formulation or treatment. It appears that reflection was activated when expectations did not match reality and this was followed by three different strategies: 1.mentally referencing a supervisor 2. attempts at recognizing transference 3. using self-talk to get the session back on track. For 5 participants, who lacked confidence in

			treatment techniques, following reflection, they retreated to non-directive counseling (e.g. affirming, listening, reflecting, asking questions). Four of the trainees, however, did push themselves to focus on interventions.
Fauth & Nutt Williams	2005	The In-Session Self Awareness of Therapist-Trainees: Hindering or Helpful?	This study was designed to build on the research on therapist's momentary states of self-awareness by examining the following:(a) whether trainees experienced their own self-awareness as distracting or helpful, as distinct from their level of self-awareness. (b) how trainees in-session self-awareness is related to their efforts to manage their self-awareness, and (c)how trainees' in session self-awareness and management strategies is manifested interpersonally during therapy. Results indicated that trainee level of self-awareness was directly related to their experience of self-awareness-the more self-awareness trainees reported the more helpful they experience the self-awareness. Trainee level of self-awareness was also related to the total number of management strategies they used, with more strategies used with higher levels of self-awareness. This is in contrast to previous research that showed higher levels of self-awareness were experienced as less helpful. There was no significant relationship between trainees' experience of self-awareness and their management strategies. Trainees' level and experience of self-awareness scores accounted for 44% of the variance in their interpersonal involvement, such that as trainees experienced their self-awareness as more helpful, they became more involved in session. Trainees' management strategies accounted for an additional 13% of the variance in involvement scores, although this results was not statistically significant. As trainees exerted more effort to manage self-awareness, they became less involved. Trainees' level and experience of self-awareness accounted for around 6% of the variance in volunteer clients' helpfulness ratings, beyond the effect of the dyad. As trainees became more self-aware and experienced this as more helpful, volunteer clients perceived their interventions as more helpful. Trainees' management strategies added 2% of additional variance to the regression, which was not statistically significant. Finally, trainees' level and experience of self-awareness scores accounted for 32% of the variance in the volunteer client's SIS (The Session Impacts Scale) score, which was not statistically significant. Trainees' management strategies accounted for another 18% of the variance in SIS scores, which was statistically significant. Trainees' level of self-awareness and their management strategies were important predictors of volunteer clients' SIS scores-as trainees were more self-aware, volunteer perceptions of the counseling relationship became more positive; as trainees exerted more effort to manage their self-awareness, volunteer perceptions of the relationship became less positive. In order to explain these contradictory results (i.e. higher level of self-awareness were seen as positive, helpful, caused more interpersonal engagement, and client perceptions of helpful coupled with more self-awareness caused more use of management strategies which was linked with counter therapeutic processes-decreased trainee involvement and less positive volunteer ratings of the relationship). The hypothesis presented was that low to moderate baseline level of self-awareness may facilitative but once the trainee's self-awareness went above baseline, more energy needed to be exerted to manage it, thus contributing to the negative effects. Also, the specific content may be important. For example, awareness of one's own reactions may be helpful but awareness of outside issues could be distracting. Also, the type of management strategy used may moderate the effects of trainees' level of self-awareness on therapy process, rather than the number of strategies used. Thus, more research is needed to parse this out.
Irving & Williams	1995	Self-awareness and reflective practice	This is a theoretical article that emphasizes the importance of reflective practice, specifically because it brings about a critical understanding of the assumptions and biases that impact one's thoughts and behaviors as a counselor. The authors speak about how counselors often have unexamined and unarticulated 'theories in use.' This is problematic because when counselors are ineffective they are unable to understand why. It is therefore contended by the authors that reflective practice is so central to the therapeutic process as this process elucidates the counselor's 'theory-in-use' and makes it available for examination and modification. According to Agryis and Schön, who proposed the idea of 'theory of use,' this construct contains two elements: The values that holders attempt to satisfy and the behavioral strategies used to satisfy these values. However, the authors discuss that many people may still be unaware of lack of awareness, and this is significant barrier to reflective practice. The authors, therefore, discuss the importance of counselors becoming critical thinkers and supervision being the context to support this process. Thus, the focus of supervision should be heavily focused on the counselor rather than the counselor's caseload. This ensures that the counselors develop into good mirrors for their clients to accurately examine their own beliefs, assumptions, and "theories in practice." Looking at patterns in clinical work, such as which clients were assigned the difficult label, can help further elucidate the counselor's thoughts and assumptions that may be unavailable to conscious inquiry.
Nutt Williams	2010	A Psychotherapy Researcher's Perspective on Therapist Self-Awareness After a Decade of	This paper is a review of the authors and others' research on therapist self-awareness and how this impacts treatment. In summary, the author concludes that therapist self-awareness, which she conceptualizes as transitory states of awareness of immediate thoughts, emotions, physiological responses and behaviors during a therapy session. This is contrast to global self-knowledge, which is another area of self-awareness. In summary, the author states that there is contradictory research on this subject. Some studies find that

		Research	therapist self-awareness to be hindering or associated with anxiety, while others have found that therapist self-awareness has a positive impact on other in-session processes. Counselor attempts to self-manage these states have been studied, including self-care/self-reflection, Cognitive/Relaxation Techniques, Actively Returning the Focus to the Client, Attempting to Suppress or Ignore Self-awareness, and Returning to Basic Therapeutic Techniques, with no consensus on the effectiveness of either one.
Nutt Williams	2003	The Relationship Between Momentary States of Therapist Self-Awareness and Perceptions of the Counseling Process	The purpose of the present study was to empirically examine therapist's moment-to-moment awareness in relation to global factors (such as the therapist's pre-session anxiety) and more specific process variables (such as client self-assessment of therapists' helpfulness). Results indicated that therapist's level of anxiety before session was positively correlated to their momentary self-awareness in session; the more anxious they were before session, the more aware they were of their thoughts, feelings, behaviors, and physiological responses during session. Therapist momentary self-awareness was negatively related to client perceptions of therapist helpfulness; the more self-focused the therapist was from moment to moment, the less helpful the clients perceived them. The more therapists were able to identify their client's reactions, the more helpful they were rated by their clients. Finally, momentary self-awareness was not significantly associated with the match between therapist and client on client reactions. Therapists reported using at least one strategy just over half of the time to manage hindering momentary self-awareness. Most often they focused on intervention planning and refocusing on the client. When they experienced lower level of momentary self-awareness, they reported they did not use any management strategies.
Nutt Williams et al.	2003	Development and Validation of the Self-Awareness and Management Strategies (SAMS) Scales for Therapists	This article described the process of validating the SAMS scale (Self-Awareness and Management Strategies Scales for Therapists), which was developed to empirically measure therapists' momentary states of self-awareness. As described in many articles by the authors, this type of self-awareness is critical for effective therapy. The validation process occurred in 3 phases; Phase 1 was a close review of the empirical and theoretical literature and items were developed based on these findings. Phase 2 was a pilot study to assess the clarity of directions and items. Phase 3, the scale was distributed to a national sample to obtain reliability and validity. Analysis of the SAMS scales suggest the scales have internal consistency, and thus is a reliable measure to assess therapists' retrospective reports of hindering self-awareness and management strategies during therapy sessions. Convergent validity and discriminant validity was established as well through comparison of scored on the Self Consciousness Scale and the Self-management Scale.
Nutt Williams et al.	2003	What Happens When Therapists Feel Bored?	The purpose of this study was to understand the ways therapists experience distracting self-awareness (including their thoughts, feelings, physiological responses and behaviors) during sessions and the management strategies they choose to empty. This study is a qualitative study on experienced and novice therapists. Through an interview that focused on nine questions relating to therapist's perceptions of distracting self-awareness during session and the types of strategies they use to manage these distractions, the researchers aimed to develop an understanding of how momentary states of self-awareness impact clinical practice. Results indicated that both novice and experienced therapists reported being aware of some distracting thoughts and the need for intervention planning. Novice therapists also reported self-critical thought. In contrast, the experienced therapists were aware of outside distracters (i.e. money, their homes, personal relationships). It was typical for therapists to be aware of distracting feelings. Novice therapists reported feeling lost or anxious, while experienced therapists reported feeling attracted to their clients or bored. Both reported as a variant category feeling frustrated and angry. Therapists also reported being distracted by their own bodies or own nonverbal behaviors during sessions. Typically, therapists were cued to self-awareness through their own internal, physiological, reactions (e.g. rising blood pressure related to feeling frustrated). Novice therapists also became aware through their clients' behaviors such as when clients looked at them expectantly. As a variant response, session content occasionally cued self-awareness such as during challenging or difficult sessions. To manage distracting self-awareness, therapists used self-coaching and to refocus on the client. Novice therapists reported coaching themselves while experienced therapists reported refocusing on the client as their main management strategy. Additionally, novice therapists disclosed their confusion or feelings of being overwhelmed as a way to manage their reactions. As a variant category, both used basic techniques such as open-ended questions to help them get back on track. Experienced therapists discussed taken a break such as a long pause or even leaving the room as a way to manage their internal reactions. There were no strategies reported for preventing distracting self-awareness, but novice therapists engaged in deep breathing and relaxation exercises prior to session to ward off the negative effects of distracting self-awareness. Experienced therapists relied on self-reflection and taking breaks to better prepare themselves for distracting self-awareness. They also reported ways they get centered before session similar to novice therapists and the importance of self-care. Both reported an increase in being able to manage distracting self-awareness over time through the reduction of anxiousness. Managing these distracting moments also got easier and more effective with time.

Theoretical Training Models of Reflective Practice

Authors	Year	Abbreviated Title	Summary
Collins, Arthur, Wong-Wylie	2010	Enhancing Reflective Practice in Multicultural Counseling Through Cultural Auditing	This article states that there seems to be strong agreement that self-awareness of values and biases foundationally enhances multicultural counseling competence. Self-awareness involves ongoing reflection and learning from insight into how one views clients who are culturally diverse. This article introduces a cultural auditing process, which is designed to address the multicultural competency development process, with reflective practice being a central component of achieving cultural competency. The article addresses the gap between the acknowledgement of the importance of reflective practice and theory about how to become a reflective practitioner. The article proposes a 13-step cultural auditing process, which is designed to facilitate the counselor's thinking around their own worldview and experiences and those of their clients. The article speaks about Schön's reflection in and on action and adds a third dimension, reflection-on-self in and on action (Wong-Wylie, 2007). The emphasis here is on building awareness of personal and cultural identities and awareness of client cultural identities to form the foundation of a working alliance. The process of cultural auditing is an extension of reflective practice; it provides a way to think about self, client, and the working alliance in the moment of work and after. The reflective process is believed to stimulate change in both the counselor and client as well as in the quality of their relationship.
Guffrida	2005	The Emergence Model: An Alternative Pedagogy for Facilitating Self-Reflection and Theoretical Fit In Counseling Students	This article focuses on how counselors develop their theoretical orientations in a reflective way, and the lack of research identifying how to help this process in training. The author argues that critical self-reflection and theoretical fit are highly important for successful counselors, and therefore it is important that pedagogical practices that achieve this be identified. There is a dearth of literature currently in these two areas. This article reviews counselor pedagogical literature in order to identify existing practices that can facilitate critical self-reflection and theoretical fit among students. Two models of learning, radical constructivism and transformative learning, are examined as well, and the article concludes with an brief outline of an alternative model for counselor education, called the Emergence Model. The Emergence Model introduces students to interventions through a non-judgmental observation of themselves and their practice. The focus initially is on basic counseling skills (i.e. listening, empathy). The role of the counselor educator is to help students identify their natural helping instincts and to consider the strengths and limitations of these interventions. The goal is to move from looking at whether the intervention was right to what the student learned from the intervention. When theory is introduced, the Emergence Model uses a similar approach to examine interventions born out of theory. This model is in contrast to modernist philosophy that says that theory must precede practice. While the Emergence Model carries the risk of students intervening wrongly (i.e. not grounded in anything), the authors argue that ultimately their practice is strengthened through this type of training. The authors also stress that counselor educators should continually encourage self-reflection within this model through assignments such as reflective journaling and case analyses. In the conclusion, the author states that although the Emergence Model carries the potential for facilitating self-reflection and theoretical fit, the model must be researched in order to establish its validity.
Mellor	1998	On Reflection: One Psychologists Explorations around an episode of reflecting	This article offers a model for reflection through the author presenting an example of his reflective process on a particular session. This process was adapted from Palmer et al., based on Carper, which provides comprehensive questions and a clear breakdown on areas to reflect on, rather than general topics to reflect upon. Some things were changed to be adapted to the psychologists setting. The outline of reflection is as follows: Pre-reflection: what planning was or should be undertaken before the event. Celebration: what is good about the event? Description: of the actual experience and factors that brought it about. Significant people in the background, key process to reflect about. Reflections: What was trying to be achieved? Why did you intervene as you did? What were the feelings about, and the consequences of your actions? How do you know this? Influencing Factors: What internal factors influenced you? (e.g. intuition, previous experience, feelings etc.). What external factors influenced you? (e.g. professional rules, formal procedures etc.) What sources of knowledge influenced or should have influenced you? Could you have dealt differently with the situation? Learning: How do I now feel about the experience? How does this relate to past experiences? How does it relate to future experiences? What broader issues arise from this experience (ethical, social, political). How has this experience changed my understanding of my ways of knowing? Personal, ethical, empirics aesthetics (the art of professional practice), intuitive knowledge and appreciation of a sense of form. What might I be missing in this reflection? Are there any other forms of reflection I could carry out? The article then gives an example of how the author utilized this reflective model in practice within the domain of educational psychology.
Park-Taylor et al.	2009	Toward Reflective Practice: A Multicultural Competence Training Model	This article addresses the dearth of training models that enhance cultural competence, specifically in community mental health centers, which serve as training sites for psychologists. First the model is described, followed by a report on the results of a pilot study looking at the training at the Brookline Community Mental Health Center. The model that is described in this article draws from the APA guidelines on multicultural education, training, research, practice, and organizational change for psychologists. In particular,

Authors	Year	Abbreviated Title	Summary
		From A Community Mental Health Center	guidelines 1,2,,5 and 6 are focused upon in the model, as they are most relevant to community mental health centers. The model was developed at The Brookline Community Mental Health Center (BCMHC). The first aim of the model is teaching and learning through reflection, as this contributes to clinical competence, and is especially important for cultural competence, as it facilitates self-awareness. This is largely accomplished through what is called a diversity team, whose aim is to increase trainees' cultural competence through open dialogue, talks, and forums about identities, biases, lived experiences and how these impact clinical work and training. The second part of the model is learning through experiencing. The goal of this portion is to increase knowledge and skills through delivering culture-focused therapy. Results form a pilot study looking at the training and use of this model at BCMHC showed that between 63.2% and 73.6% of participants agreed or strongly agreed with statements regarding the efficacy of the BCMHC's diversity training in enhancing their MC in the areas of knowledge, skills, and awareness. Open-ended questions also revealed that a majority of participants reported that the training had a positive impact on the MC. There was also a significant correlation in the expected direction between the Multicultural Competence Inventory and the BCMHC Diversity Training Questionnaire.
Shealy	2004	A Model and Method for Making a Combined Integrated Psychologist	This article presents a model and method for training students in professional psychology programs in basic values of education and training from a C-I (combined and integrated) perspective (e.g. self-awareness, self-assessment, and self-reflection). This article addressed that both the Consensus Conference on Combined and Integrated Doctoral Training in Psychology (Bailey, 2003) and the Competencies Conference-Future Directions in Education and Credentialing in Professional Psychology, developed guidelines and language for the knowledge, areas, skills, and values for professional psychologists, but did not articulate the methods and means to do this. The Equilintegration Theory (E-I), presented in this article, is a model that seeks to explain the process by which values and attitudes are acquired and under what circumstances they are resisted. Shealy asserts that having self-awareness and the ability to engage in self-reflection is central to being a professional psychologist. Hence the development of E-I Theory and the Beliefs, Events, and Values Inventory (BEVI), an 494 Item inventory designed to identify and predict a variety of developmental, affective, and attribution processes and outcomes related to E-I theory. The BEVI is also designed to help translate EI Theory into practice by helping students and trainees assess and understand these issues as they relate to clinical activity and their own professional growth and development.
Sheikh, Milne, MacGregor	2007	A Model of Personal Professional Development in the Systematic Training of Clinical Psychologists	This article was published in Great Britain. The introduction highlights that training in reflective practice has become a critical element in training programs in the UK, with policy statements and national policy affirming the importance. Within clinical psychology, this has lead to a new module in training termed "Personal and Professional Development." The British Psychological Society calls for clinicians to understand their own limits of competence; using supervision to reflect on practice, and developing strategies to handle the impact on practice. This article appears to purport the purpose of reflective practice to develop awareness of how personal experience shapes one's worldview, and how work and self interact. The article discusses that this is necessary for optimal professional functioning. The article reports how to foster this type of development through presenting their model of personal and professional development. A review of the literature is presented on enhancing personal and professional developments, followed by a presentation of the integrative model illustrate within a clinical psychology training program. Some initial data on this model is then presented. The model is based on Kolb's Experiential Learning Model. The goal of the program is to develop the counselor's self-awareness, resilience, and personal effectiveness. Training in personal and professional development is embedded in different parts of training and is a module on its own, within the training program. For a more detailed description see p.282. Initial data on the effectiveness of the delivery of PPD with the training program reveals that the program is being received positively, and it is addressing its intended learning outcomes.

Reflective Practice and Theoretical Orientation

Authors	Year	Abbreviated Title	Summary
Bennett-Levy et al.	2001	The Value of Self-Practice and Self-Reflection in the Training of CBT Therapists	This study was designed to assess the usefulness of self-practice and self-reflection of CBT techniques among trainees. The authors acknowledged that self-practice of techniques as well as critical self-reflection may deepen the trainee's self-awareness, which may have a benefit on clinical effectiveness. The study sought to answer the following questions: Are self-practice (SP) and self-reflection (SR) perceived as useful by trainees? If so, then what are the beneficial outcomes? What processes may explain its usefulness? What are the implications and recommendations for future training courses? Results indicated the following: Participants described two process of mechanisms: Experiencing from the client's perspective and reflecting on experience, which led to a core process mechanism, described as a deep sense of knowing and understanding from engagement in and reflection on the activities. This deeper sense of knowing seemed to give rise to several outcomes: enhanced therapeutic understanding, saw the professional usefulness of the activities,

increased understanding of the therapist role, increased understanding of the cognitive model, increased understanding of change processes, personal usefulness (greater self-understanding and experience of CT as an effective tool for personal change), enhanced perception of skill level, enhanced self-perception of competence. The major impact of SP/SR seemed to be on therapeutic understanding. This accounted for over 90% of the data. Less than 10% of the data was on therapist skill and self-concept, which may be explained by the fact that the course was only 13 weeks long. Ways in which trainees suggested SP/SR might have on impact on therapist skills included: increased sensitivity and understanding in the application of CT techniques; enthusiasm and belief in CT which was communicated to clients; greater empathy; use of personal metaphors; and increased awareness of the impact of one's own schemas. "Inspection of this list might suggest that SP/SR has its primary effect on what Scho¨n (1983, 1987) terms ''professional artistry''. This would be consistent with his view that, while technical-rational knowledge can be learned by more traditional teaching approaches, professional artistry is best learned through professional self-reflection" (p.13).

Binks, Jones, and Knight	2013	Facilitating Reflective Practice Groups in Clinical Psychology Training	This article was published in the UK, where personal and professional development (PPD) is a core competency within clinical psychology training. The capability to reflect critically on one's work and self a key aspect of PPD. This article builds on some prior research on reflective practice groups, which in the UK is regarded as the most beneficial learning method for addressing the PPD of clinical psychology trainees. Reflective practice groups are facilitated groups in which trainees discuss theory, experiences of training, clinical work, and their personal selves. The authors build on the prior research by examining the perspective of facilitators of the groups, as they are able to provide complimentary and valuable information to the trainees. In particular, the study examined trainee's distress as participants in the group, and how facilitators make sense of their roles and experiences including in relation to trainee distress. Seven clinical psychologists were interviewed who had facilitated reflective practice groups within the last 10 years. Through semi-structured interviews, and the interpretive phenomenological analysis the following results were described. Three master themes and 15 subthemes were developed. Master theme 1 is conceptualizing the meaning and value of trainee distress/difficulty, with the following subthemes: distress, is inherent to the process. Emotional learning (and in particular those who confronted and explored their distress benefited from a deeper level of understanding through emotional learning). Connecting with clients (the opportunity to experience distress and difficulty through self-examination was critical to the trainee's ability to connect with the client position and to work more effectively). Conceptualizations of clinical psychology and engagement (it was noted that trainees varied in their engagement with the distress associated with the self-reflection groups, and this might be mediated by trainee's divergent conceptualizations of the clinical psychologist role. Some participants questioned whether trainee engagement with the personal was absolutely integral to the clinical psychologists role, and if so whether this was communicated effectively. Threats to Trainee Well-being (some participants worried that trainee revelations might threaten their emotional well-being. Master theme 2 is Current and Future External Relationships (most participants discussed the current and future relationships of trainees and potential blurring of boundaries necessitating trainees to consider how much to disclose. Therapy/Not Therapy (many participants experienced the boundary between RP and therapy within the groups as non-distinct, with many participants relying on their therapeutic understanding and skill to facilitate the groups, thus further adding confusion for trainees regarding the boundary between RP and therapy. Threat and Opportunity of the Unstructured Space (most participants regarded the group as unstructured providing the trainees with a depth of possible learning outcomes). Mediating Safety (participants saw their roles as protecting the safety and boundaries of trainees within the group). Trainee Rebellion Against Forced Engagement (participants discussed that some trainees engaged in anti group dynamics in response to the mandatory nature of the group). Reflecting on the Future of the Groups (many participants used the interview to reflect on the future role of the groups in the training program, with most expressing a feeling of certainty that the group should remain a part of the program. Others expressed ambivalence and suggested a range of options for reflective practice groups such as an MBCT reflective group. Master Theme 3 is experience of the facilitator role with the following subthemes. Containing their emotional experience (participants indicated that they experienced strong emotional reactions within the groups, which they had to contain). Parallel Process of Evaluation (participants expressed that they perceived trainees to be evaluating their professional competence and understood this to mirror trainees critical judgment of each other). Being Held as the Facilitator (majority of participants expressed that their experience felt like they were contained in the role of facilitator through the mechanism of being provided with supervision). The article ends with a discussion and limitations and further research. Small and homogenous sample size is cited as a limitation. Suggestions for further research include qualitatively studying the learning processes that connect trainees' emotional experiences within the groups to PPD.
Davidson	2006	Supervision and Mentorship: The	The purpose of this article is to address how psychoanalytic supervision helps supervisees develop critical practice. The article relates to reflective practice in that what is described

		Use of the Real in Teaching	are ways analytic supervisors help their supervisees think critically about their clinical work and the most effective techniques to do this. She describes supervision as encompassing didactic teaching, personal analysis, and apprenticeship. Ultimately the purpose is for supervisees to learn to avoid rigid formulations of theory. This is addressed in supervision through the supervisor helping the supervisee tolerate uncertainty. The supervisee becomes an apprentice to the supervisor, who emphasizes "the dyadic process over the importance of theory, giving theory the intellectual place it deserves, while protecting hands on experience."(p.189). The supervisee is able to develop their own voice through a filtering process whereby the supervisee synthesizes self-knowledge, experience, supervision, and reading. The article then goes on to summarize several models of supervision. The author discusses several issues with using some of these models such as the metatherapeutic model. This model uses the supervisor's and supervisee's countertransference both to each other and the patient as relevant sources of information. The author cautions that such practice may blur the lines between supervision and analysis. The author further discusses that supervision becomes more complicated in the present multicultural climate where superviseesare working with supervisors and patients from different cultures and in different languages. The author goes on to state that in such circumstances, the supervisees must initially instruct the teacher in his or her culture before the expert's knowledge can be applied. The article concludes with a discussion about how supervision is a mentorship relationship. Mentorship includes the responsibility of constantly being the observer for the trainee through example setting and helping the supervisee develop their personality in dealing with particular situations. It becomes an important but noncompetitive adjunct to the therapist's personal psychoanalysis and patient's treatment.
Farrand, Perry, Linsley	2010	The Use of Reflective Blogs to Support SP/RP	Based on the work of Bennett Levy (2001 and 2006), this study sought to look at whether the use of reflective blogs supported a SP/SR approach toward CBT training. The module was comprised of 5 days of teaching delivered 3 weeks apart so that trainees could reflect, with one supervision day 2 months later. One reflective blog was required for each of the 5 CBT techniques learned. Trainees were then invited to participate in a focus group to discuss their experience of using reflective blogs. Results indicated that the requirement to post reflective blogs helped establish the value of practicing CBT techniques, and was mainly achieved through reading the posts of others. The lack of anonymity seems to motivate participants to post. The reflective blogs also seemed to help establish a learning community where the learning experience was normalized. Several participants spoke about how seeing other postings provided examples of the skill of reflection helped to challenge and adapt their own reflective processes. The blog seemed to help set the agenda for the group supervision session, which started out each teaching day. Issues with the reflective blogs seemed to be that participants expressed a desire to role-play the techniques, something that wasn't done because the blogs were expected to take the place of this training exercise. Technical problems were also reported.
Iszak	2006	Achieving Self-Reflective Practice: A Comparative Psychoanalytic Approach to the Training of Clinical Psychology Doctoral Students	This dissertation focused on exploring reflection within professional psychology through offering a critical review of the literature and a comparison of theory on reflective practice within clinical psychology. It focused theoretically on psychoanalysis in order to determine how this body of literature could contribute to a working model of self-reflective practice for clinical psychology doctoral students. This dissertation provided a new definition and emphasis for doctoral students of clinical psychology.
Knight, Sperlinger, and Maltby	2010	Exploring the Personal and Professional Impact of Reflective Practice Groups	Authors studied the impact of reflective learning groups on the personal and professional growth of clinical psychologist. This study took place in the United Kingdom. The purpose of the study was to begin to empirically evaluate the method of utilizing reflective learning groups to enhance reflective practice among clinical psychology students in a doctoral program. The reflective learning groups were meant to be an opportunity for students to learn about group dynamics, as well as a means of aiding students to develop reflectivity on their actions, in relation to themselves and in relation to their impact on others. Through the development of a questionnaire measuring the perceived value and distress of the reflective groups, researchers measured the effectiveness of these groups through a sample of clinical psychologists who were enrolled in the group class between 1987 and 2007. The study showed that almost three quarters of former trainees highly valued the reflective learning groups while under half of those surveyed reported that the groups caused distress. Notably, 40% of those surveyed indicated they learned more about reflective practice from other places such as supervision, personal therapy, and coursework. Recommendations for improving the groups included smaller groups (10-13 students), an active facilitator who clearly states the model he or she is operating the group from, and a clear explanation of the purpose and scope of the group upon commencement.
Laireiter and Willutzki	2003	Self-reflection and Self-practice in Training of	This article addresses how self-reflection and self-practice of CBT techniques have become a more important component of CBT training in recent years. The authors cite literature on the goals of these practices, which is just at the beginning of being developed given the

		CBT Therapy: An Overview	more recent focus (i.e. identification and management of the personal involvement of the therapist, improvement of self-insight, self-knowledge, and sensitivity, reduction of negative effects on client, such as burnout, psychological and interactional problems, and motivational issues, fostering the development of good personal and interpersonal skills, model-learning to conduct therapy, becoming aware of subtle therapeutic interactional processes through behaving like a client, fostering the acquisition of therapeutic techniques and methods. The authors group models of self-practice and self-reflection into four prototypical categories: person-centered models (just looking at person and not his/her professional roles within a group format through academic training or individual therapy), practice-centered concepts(focus on the experiences, behaviors, and interpersonal performances of therapist during his/her therapeutic work-usually takes place in self-exploratory practice groups or supervision), technique related or self-practice models (concerned with the self-application of therapeutic methods-situated in supervised group, alone, or in unsupervised groups-sometimes combined with self-reflection as in Bennet-Levy, 2001), and training therapy models (two types: one is a combination of self-practice and self-reflection where cbt treatment models are applied to the trainee in a dyadic or group session. The purpose is for the experiences of the trainee to be integrated into his/her self-conception. The second is self-reflection therapies. In these programs, elements of CBT techniques are used to intensify self-exploration and personal involvement to work through life experiences, conflicts, interpersonal issues etc. A combination of these are used in different countries and settings depending on the emphasis of this type of work. Unfortunately, there are few studies on any of this. Most of the few were published in Germany, except one by Bennet-Levy et al., 2001. Thus far, no studies looked at the effects of self-reflection and self-practice on therapeutic effectiveness. The article ends with a summary of the very limited literature on the outcome of self-reflection and self-practice.
Pegeron	1996	Supervision as an Analytic Experience	This article discusses how to approach psychoanalytic supervision from the perspective whereby it is more than teaching and less than treatment. Concerns about supervision going beyond the boundary of teaching and into treatment has obscured the usefulness of looking at the relationship between supervisor and supervisee and the process of learning and growth. This paper explores how the analytic process can be applied to supervision. The goal of supervision, according to this article, is to help supervisees expand access to their psychic lives as this relates to their development as psychoanalysts. The ultimate goal is to form a professional analytic identity defined as the realization by supervisees that their personal experiences relate to the transference and are tools that must be employed in the therapeutic process. The supervisee thus must be prepared to acknowledge all inner perceptions. The acquisition of skills is not enough. Abrams (1993) outlines four supervisory styles: the didactic (favors imparting specific information), the Socratic (which highlights question and answers), the strategic (which focuses on solving inevitable problems), and the interactive (has a climate of collegial exchange). Other models understand supervision as either patient-centered (focused on understanding the patient), therapist-centered (focused on the therapist and countertransference) or process-centered (which emphasizes the interaction between patient and therapist and therapist and supervisor). In this article the author delineates a model whereby supervision mirrors some of the key process of analysis. The author discusses the importance of the nature of the engagement of the supervisory relationship. Supervision should be an intense, emotionally charged experience, but should not stimulate regression. However, transference and countertransference reactions do get triggered and create a bind in supervision. Helping supervisees understand and tolerate their own resistance is an integral part of becoming an analyst and can be an important part of supervision. Thus, understanding these reactions and enactments become a piece that stimulates reflection and growth. However, it is recommended that as these emotional reactions are pointed out the suggestion is that they be discussed with their own analysts. The delicate balance of helping the supervisee make the dynamics of treatment understood and felt through a strong focus on the affective reactions in supervision must be tempered in order to keep the lines straight between supervision and treatment. Thus, countertransference difficulties cannot be resolved in supervision, but can be an effective stimulus for self-analysis and continued work in ones' own analysis. From the perspective of supervision as a pedagogic experience, the supervisor best shows the use of listening and intervention while staying attuned to the parallel process in supervision and supervisees transference and countertransference. The supervisor must have a 'fourth ear.' Their goal is to understand each patient's dynamics and help the supervisee understand how to apply techniques and understand their countertransference.
Sutton, Townend, Wright	2007	The Experience of Reflective Learning Journal by CBT Psychotherapy Students	The aim of this study was to evaluate the value of a learning journal from the perspective of postgraduate students in CBT. Through qualitative interviews the data revealed that learning journals allowed for thoughts and feelings to be expressed and specifically for the discovery of what they were thinking and feeling. The journals also uncovered subjective thoughts and feelings, which helped provide a deeper understanding and empathy for clients. Another benefit reported was being able to look back at older entries and see growth in self-awareness and learning. Students reported constructing their journals in

various ways (content, format, frequency, amount of writing and method). Writing weekly was the most prominent and amount varied from 3,000 to 10,000 words or by number of entries. Over time students reported moving away from writing about course content to focusing on personal and client based issues. There was some uncertainty expressed about the writing requirement for the journal creating some decreased motivation to write. Ambiguity was also expressed about how the journals would be evaluated. There was also discussion that there was little support for what was brought up through the journals and some ethical questions related to this. Some students also discussed feeling constrained in that they did not feel comfortable revealing too much personal information. Overall, students considered the learning journals to be considered integral to their development. The following recommendations were suggested: more focus around expectations, that the journals not be assessed by the course teachers, but rather by teachers from other counseling courses, that the journals be marked through a structured format, and improved support systems through getting support from teachers and fellow students.

Experiential Learning Theory

Authors	Year	Abbreviated Title	Summary
Eraut	1994	Developing Professional Knowledge and Competence	Eraut analyzes what he refers to as control knowledge in a professional context. He defines the term as knowledge about knowledge and its use, which guides one's thinking and learning. Eraut uses the term metaprocess to describe the thinking involved in directing one's own behavior and controlling one's engagement in professional processes. This includes the process of acquiring information, ranging from existing knowledge in the particular profession to skills in collecting and interpreting information. It also includes deliberative processes, such as planning, problem solving, analyzing, evaluating and decision-making, as well as, the process of communicating information. In its most basic form, control knowledge includes self-awareness. At its core it is the process of self-management. Eraut posits, it is acquired through reflection and feedback. A key factor in learning this skill is the ability to get feedback within the work situation itself. He cites Schön, who demonstrated that for many professionals there is a gap between account and action, which is a natural consequence of the professionals' perceptual framework. Eraut, however, notes that acquiring the skill to bridge this gap requires more than simply thinking critically about the particular problem to be solved. It is thinking about the thinking, which informs decisions about what to do and think next. The practical aspects of Eraut's approach to acquiring these skills do not specifically address clinical psychologists. Rather he deals with other categories such as nurses, social workers and optometrists in the English healthcare system, as well as, teachers, accountants and engineers, among others. He suggests that in practice, competence may be defined as a combination of capability evidence (an assessment of professional knowledge and thinking in a non-performance context) and performance evidence. Performance in the workplace is often judged by the nature of the work allocated to a newly qualified professional and career progress, rather than by paper-based examinations or standards. This dynamic developmental model of competence links competency development to continuing on-the-job learning and performance criteria.
Gibbs	1988	Reflective Cycle	Gibb's (1988) reflective cycle is modeled after Kolb's experiential learning with more provision on how to operationalize the different stages . In the first stage, Description, an event is described. Following this feelings are tended to. An Evaluation of whether the experience was good or bad is then made, followed by an analysis of the situation. The next stage, conclusion, asks the learner about what else they could have done. Finally, the last stage, action plan, the learner is asked to reflect on what they would do if confronted again with the experience.
Kolb	2001	Experiential Learning Theory	In many ways, reflective practice shares many qualities with experiential learning theory; Experiential learning involves an active and critical exploration of experience leading to new understanding. This is the essential component of reflective practice. Kolb's experiential learning models identifies that the cycle starts with having a concrete experience. This should then lead to reflective observation; the attempt to view the experience from an observer's perspective with attention paid to feelings, thoughts, actions, values and beliefs. This is then followed by abstract conceptualization; the learner attempts to identify patterns, apply theory and knowledge and then begins to identify hypotheses. The final stage in the cycle is active experimentation. This is the stage whereby the results of reflection get turned into practice.

Reflective Practice In Other Fields

Author	Year	Abbreviated Title	Summary
Anderson, Knowles, Gilbourne	2004	Reflective Practice for Sports Psychologists	This article (published in the UK) aims to present the value of reflective practice in training sport psychology trainees to have the requisite humanistic skills in their service. The article emphasizes that the characteristics of a practitioner has a central role in whether service delivery is or isn't effective, with the ability to forge a good relationship of paramount importance. Sports psychology programs have been noted to be ill equipped to help trainees develop the interpersonal skills to create positive relationships. The article further

notes that to be able to foster positive relationships, knowledge of self is required including, being aware of one's limitations, self-interests, prejudices, and frustrations. The paper argues that reflective practice is an approach to training and practice that can help practitioners explore their decisions and experiences and increase their self-knowledge. The article focuses mainly on reflection on action, or the active processing of experiences after the event. It is pointed out that reflective practice can serve different interests such as technical, practical and critical. For technical purposes, the question is have standards and competencies been met. For practical purposes, the question becomes about exploring personal meaning in a situation. If the purpose is to fill a critical role, then the concern is examining constraints of social, political, and economic factors. Those who are truly reflective theoretically operate at all three levels. Techniques and methods of RP are also described. For example, the article states that reflection can be spontaneous or planned, personal, or public, conversational or written. Journal writing is a common technique. It can be based on RP models such as Gibbs and John (developed 21 questions for nurses to facilitate reflection). The article suggests that sharing reflections with others stimulate more open exploration, such as with a supervisor, provided that rules and boundaries are understood mutually. However, the article warns that RP is not a collection of techniques, but an attitude towards practice. Proposed benefits of RP are also discussed in the article including a clearer understanding of practice, clinical effectiveness, feelings of freedom to be able to analyze intricate problems, can increase personal awareness and knowledge in action, accountability, and enhance effectiveness. Finally, the article addresses dissemination and research formats acceptable for the study of reflective practice, and concludes that academic cultures must value reflective practice in order for it to be incorporated on an institutional level.

| Boud | Facilitating Learning In Continuing Education | The authors ask the question, how do you turn experience into learning? The premise of this book is that reflection allows for this process to occur. According to the authors, the definition of reflective practice is: "those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understanding and appreciations." Reflection is understood to be a process, not an end. It carries the objective of making practitioners ready for new experience. The outcomes of reflection are believed to be the following: new ways of doing something, clarification of an issue, development of a skill, resolution of a problem, new ideas may be identified. The benefits of reflection may be lost if not linked to action, yet this is extremely difficult to do. The impetus to reflect, in adult learners, may come from a "loss of confidence or disillusionment with one's existing situation." It can also be promoted by positive states. For those who have a developed a capacity to reflect, the personal affective aspect would be a more frequent impetus rather than specific activities planned by others. Boud et al. place much more importance on the "affective aspects of learning" how this provide opportunities to learn, and barriers to it. The authors lay out their model of reflective practice beginning with looking at the characteristics of a learner. The Learner: the learner's response to new experience is determined by past experiences with learning. Have they had success in learning? Have they felt competent? If yes, they will be drawn into the learning experience much more easily than others. If they have had negative experiences in learning, this will affect their ability to take in new information; they may be overwhelmed by the negative associations. The implications of this are that the learner must be understood and the environment must support the learner. The Intent of the Learner: the intent of the learner permeates every stage of the process from the choice to engage in a particular activity to the results of the reflective process. In the replaying of the experience to reflect upon it, particular attention may be given to those elements, which appear to be relevant to the goals of the learner. In order to promote reflection, the learner must set aside time after the experience to reflect. Returning to the experience: recollect the salient events, recounting of the experience. As we re-experience the event, we realize what we might have been feeling, and why we did and said what we did. By doing this we ensure our reflections are tied to what actually happened, versus what we wished may have happened. Returning to experience may need to be done many times. One time to focus on the experience, (describe it without any judgments, however what we can see is the judgments that did come up for us during the process or feelings that affected how we acted; seeing our feelings at this stage can lead us to the next review) again to focus on one's feelings, and again to become aware of ideas associated with it. |
| | | Attending to the feelings: 1. utilize positive feelings: focus on positive feelings at the time of the experience, or excitement over the "possible benefits to be derived from the processing of the event. "Utilizing positive feelings is very important, as they give us the motivation to persists in challenging situations. "unless we believe in ourselves and our own capabilities we can constrain ourselves to such an extent that we deny ourselves learning opportunities and fail to extract what is available to us in any given situation (This has implications for supervision; at the earlier stages of a supervisees career need to be especially validating to promote reflection. It is a tricky balance act of promoting reflective processing in supervisees while also not overwhelming them with anxiety.2. Removing obstructing feelings: this involves "removing the impediments to a thorough examination of the experience" Has implications for supervision; how do you remove these impediments. |

Also connects to the learner. Do certain learner have more impediments, are certain learners more difficult in helping to remove the impediments because of defensive. This needs to be worked out in supervision.

We need to sensitively deal with these barriers because they have an impact on our learning. The goal is to remove the barriers, discharge them. Re-evaluating the experience: involves looking at the experience again with a different intent, associating new knowledge to old knowledge, and integrating the new knowledge so that it becomes part of the learner's behavior. Boud et al. put the above two steps before this step to emphasize that it is not good to jump to this stage, as we may be reflecting on false assumptions or reflecting on information which we do not understand fully. The first two stages can help us avoid doing this, but can't always prevent it (the exception to this is when we have an insight. We tend to jump to this stage).

4 elements of re-evaluating the experience: learner does not process linearly: 1. Association: "is the connecting of the ideas and feelings which are part of the original experience and those which have occurred during reflection with existing knowledge and attitudes, It is helpful to make many associations. The new association can challenge us intellectually and affectively, can lead us to realize are old ideas were unworkable. How do we form these associations? A. psychoanalytic technique of free association; explore whatever comes up in our mind, suspend rational thought. Can do this through writing, drawing, to another person. The more association as this stage the greater the potential for integration at later stages. 2. Integration: association needs to processed to see if they are meaningful and useful. Associations bring ideas together without any order or discrimination. Integration begins the process of making sense of the associations. How do we integrate? A. "Seeking the nature of relationships that have been observed through association." B. "Drawing Conclusions and arriving at insights into the material which we are processing." Insights then form the basis for further reflectivity. Authors suggest using brain-patterns, venn diagrams, concept maps to deal with the complex material, writing down material, using metaphors in areas of knowledge that do not lend itself to visualization. 3.Validation: in validation looking at what we've integrated and do some reality testing. Test for internal consistency between new appreciations and existing knowledge and beliefs. And from trying out our new perceptions in new situations. If contradictions present need to reappraise.

How do we validate?

A. Rehearsal of the knowledge we have integrated into application into our lives. Can be done internally or through enactment. B. Appropriation: some learning becomes so important because it relates to us. it becomes part of our identity. Integrated material becomes interpreted in light of this.

Authors at the end of chapter talk about how a listener can aid a learner in the reflective process at each stage: returning to experience: the listener can help the learner draw out the description of the experience, listening intently to what the learner focuses on and what the learner does not focus on, trying to see if the learner is overlooking anything. Attending to feelings: listeners help learners become aware of feelings that we there during the experience. Also important to identify any barrier feelings. Re-evaluation stage: listeners need to draw on more of their technical skills as opposed to personal resources. Can use the skills mentioned above for this area.

Boud & Walker	1998	Promoting Reflection in Professional Courses: The Challenge of Context	This article addresses some of the issues associated with the widespread incorporation of reflective practice into the coursework and training of many professional programs, across several disciplines. First addressed is what are the problems. These are 1. recipe following-classroom activities that make students reflect on demand through a sequence of steps, without regard to meaning, their own questions or uncertainty. 2. Reflection without learning-not all reflective processes lead to learning. Teachers must be skilled to present appropriate reflective activities. 3. Belief that reflection can be easily contained: the learning environment must be supportive of tension and questioning. 4. Not designing for a formal learning context: reflective activities should not be used as assessment tools to display what a student knows. This leads to students censoring and is generally not a good way to assess learning. 5. Intellectualizing reflection: it is not only a cognitive practice, emotions are central to learning. Teachers need to create an environment in which the expression of emotion is accepted. 7. Inappropriate disclosure: need to plan and train how to use personal journal and reflection in an ethical and non-risky way. 8. Uncritical acceptance of experience: this is a warning not to accept reflection without question. It not coherent, complete or masterable. 9. Going beyond the expertise of the teacher: teachers should not feel they need to go beyond their expertise to address issues that come up for their students in reflective activities. 10. Excessive use of teacher power: to use reflective activities, teachers must have mature awareness and not exert excessive power and control over students as a result of the intimidate knowledge that comes out of the reflective activities. Context and Reflection: Context is the most important influence on reflection and learning. Context includes the language we use, assumptions we hold, which social groups are dominant or oppressed, who has resources, and other economic and political considerations. The authors then discuss recommendations for creating ripe conditions for reflection to be promoted. These include: knowing what teachers can and cannot do, the

			need to build trust and the challenges of doing this, the need to create situations for learners to create their own meaning, the ways disciplines and professions frame what is possible in the higher education setting, consideration of whose interests are being pursued in reflective activities, and the importance of creating and respecting boundaries between institutions and the learner. Teachers especially must be aware of all contexts for all the aforementioned to be implemented.
Gustafsson, Asp, Fagerberg	2006	Reflective Practice in Nursing Care: Embedded Assumptions in Qualitative Studies	This meta-analysis sought to synthesize the qualitative literature on reflective practice within the field of nursing. Results indicated that despite many reports containing empirical data, assumptions are mainly based on theory, limiting the empirical evidence. Results also showed that reflection has a central function in RN learning, as both RN leaning and RP is constructivist in nature. The following patterns were revealed: 1. RP as an agent-The theme of agent describes RP as an internally driven cognitive process mainly focused on the RNs values, attitudes, beliefs, and self-awareness. This is especially important within nursing given the prominence of the RN-patient relationship. Agent for clinical nursing-RP was shown to be an agent for clinical nursing, for three reasons. (1) RP is a facilitator for holistic care-it is about reflecting on the nature of care and attitudes towards care. (2) RP conveys an ethical dimension. It is a process that facilitates articulation of ethical issues. (3) RP is a facilitator for change and improvement. Agent for nursing knowledge-this category pertains to nursing knowledge, and in particular tacit knowledge. RP is considered a pathway to make sense and understand tacit nursing knowledge. Tacit knowledge is understood to spread the knowledge of professional practice, theoretical understanding, and lived experience. RP is also understood to generate knowledge and understanding of everyday practice, the ability to apply theory to practice, analytically with all of the above leading to greater clinical effectiveness. Agent for the nursing profession-The process of RP enriches the nursing profession through the individual. RP allows for awareness and understanding of intuitive responses, which is the artistry of nursing. It also allows for the explication of how RNs do their work and gets at their depth of practice. Another theme described is that RP is an outward process as well. Although it begins as an individualized inward process, it also takes place together with others. RP is also described as a tool for clinical nursing, whereby new nursing knowledge and experiences are integrated with previous knowledge. There is an indication that there must be an explicit purpose for the developmental process of RP. Another theme indicated that RP is a tool to build nursing knowledge and generates creative nursing. However, it must take place where it is not taken for granted. RP is also described as a benefit for the nursing profession, as a whole. Another theme identified is criticism of RP in nursing care. The theme is composed of criticism and problems within RP for a lack of evidence that it improves outcome for patients. Also mentioned is that there is no doctrine of RP explaining the theory-active gap through separating thought and action involved in each. It is difficult to articulate the activities that promote RP. Conceptualizations of reflection in the field are ambiguous and confused. The article ends with a summary and synthesis of the above described findings.
Knowles, Gilbourne, Tomlinson, Anderson	2007	Reflections on the Application of Reflective Practice for Supervision in Applied Sport Psychology	This article aims to increase the literature base of RP and sports psychology through exploring the writing of a supervisor and supervisee who explore there experiences with reflective practice I the supervision process. This aims to establish a framework from which subsequent writing of supervisors and supervisees can be evaluated. The article first addresses that in reflective writing it must be stressed that personal experience is central to the writing process and that the writing process must be developed around a particular epistemology such as self-narrative. The article points out that reflective accounts has been gaining popularity within the field of sports psychology. However, little is known about how to do this effectively. The author lays out a process developed based on her own experience. (1) the supervisor must actively teach and engage in reflective supervision to model the practice (2) the reflective process must include others to stimulate a spirit of shared reflection (3) to develop layered reflection, many mechanisms should be used. Self-reflection should be the first layer of this process, group reflecting is level 2, and level 3 is widening the networks to explore different theoretical approaches to consultancy. The article also provides examples of individual and shared reflection for supervisor and supervisees such as group meetings, role-plays, and through required annual written progress reports. The article concludes with presenting the reflective writing of sports psychologist in training over a 3-year period. The supervisee shares that he learned to reflect using Gibbs (1988) Six-Stage reflective cycle within supervision. Reflections on and in action are shared. Finally, the article concludes with a more detailed discussion on reflective writing based on the work of Goodman (1984), who spoke about three level of reflections which align with 3 levels of cognitive interest as outlined by Habermas: (1) technical cognitive interest, which is a limited form of reflection that deals with measurable issues such as efficiency, effectiveness, and accountability. Level 2 is associated with practical cognitive interest, which focuses on the consequences of actions and touches on underlying rationale for practice. Level 3 contains intuitive associations, reflection on ethical issues, and locates practice in the wider social and political scheme.
Mamede & Schmidt	2004	The Structure of Reflective Practice in	The purpose of this study was to analyze the reflective thinking of medical doctors. Before this study, no empirical studies were done on reflective practice, despite the emphasis placed on those in training to engage in reflective practice as a means of attaining clinical

		Medicine	expertise. This study developed a measure of reflective thinking, based on the work of Dewey and Schön. Five dimensions of reflective practice are measured in the questionnaire: 1. deliberate induction (in response to an unfamiliar problem the reflective doctor will take time to generate alternative explanations). 2. Deliberate Induction (the logical deduction of consequences of the alternative hypothesis in terms of signs and symptoms patient would have if the hypotheses were true). 3. Testing these hypotheses against the problem at hand (testing predictions against the problem leads to hypotheses verification). These 3 are based on Dewey's work and get at skill required for RP. The following two get at attitude necessary for RP. 4.An attitude of openness towards reflection (must be able to tolerate uncertainty or ambiguity usually present in periods of reflection). 5. Meta-reasoning (to think about one's own thinking and to critically review beliefs and assumptions about a problem). After being given to a group of primary care physicians, the questionnaire was submitted for confirmatory factor analysis. Results showed that the data fit the hypothesized 5-factor solution well.
Mamede, Schmidt, Penaforte	2008	Effects of Reflective Practice on the Accuracy of Medical Diagnoses	This study attempts to fill in a gap in the medical literature related to empirical evidence supporting theoretical notions about the benefits of reflective practice (i.e. reflective practice leads to patients' problems being thought through more thoroughly, improved clinical judgment, a minimization of errors). The authors hypothesized that reflective practice would have a positive effect on the accuracy of diagnosis of complex clinical cases, but will not affect the diagnostic accuracy of simple cases. The study took place in 2 teaching hospitals in Brazil with 42 internal residents in their second years of training. Results of the study revealed that reflective practice was associated with generation of more accurate diagnostic accuracy of complex cases and did not affect the diagnosis of simple cases.
Mann, Gordon, Macleod	2009	Reflection and Reflective Practice in Health Professions Education: A Systematic Review	This article has as its purpose to summarize the literature on reflective practice to evaluate the evidence on reflective practice and its utility in health professional education. RP is considered very important in enhancing competence, but the evidence to inform training is largely theoretical. Most models of RP include the following: critical reflection on experience and practice to enable identification of learning needs , understanding personal beliefs, attitudes, and values in the context of the professional culture, a linking and integrating of new knowledge to existing knowledge. These capabilities may underlie a professional who is self-aware and can self-monitor. The issue is that there is little research on how to promote reflection and which approaches have efficacy or impact. The literature is dispersed across education, nursing, and psychology, among others. One of the aims of this article was to try to distill the common characteristic of teaching and learning that promote RP across professions. The search for article on the process and outcome on RP in all health professions yielded 29 articles, with largest majority from nursing and medicine, and 17 out of 29 utilizing qualitative approaches. The following questions were developed: Do practicing health professional engage in reflective practice? What is the nature of student's reflective thinking? Can reflective practice be assessed? Can reflective thinking be developed? What contextual influences hinder or enable the development of reflection and reflective capability? What are the potential positive or negative effects of promoting reflection? The authors cite the studies that address these questions and provide a description of the results of the studies. Of note, because of the dearth of literature on RP in health professions outside of nursing and medicine, these articles were cited under other health professions and grouped together.
Mezirow	1991	A Critical Theory of Adult Learning and Education	Mezirow describes several types of reflectivity. Generally, reflectivity is the act of becoming aware of a specific perception, meaning or behavior of our own or of habits we have of seeing, thinking, acting. Affective Reflectivity: Is becoming aware of how we feel about the way we are perceiving, thinking, or acting. Discriminant Affectivity: is assessing the efficacy of our perceptions, thoughts, actions, and habits of doing things; identifying immediate causes; recognizing contexts in which we are functioning and identifying our relationships in the situation Judgmental reflectivity: making and becoming aware of our value judgments about our perceptions, thoughts, actions, and habits. Conceptual Reflectivity: (pertains to perspective transformation) is becoming conscious of our awareness and critiquing it as, for example, when we question the constructs we are using when we evaluate another person. Psychic Reflectivity: (pertains to perspective transformation) is recognizing in oneself the habit of making judgments about people on the basis of limited information about them, and recognizing the interests and anticipations which influence the way we perceive, think or act. Theoretical Reflectivity: (Mezirow believes this is central to perspective transformation) is becoming aware that the reason for a habit of judgment or for conceptual inadequacy is because of a set of taken-for-granted cultural or psychological assumptions.
Sobral	2001	An Appraisal of Medical Students' Reflection-in	The purpose of this study was to see whether reflection-in-learning changes in medical students at the University of Brasilia, as they strive for more control over their learning and as they start their clinical apprenticeship. The study specifically sought to look at whether subgroups of students could be identified based on the degree and direction of change in

		Learning	self-reflection during a cooperative learning experience, whether subgroups differed with respect to their drive for self-regulated learning and the appraisal of their learning experience, and whether enhanced reflection-in-learning is predictive of greater diagnostic thinking and academic achievement. Results indicated a significant, but small change, in level of reflection from the start to the end of the term, in the case of course participants. Differences between experimental and control groups was very significant. Three different subgroups emerged: high level reflection and positive change, low level and positive change, and low level and negative change. Subgroups with positive change and high level of reflection showed higher means for scores on perceived competence for self-regulated learning and for meaningfulness of the learning experience. This group also showed higher grade point averages and higher scores on the Diagnostic Thinking Inventory.
Sobral	2001	Medical Students Reflection in Learning	The aim of this study were to examine how medical students' reflection in learning changes from the start to the end of a regular term, to identify whether there are relationships between measures of reflection and approaches to studying, perceived learning outcomes, and academic achievement. Results indicated that there were positive, significant relationships between the RLS, CVI and s-ASI's meaning orientation. Academic achievement was significantly, but weakly, related to the RLS. High achievers showed stability or positive change in RLS more frequently, and stronger/stable personal efficacy in self-reflection. Further, greater drops in RLS scores tended to be associated with poorer grade achievement. The findings suggest that better knowledge of the reflection profile may help students in their quest to be become self-regulated learners.
Teekman	2005	Exploring Reflective Thinking in Nursing Practice	The study revealed a number of aspects related to the clinical thinking of nurses. The results on reflective practice will be summarized below. The study found 3 different focus of reflective thinking at consecutive levels: reflective thinking for action, reflective thinking for evaluation, and reflective thinking for critical inquiry. The study strongly indicated that reflective thinking was foremost used for action, whether the thinking occurred prior, during, or after the action. This a cognitive activity to help act, provide care, intervene to change the situation. It required respondents to focus on the situation, generate a range of options and choose an option. It occurred when responded realized they were facing doubt or complexity and felt obliged to act. This research also found that anticipatory reflection is an integral component of reflection for action. Reflective thinking for evaluation differs from the above in that it's main focus is on creating and understanding wholeness from the situation. It occurred after reflection for action. It is concerned with analyzing and clarifying individual experiences, meaning, and assumptions so as to evaluate actions and beliefs. This level of reflection also contributes to self awareness. Reflective thinking for critical inquiry occurred less frequent than the 2 above. This is reflective thinking about the wider context of underlying health and wellness (e.g. hidden power structures, allocation of resources, equity of healthcare delivery). The following model process model of reflective thinking was proposed. The authors propose that any model should incorporate the 3 levels of reflective thoughts as well as the dynamism inherent in the process. The cycle described is that the individual has unique pre-perceptions as a result of personal life circumstances, which then causes the individual to make sense and meaning of experiences in light of prior experience. A range of mental activities takes place, called reflective thinking including, comparing and contrasting to discourse with self to create meaning of the event and to act. The model is a spiral that leads to increasing amount of experiential insights and knowing.

REFERENCES

Anderson, A. G., Knowles, Z., & Gilbourne, D. (2004). Reflective practice for sport

psychologists: Concepts, models, practical implications, and thoughts on dissemination.

The Sport Psychologist, 18(2), 188–203.

Belar, C. (2009). Advancing the Culture of Competence. *Training and Education in

Professional Psychology, 3*(4), 563-565. doi: 0.1037/a0017541

Belar, C., Brown, R. A., Hersch, L. E., Hornyak, L. M., Rozensky, R. H., Sheridan, E. P., . . .

    Reed, G. W. (2001). Self-assessment in clinical psychology: A model for ethical

    expansion of practice. Professional Psychology: Research and Practice, 32(2), 135–141.

    doi:10.1037//0735-7028.32.2.135

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value

    of self-practice of cognitive therapy techniques and self-reflection in the training of

    cognitive therapists. *Behavioral and Cognitive Psychotherapy, 29*(2), 203–220.

    doi:10.1017/S1352465801002077

Bollich, K. L., Johannet, P. M., & Vazire, S. (2011). In search of our true selves: Feedback as a

    path to self-knowledge. *Frontiers in Psychology, 2*, article 312.

    doi:10.3389/fpsyg.2011.00312

Boud, D. (1986). *Facilitating learning in continuing education: Some important sources.*

    London, UK: Carfax Publishing.

Boud, D., & Walker, D. (1998). Promoting reflection in professional courses: The challenge of

    context. *Studies in Higher Education, 23*(2), 191–206. doi:0307-5079/98/020191-16

Burgess, S., Rhodes, P., & Wilson, V. (2013). Exploring the In-Session Reflective Capacity of

    Clinical Psychology Trainees: An Interpersonal Process Recall Study. *Clinical

    Psychologist, 17*, 122-130. doi:10.111/cp.12014

Childs, D. (2011). Mindfulness and clinical psychology. *Psychology and Psychotherapy: Theory,

    Research, and Practice*, *84*, 288–298. doi:10.1348/147608310X530048

Collins, S., Arthur, N., & Wong-Wylie, G. (2010). Enhancing reflective practice in multicultural

    counseling through cultural auditing. *Journal of Counseling and Development, 88*(3),

    340–347. doi:10.1002/j.1556-6678.2010.tb00031.x

Dallos, R., & Stedmon, J. (2010). *Reflective practice in psychotherapy and counseling*. New

York, NY: McGraw Hill.

Davidson, L. (2006). Supervision and mentorship: The use of the real in teaching. *The Journal of*

the American Academy of Psychoanalysis and Dynamic Psychiatry, 34, 189–195.

Retrieved from

http://guilfordjournals.com/doi/abs/10.1521/jaap.2006.34.1.189?journalCode=jaap

Eraut, M. (1994). *Developing Professional Knowledge and Competence*. Philadelphia, PA:

Farmer Press.

Farrand, P., Perry, J., & Linsley, S. (2010). Enhancing self practice/self-reflection (SP/SR)

approach to cognitive behaviour training through the use of reflective blogs. *Behavioral*

and Cognitive Psychotherapy, 38(4), 473–477. doi:10.1017/s1352465810000238

Fauth, J., & Nutt Williams, E. N. (2005). The in-session self-awareness of therapist trainees:

Hindering or helpful? *Journal of Counseling Psychology, 52*(3), 443–447.

doi:10.1037/0022-0167.52.3.443

Fouad, N. A., Hatcher, R. L., Hutchings, P. S., Collins, F.L., Jr., Grus, C. L., Kaslow, N. J., . . .

Crossman, R. E. (2009). Competency benchmarks: A model for understanding and

measuring competence in professional psychology across training levels. *Training and*

Education in Professional Psychology, 3(4)*,* S5–S26. doi:10.1037/a0015832

Gambrill, E. (2005). *Critical thinking, evidence-based practice, and mental health*. New York,

NY: Columbia University Press.

Gambrill, E., & Gibbs, L. (2009). *Critical thinking for helping professional: A skills-based*

workbook (3rd ed.). New York, NY: Oxford University Press.

Gibbs,G. (1988). *Learning By Doing: A Guide to Teaching and Learning*. London, FEU:

Oxford Press.

Gillmer, B. & Marckus, R. (2003). Personal professional development in clinical psychology

training: Surveying reflective practice. *Clinical Psychology*, *27*, 20-23.

doi:10.1002/cpp.660

Griffith, B., & Frieden, G. (2000). Facilitating reflective thinking in counselor education.

Counselor Education and Supervision, 40(2), 82–94.

doi:10.1002/j.1556-6978.2000.tb01240.x

Guffrida, D. A. (2005). The emergence model: An alternative pedagogy for facilitating self-

reflection and theoretical fit in counseling students. *Counselor Education and*

Supervision, 44, 201–213.

Gustaffson, C., Asp, M., & Fagerberg, I. (2008). Reflective practice in nursing care: Embedded

assumptions in qualitative studies. *International Journal of Nursing Practice, 13,* 151–

160. doi:10.1111/j.1440-172X.2007.00620.x

Hoshmand, L. T. (1994). *Orientation to inquiry in a reflective professional psychology*. Albany,

NY: State University of New York Press

Irving, J. A., & Williams, D. I. (1995). Critical thinking and reflective practice in counseling.

British Journal of Guidance and Counseling, 23(1), 107–115.

doi:10.1080/030698889500760101

Iszak, M. G. (2006). *Achieving self-reflective practice: A comparative psychoanalytic approach*

to the training of psychology doctoral students. Unpublished doctoral dissertation, The

Chicago School of Professional Psychology, Chicago, IL.

Kaslow, N. J., Bebeau, M. J., Lichtenberg, J. W., Portnoy, S. M., Rubin, N. J., Leigh, I. W., . . .

    Smith, I. L. (2007). Guiding principles and recommendations for the assessment of

    competence. *Professional Psychology: Research and Practice, 38*(5), 441–451.

    doi:10.1037/0735-7028.38.5.441

Kaslow, N. J., Rubin, N. J., Forrest, L., Elman, N. S., Van Horne, B. A., Jacobs, S. C.,…Thorn,

    B. E. (2007). Recognizing, assessing, and intervening with problems of professional

    competence. *Professional Psychology: Research and Practice, 38*(5), 474-478.

    doi: 0.1037/0735-7028.38.5.47

Knight, K., Sperlinger, D., & Maltby, M. (2010). Exploring the personal and professional impact

    of reflective practice groups: A survey of 18 cohorts from a UK clinical psychology

    training course. *Clinical Psychology and Psychotherapy, 17,* 427–437.

    doi:10.1002/cpp.660

Knowles, Z., Gilbourne, D., Tomlinson, V., & Anderson, A. G. (2007). Reflections on the

    application of reflective practice for supervision in applied sport psychology. *The Sport*

    Psychologist, 27, 109–122. Retrieved from

    http://web.a.ebscohost.com.lib.pepperdine.edu/ehost/pdfviewer/pdfviewer?sid=d8c7aee3-

    1df5-486b-ab59-83225f21707a%40sessionmgr4005&vid=86&hid=4207

Kolb, D. A. (2001). Experiential learning theory: Previous research and new directions.

    Perspectives on Thinking and Cognitive Styles, 25, 227–247. doi:10.5172/jmo.16.1.100

Laireiter, A. R., & Willutzki, U. (2003). Self-reflection and self-practice in training of cognitive

    behavior therapy: An overview. *Clinical Psychology and Psychotherapy, 10,* 19–30.

    doi:10.1002/cpp.348

Lavender, J. (2003). Redressing the balance: The place, history, and future of reflective practice in clinical training. *Clinical Psychology, 27,* 11–15. doi:10.1037/0022-0167.43.1.10

Leigh, I. W., Bebeau, M., Nelson, P. D., Rubin, N. J., Smith, I. L., Lichtenberg, J. W., . . . Kaslow, N. J. (2007). Competency assessment models. *Professional Psychology Research and Practice, 38*(5), 463–473. doi:10.1037/0735-7028.38.5.463

Lichtenberg, J., Bebeau, M., Nelson, P. D., Smith, I. L., Sanford, M. P., Leigh, I. W., . . . Kaslow, N. J. (2007). Challenges to the assessment of competence and competencies. *Professional Psychology: Research and Practice, 38*(5), 474–478. doi:10.1037/0735-7028.38.5.474

Mamede, S. M., & Schmidt, H. G. (2004). The structure of reflective practice in medicine. *Medical Education, 38,* 1302–1308. doi:10.1111/j.1365-2929.2004.01917.x

Mamede, S., Schmidt, H. G., & Penaforte, J. (2008). Effects of reflective practice on the diagnoses of medical illnesses. *Medical Education, 43*(5), 468–475. doi:10.1111/j.13652923.2008.03030.x

Mann, K., Gordon, J., & Macleod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Science Education, 14,* 595–621. doi:10.1007/s10459-007-9090-2

Mellor, N. (1998). On reflection: One psychologist's explorations around an episode of reflecting. *Educational Psychology in Practice, 14*(3), 167–178. doi:10.1080/0266736980140303

Mezirow, J. (1981). A critical theory of adult learning and education. *Adult Education, 32*(1), 3-24. Retrieved from http://aeq.sagepub.com/content/32/1/3.short?rss=1&ssource=mfc

Moffet, L. A. (2009). Directed self-reflection protocols in supervision. *Training and Education in Professional Psychology, 3*(2), 78–83. doi:10.1037/a0014384

Nelson, M. L., & Neufeldt-Allsetter, S. A. (1998). The pedagogy of counseling: A critical examination. *Journal of Counselor Education and Supervision, 38*(2), 1–31. doi:10.1002/j.1556-6978.1998.tb00560.x

Neufeldt, S. A., Karno, M. P., & Nelson, M. L. (1996). A qualitative study of experts' conceptualization of supervisee reflectivity. *Journal of Counseling Psychology, 43*(1), 3-9. doi:10.1037/0022-0167.43.1.3

Nut Williams, E. (2003). The relationship between momentary states of therapist awareness and perceptions of the counseling process. *Journal of Contemporary Psychotherapy, 33*(3), 177–187. doi:0022-0116/03/0900-0177/0

Nut Williams, E. (2010). A psychotherapy researcher's perspective on therapist self-awareness and self-focused attention after a decade of research. *Psychotherapy Research, 18*(2), 139–146. doi:10.1037/1931-3918.S.1.17

Nut Williams, E., Hurley, K., O'Brien, K., & DeGregorio, A. (2003). Development and validation of the self-awareness and management strategies scales for therapists. *Psychotherapy Theory, Research, Practice, and Training, 40*(4), 278–288. doi:10.1037/0033-3204.40.4.278

Nut Williams, E., Polster, D., Grizzard, M. B., Rockenbaugh, J., & Judge, A. B. (2003). What happens when therapists feel bored or anxious? A qualitative study of distracting self-awareness and therapists' management strategies. *Journal of Contemporary Pyschotherapy, 33*(1), 5–19. doi:10.1023/A:1021499526052

Orchowski, L., Evangelista, N. M., & Probst, D. R. (2010). Enhancing supervisee reflectivity in

    clinical supervision: A case study illustration. *Psychotherapy Theory, Research, Practice,*

    and Training, 47(1), 51–67. doi:10.1037/a0018844

Owen, J., & Lindley, L. D. (2009). Therapists' cognitive complexity: Review of theoretical

    models and development of an integrated approach to training. *Training and Education in*

    Professional Psychology, 4(2), 128–137. doi:10.1037/a0017697

Park-Taylor, J., Budianto, L., Grace, S. K., Pfeifer, G., Laidlaw, P., Sakurai, M., & Pfeifer, J.

    (2009). Toward reflective practice: A multicultural competence training model for a

    community mental health center. *Professional Psychology: Research and Practice, 40*(1),

    88–95. doi:10.1037/a0013828

Parsons, R. D., & Zhang, N. (2014). *Counseling theory: Guiding reflective practice*. Thousand

    Oaks, CA: Sage Publications.

Pegeron, J. P. (1996). Supervision as an analytic experience. *The Psychoanalytic Quarterly, 65,*

    693–710.

Peterson, R. L, Abrams, J. C., Peterson, D. R., & Stricker, G. (1997). The national council of

    school and programs of professional psychology educational model. *Professional*

    Psychology: Research and Practice, 28(4), 373–386. doi:10.1037/0735-7028.28.4.373

Peterson, R. L., Abrams, J. C., Peterson, D. R., & Stricker, G. (2006). The national council of

    school and programs of professional psychology educational model. *Training and*

    Education in Professional Psychology, 8(1), 17–36. doi:10.1037/1931-3918.S.1.17

Roberts, M. C., Christiansen, M. D., Borden, K. A., & Lopez, S. J. (2005). Fostering a culture

    shift: Assessment of competence in the education and careers of professional

    psychologists. *Professional Psychology: Research and Practice, 36*(4), 355–361.

    doi:10.1037/0735-7028.36.4.355

Ronnestad, M. H., & Skovholt, T. M. (2001). Learning arenas for professional development:

    Retrospective accounts of senior psychotherapists. *Professional Psychology: Research*

    and Practice, 32(4), 181–187. doi:10.1037//0735-7028.32.2.181

Ronnestad, M. H., & Skovholt, T. M. (2003). The journey of counselor and therapist: Research

    findings and perspectives on professional development. *Journal of Career Development,*

    30(1), 5–44. doi:10.1023/A:1025173508081

Rubin, N., Leigh, I. W., Nelson, P. D., Smith, I. L., Bebeau, M., Lichtenberg, J. W., . . . Kaslow,

    N. J. (2007). The competency movement within psychology: A historical perspective.

    Professional Psychology: Research and Practice, 38(5), 452–462.

    doi:10.1037/0735-7028.38.5.452

Scaife, J. (2010). *Supervising the reflective practitioner: An essential guide to theory and*

    practice. New York, NY: Routledge.

Shealy, C. N. (2004). A model and method for making a combined-integrated psychologist:

    Equilintegration theory and beliefs, events, and values inventory. *Journal of Clinical*

    Psychology, 60(10)*,* 1065–1090. doi:10.1002/jclp.20035

Sheikh, A. I., Milne, D. L., & MacGregor, B. V. (2007). A model of personal professional

    development in the systematic training of clinical psychologists. *Clinical Psychology and*

    Psychotherapy, 14, 278–287. doi:10.1002/cpp.540

Skovholt, T. M., & Ronnestad, M. H. (1992). Themes in therapist and counselor development. *Journal of Counseling and Development, 70,* 505–515. doi:10.1002/j.1556-6676.1992.tb01646.x

Skovholt, T. M., Ronnestad, M. H., & Jennings, L. (1997). Searching for expertise in counseling, psychotherapy, and professional psychology. *Educational Psychology Review, 9*(4), 361-371. doi:1040-726x/97/1200-0361

Sobral, D. T. (2001a). An appraisal of medical students' reflection-in-learning. *Medical Education, 34*(3), 182–187. doi:10.1046/j.1365-2923.2000.00473.x

Sobral, D. T. (2001b). Medical students reflection-in-learning in relation to approaches to study and academic achievement. *Medical Teacher, 23*(3), 508–513. doi:10.1080/01421590120042973

Sutton, S., Townend, M., & Wright, J. (2007). The experience of reflective learning journals by cognitive behavioral psychotherapy students. *Reflective Practice: International and Multidisciplinary Perspective, 8*(3), 387–404. doi:10.1080/14623940701425048

Teekman, B. (2005). Exploring reflective thinking in nursing practice. *Journal of Advanced Nursing, 31*(5), 1125–11 5. doi:10.1037/a0018844

Trieweiler, S., & Stricker, G. (1997). *The scientific practice of professional psychology*. New York, NY: Plenum.

Wise, E. H., Nutt, R. L., Schaffer, J. B., Sturm, C. A., Rodolfa, E., & Webb, C. (2010). Life-long learning for psychologists: Current status and a vision for the future. *Professional Psychology: Research and Practice, 41*(4), 288–297. doi:10.1037/a0020424

APPENDIX B

Reflective Practices Survey (RPS)

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES
Principal Investigator: Rachel Fried, M.A.
Title of Project: The Use of Reflective Practice By Psychology Interns

      1.   I agree to participate in a research study being conducted by Rachel Fried, M.A., doctoral candidate in clinical psychology at Pepperdine University who is conducting this study to fulfill dissertation requirements. Dr. Edward Shafranske, Professor, Graduate School of Education and Psychology, Pepperdine University supervises this study.
      2.   I understand that participation in this study is completely voluntary and that there will be no negative consequences if I choose not to participate. In addition, I understand I may choose to stop participating in the study at any time, for any reason, and there will be no adverse consequences to me.
      3.   I have been asked to participate in this study because I am currently a pre-doctoral psychology intern.
      4.   The overall purpose of this research is to survey psychology interns' behaviors, and beliefs about reflective practice.
      5.   My participation in this study will consist of completing a brief web-based questionnaire. As part of the questionnaire I will be asked to respond to the following areas: degree of engagement in behavioral practices of reflective practice, extent to which supervisors encouraged engagement in reflective practices, open-ended questions about beliefs about reflective practice, and demographic items (age, gender, primary theoretical orientation, etc.).
      6.   I understand that participation in this study will be confidential. I will not be asked to divulge any personally identifying information on any of the research forms or questionnaire. I understand that SurveyMonkey utilizes SSL (Secure Sockets Layer), a protocol to ensure secured, encrypted, connections. I further understand that my anonymity will be protected through not obtaining information about IP addresses accessing the survey website. Any findings from this study that are published in professional journals or shared with other researchers will only involve group data with no personally identifying information included.
      7.   My participation in the study will take approximately 15-20 minutes to complete. I understand that the questionnaire is written in English.
      8.   I understand that there is no direct benefit for me to participate in this research; however, the results of the study may further understanding of the nature of reflective practice and its usefulness and may be of benefit to future trainees and supervisors. I may feel a sense of satisfaction from contributing to research on psychology training. I understand that upon completion of the survey I will be given an opportunity to enter a drawing for one of three $25.00 gift certificates to Amazon.com. If I choose to enter the drawing, I understand I will be asked to provide an email address. I understand that if I choose to participate in the drawing, my email address will not be linked to my survey responses and will be destroyed once the certificates have been awarded. However, my anonymity as a participant will be compromised as the researcher may learn my identity. Following the data collection period, the drawing will be conducted and I will be notified if I win via the email address I provide. Winners will receive the gift certificate via email.

9. I understand that participation in this study involves no more than minimal risk. Such risk is similar to what is encountered in daily life or during the completion of routine psychological questionnaires. It is possible that I may experience some emotional discomfort in responding to certain questions. I understand that I am free to not answer any questions that I do not want to answer. I also understand that I will be provided contact information for the principal investigator and faculty supervisor should I have any concerns I want to discuss further. Additionally, in the unlikely event that emotional distress continues well past the point of study participation, I may contact the principal investigator or faculty supervisor to help locate a psychotherapy referral in my area. If I experience any other adverse events, I understand I may notify the principal investigator and/or discontinue participation.

11. During data collection, data will be kept on the investigator's password protected computer and a USB flash drive. Following study completion, data will be stored on a USB flash drive and kept by the investigator in a locked file for 5 years before being destroyed.

12. I understand that the investigator is willing to answer any inquiries I may have concerning the research described. I understand that I may contact Rachel Fried at Rachel.fried@pepperdine.edu or Dr. Edward Shafranske at eshafran@pepperdine.edu if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I may contact Dr. Thema Bryant-Davis, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB), Pepperdine University, 6100 Center Drive, Los Angeles, CA 90045, or by telephone at 310-568-2389.

13. I understand to my satisfaction the information regarding my participation in the research project. All my questions have been answered to my satisfaction. I hereby consent to participate in the research described above.

Please indicate one of the following responses:
Yes, I give my consent to participate in this study.
No, I do not give my consent to participate in this study.

<p align="center">Demographic Questionnaire</p>

Instructions: For each item, please select the choice that is most appropriate for you. If there is not an answer choice that is appropriate, please select "other" and type your response in the box provided. If you prefer not to answer any item, you may leave it blank.

1. Type of doctoral program:
A. Clinical
B. Counseling
C. School
D. Combined
E. Other _____

2. Degree sought:
A. Ph.D.
B. Psy.D.
C. Ed.D.
D. Other _____

3. Is your doctoral program APA or APPIC accredited?
A. Yes
B. No

4. Which of the following best describes your primary theoretical orientation?
A. Cognitive-Behavioral (including cognitive and behavioral)
B. Existential/Humanistic
C. Family Systems
D. Psychodynamic
E. Other _____

7. What is your age?
_____

8. Which gender do you identify with?
A. Female
B. Male
C. Other (transgender, intersex) _____

9. Which of the following best describes your racial/ethnic identification? Check all that apply.
A. African-American/Black
B. American Indian/Alaskan Native
C. Asian/Pacific Islander
D. Hispanic/Latino
E. White (non-Hispanic)
F. Bi-racial/Multi-racial
G. Other _____

10. Are you currently in your own psychotherapy?
A. Yes
B. No

The following survey is about reflective practice and psychology interns in training. Reflective practice can be defined as using focused inquiry to increase personal and professional self-awareness. The goal is for a professional to attain a comprehensive understanding of his or her work and to increase competency in practice. This survey will ask you to answer questions about your engagement in reflective practice outside and within supervision sessions as well as the reflective practices that you believe contribute to your clinical effectiveness. In addition, there are two open-ended questions at the end of the survey. The survey should take no longer than 15-20 minutes.

Before you begin this survey, please think about all of your cases over the last month in which

you provided psychological treatment (i.e. individual psychotherapy or couple's psychotherapy). In the space provided below, please write the first initial of each case.

From the list of therapy cases above, please choose a case that best fits the following categories and then write the first initial of the case on the corresponding line. Please choose three different cases. Please note: If you can only identify cases in two of the categories, please complete the survey on those cases in those two categories.

Clinically challenging refers to cases that pose particular challenges for the clinician, such as difficulties in forming a therapeutic alliance, complex symptom presentation, client high risk behaviors, noncompliance with treatment recommendations or resistance, a therapeutic crisis, a therapeutic stuck-point, disruptive clinical event, or client hostility directed at the therapist.

1. A case in which the therapeutic work is going well_____

2. A clinically challenging case in which the therapeutic work is going well_____

3. A clinically challenging case in which the therapeutic work is NOT going well and you feel ineffective_____

Please indicate the frequency of your personal use of the following reflective practices, **over the past month, specific to the client you chose as your case in which the therapeutic work is going well.**

1. I devote time to examine my personal beliefs and values.

       Never   Once per month   More than once per month   Every week

2. I devote time to reflect on the influence of my cultural background and diversity characteristics.

       Never   Once per month   More than once per month   Every week

3. I pay attention to bodily sensations I am having during session (e.g., tension) with this client.

       Never   Once per month   More than once per month   Every week

4. I pay attention to the thoughts I am having during session with this client.

       Never   Once per month   More than once per month   Every week

5. I pay attention to the feelings I am having during session (e.g. anger, frustration, sadness) with this client.

          Never   Once per month   More than once per month   Every week

6. I devote time to the self-assessment of my clinical skills

          Never   Once per month   More than once per month   Every week

7. I devote time to reflect on how to increase my clinical effectiveness with this client.

          Never   Once per month   More than once per month   Every week

8. I devote time to reflect on how to apply theory to clinical practice with this client.

          Never   Once per month   More than once per month   Every week

9. I devote time to think about the quality of the therapeutic alliance/relationship with this client.

          Never   Once per month   More than once per month   Every week

10. I reflect on my interventions while conducting therapy with this client.

          Never   Once per month   More than once per month   Every week

11. I devote time to reflect on the influence of my clients' multicultural identities.

          Never   Once per month   More than once per month   Every week

12. I devote time to reflect on supervisor feedback on this client

          Never   Once per month   More than once per month   Every week

13. I maintain a journal about my conduct of psychological treatment with this client.

          Never   Once per month   More than once per month   Every week

14. I review recordings of my conduct of psychological treatment with this client.

          Never   Once per month   More than once per month   Every week

15. I devote time to reflect after a therapy session with this client, in addition to writing a therapy note.

          Never   Once per month   More than once per month   Every week

16. I devote time to reflect on what I need supervision in or consultation on with this client.

Never   Once per month   More than once per month   Every week

17. I devote time to reflect on my self-care with this client.

Never   Once per month   More than once per month   Every week

18. Please use this space to share any other practices that you employ in reflecting on your conduct of psychological treatment with this client and the frequency of your use.

Never   Once per month   More than once per month   Every week

19. Over the course of the past month, how many times have you reviewed the relevant scientific literature applicable to this case?

Never   Once per month   More than once per month   Every week

20. Over the past month how often did you intentionally seek time with a peer to discuss your work with this client?

Never   Once per month   More than once per month   Every week

Please indicate the frequency of your personal use of the following reflective practices, **over the past month, specific to the client you chose as your clinically challenging case in which the therapeutic work is going well.**

1. I devote time to examine my personal beliefs and values.

Never   Once per month   More than once per month   Every week

2. I devote time to reflect on the influence of my cultural background and diversity characteristics.

Never   Once per month   More than once per month   Every week

3. I pay attention to bodily sensations I am having during session (e.g. tension) with this client.

Never   Once per month   More than once per month   Every week

4. I pay attention to the thoughts I am having during session with this client.

Never   Once per month   More than once per month   Every week

5. I pay attention to the feelings I am having during session (e.g. anger, frustration, sadness) with this client.

Never   Once per month   More than once per month   Every week

6. I devote time to the self-assessment of my clinical skills

Never   Once per month   More than once per month   Every week

7. I devote time to reflect on how to increase my clinical effectiveness with this client.

Never   Once per month   More than once per month   Every week

8. I devote time to reflect on how to apply theory to clinical practice with this client.

Never   Once per month   More than once per month   Every week

9. I devote time to think about the quality of the therapeutic alliance/relationship with this client

Never   Once per month   More than once per month   Every week

10. I reflect on my interventions while conducting therapy with this client.

Never   Once per month   More than once per month   Every week

11. I devote time to reflect on the influence of my clients' multicultural identities.

Never   Once per month   More than once per month   Every week

12. I devote time to reflect on supervisor feedback on this client

Never   Once per month   More than once per month   Every week

13. I maintain a journal about my conduct of psychological treatment with this client.

Never   Once per month   More than once per month   Every week

14. I review recordings of my conduct of psychological treatment with this client.

Never   Once per month   More than once per month   Every week

15. I devote time to reflect after a therapy session with this client in addition to writing a therapy note.

Never   Once per month   More than once per month   Every week

16. I devote time to reflect on what I need supervision in or consultation on with this client.

Never   Once per month   More than once per month   Every week

17. I devote time to reflect on my self-care with this client.

Never   Once per month   More than once per month   Every week

18. Please use this space to share any other practices that you employ in reflecting on your conduct of psychological treatment with this client and the frequency of your use.

Never   Once per month   More than once per month   Every week

19. Over the course of the past month, how many times have you reviewed the relevant scientific literature applicable to this case?

Never   Once per month   More than once per month   Every week

20. Over the past month how often did you intentionally seek time with a peer to discuss your work with this client?

Never   Once per month   More than once per month   Every week

Please indicate the frequency of your personal use of the following reflective practices, **over the past month, specific to the client you chose as a clinically challenging case in which the therapeutic work is NOT going well and you feel ineffective.**

1. I devote time to examine my personal beliefs and values.

Never   Once per month   More than once per month   Every week

2. I devote time to reflect on the influence of my cultural background and diversity characteristics.

Never   Once per month   More than once per month   Every week

3. I pay attention to bodily sensations I am having during session (e.g. tension) with this client.

Never   Once per month   More than once per month   Every week

4. I pay attention to the thoughts I am having during session with this client.

Never   Once per month   More than once per month   Every week

5. I pay attention to the feelings I am having during session (e.g. anger, frustration, sadness) with this client.

Never   Once per month   More than once per month   Every week

6. I devote time to the self-assessment of my clinical skills

Never   Once per month   More than once per month   Every week

7. I devote time to reflect on how to increase my clinical effectiveness with this client.

Never   Once per month   More than once per month   Every week

8. I devote time to reflect on how to apply theory to clinical practice with this client.

Never   Once per month   More than once per month   Every week

9. I devote time to think about the quality of the therapeutic alliance/relationship with this client.

Never   Once per month   More than once per month   Every week

10.   I reflect on my interventions while conducting therapy with this client.

Never   Once per month   More than once per month   Every week

11.   I devote time to reflect on the influence of my clients' multicultural identities.

Never   Once per month   More than once per month   Every week

12. I devote time to reflect on supervisor feedback on this client

Never   Once per month   More than once per month   Every week

13.   I maintain a journal about my conduct of psychological treatment with this client.

Never   Once per month   More than once per month   Every week

14.   I review recordings of my conduct of psychological treatment with this client.

Never   Once per month   More than once per month   Every week

15.   I devote time to reflect after a therapy session with this client in addition to writing a therapy note.

Never   Once per month   More than once per month   Every week

16. I devote time to reflect on what I need supervision in or consultation on with this client.

Never   Once per month   More than once per month   Every week

17. I devote time to reflect on my self-care with this client.

Never   Once per month   More than once per month   Every week

18. Please use this space to share any other practices that you employ in reflecting on your conduct of psychological treatment with this client and the frequency of your use.

Never   Once per month   More than once per month   Every week

19. Over the course of the past month, how much have you reflected on the application of research to practice with this client?

Never   Once per month   More than once per month   Every week

20. Over the past month how often did you intentionally seek time with a peer to reflect upon your work with this client?

Never   Once per month   More than once per month   Every week

When answering the following, please consider your primary supervisor during the first half of the internship year. If you have had more than one primary supervisor in this time, please select the supervisor who supervised the majority of your individual psychological treatment cases.

Which of the reflective practices listed below have been facilitated by this supervisor in supervision? Check all that apply.

_____ 1.   Examining my personal beliefs and values.
_____ 2.   Reflecting on the influence of my cultural background and diversity characteristics.
_____ 3.   Reflecting on bodily sensations I had during session (e.g. tension).
_____ 4.   Reflecting on the thoughts I had during session.
_____ 5.   Reflecting on the feelings I had during session (e.g. anger, frustration, sadness).
_____ 6.   Engaging in self-assessment of my clinical effectiveness.
_____ 7.   Identifying ways to increase my clinical effectiveness.
_____ 8.   Reflecting on how I apply theory to clinical practice.
_____ 9.   Reflecting on how I apply research to clinical practice.
_____ 10. Reflecting on the quality of the therapeutic alliance/relationship.
_____ 11. Reflecting on the interventions I use while conducting therapy.
_____ 12. Reflecting on the influence of my clients' multicultural identities.
_____ 13. Reviewing recordings of my conduct of psychological treatment.
_____ 14. Reflecting on what is needed from supervision or consultation
_____ 15. Reflecting on self-care.
       16. None of the above practices were facilitated in supervision.
_____ 17. Other_____.

Please indicate up to three reflective practices, from the list below, that have had the greatest impact on your effectiveness in conducting psychological treatment.
1. Examining my personal beliefs and values.
2. Reflecting on the influence of my cultural background and diversity characteristics.
3. Reflecting on the bodily sensations I had during session (e.g. tension).
4. Reflecting on the thoughts I had during session.
5. Reflecting on the feelings I had during session (e.g. anger, frustration, sadness).
6. Engaging in self-assessment of my clinical effectiveness.
7. Identifying ways to increase my clinical effectiveness.
8. Reflecting on how I apply theory to clinical practice.
9. Reflecting on how I apply research to clinical practice.
10. Reflecting on the quality of the therapeutic alliance/relationship.
11. Reflecting on the interventions I use while conducting therapy.
12. Reflecting on supervisor feedback
13. Reflecting on the influence of my clients' multicultural identities.
14. Maintaining a journal about my conduct of psychological treatment.
15. Reviewing recordings of my conduct of psychological treatment.
16. Reflecting after each therapy session in addition to writing a therapy note.
17. Reflecting on what is needed from supervision or consultation?
18. Reflecting on self-care.
19. I have not engaged in any of the above practices.
20. Other_____.

1. _____
2. _____
3. _____

Please provide answers to the following questions. The questions below are designed to be answered quickly and briefly.

1. Do you experience barriers to engaging in reflective practice? Please describe these below.

2. If applicable, how has your engagement in reflective practice been helpful to your clinical practice?

APPENDIX C

Reference List for Items on the Reflective Practice Survey

RPS ITEM	Reference
Item 1	Collins et al., 2010; Dewey, 1933; Fouad et al., 2009; Hoshmand, 1994; Scaife, 2010.
Item 2	Collins et al., 2010; Dewey, 1933; Fouad et al., 2009; Peterson et al., 2006; Scaife, 2010.
Item 3	Dallos & Stedmon, 2010; Fouad et al., 2009; Neufeldt et al., 1997; Orchowski et al., 2010.
Item 4	Dallos & Stedmon, 2010; Fouad et al., 2009; Neufeldt et al., 1997; Orchowski et al., 2010.
Item 5	Dallos & Stedmon, 2010; Fouad et al., 2009; Neufeldt et al., 1997; Orchowski et al., 2010.
Item 6	Fouad et al., 2009; Kaslow et al., 2007.
Item 7	Fouad et al., 2009; Kaslow et al., 2007; Neufeldt et al., 1997.
Item 8	Fouad et al., 2009; Kaslow et al., 2007; Neufeldt et al., 1997.
Item 9	Dallos & Stedmon, 2010; Neufeldt et al., 1997; Orchowski et al., 2010; Scaife, 2010.
Item 10	Collins et al., 2010; Fouad et al., 2009.
Item 11	Fouad et al., 2009.
Item 12	Fouad et al., 2009; Hoshmand, 1994; Scaife, 2010.
Item 13	Moffet 2009; Neufeldt et al., 1997; Orchowski et al., 2010.
Item 14	Orchowski et al., 2010; Moffet, 2009.
Item 15	In communication with Dr. Shafranske.
Item 16	Fouad et al., 2009; Orchowski et al., 2010.
Item 17	Fouad et al., 2009.
Item 18	N/A

Item 19   Dallos & Stedmon, 2010; Neufeldt et al., 1997; Scaife, 2010.

Item 20   In communication with Dr. Shafranske.

APPENDIX D

Recruitment Letter to Training Directors

Subject: Invitation for Research Participation Open to Pre-doctoral Interns

Dear Training Director,

I am a doctoral student in clinical psychology at Pepperdine University. As part of my dissertation, I am studying the construct of reflective practice. My study includes an examination of the following: interns' engagement in reflective practice, the extent to which supervision facilitates reflective practice, and the reflective practices that are believed to contribute to clinical effectiveness. Finally, the study asks participants to comment about perceived barriers to reflective practice and how reflective practice is useful to clinical practice. I am contacting all APPIC-member internship sites and requesting their assistance with my study. It would be much appreciated if you would kindly forward this e-mail to your interns. The Institutional Review Board at Pepperdine University has approved this study. Information regarding participant demographics and program type will also be collected, although no personally identifying information will be collected. Completion time for this study is approximately 15-20 minutes.

If you have any questions or comments, please do not hesitate to contact me, at Rachel.fried@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, at eshafran@pepperdine.edu or Dr. Thema Bryant-Davis, Chairperson of the Pepperdine University Graduate and Professional Schools Institutional Review Board, at (310) 568-2389.

Thank you in advance for your assistance with the completion of this study.

Sincerely,
Rachel Fried, M.A.
Clinical Psychology Doctoral Student
Pepperdine University

https://www.surveymonkey.com/r/reflectivepracticeinterns

APPENDIX E

Recruitment Letter to Participants

Dear Psychology Intern,

I am a clinical psychology doctoral candidate at Pepperdine University conducting a study, as part of my dissertation, under the supervision of my dissertation chairperson, Edward Shafranske, Ph.D., ABPP. I am conducting a study on the construct of reflective practice, and how interns in training are being trained to think critically about their practice. Participation in this study entails completing an online survey about the following: interns' engagement in reflective practice, the extent to which supervision facilitates reflective practice, and the reflective practices that are believed to contribute to clinical effectiveness. Finally, the study asks participants to comment about perceived barriers to reflective practice and how reflective practice is useful to clinical practice. The survey is on the website SurveyMonkey. Information about your demographics and program type will also be collected; however, no personally identifying information will be collected. Participant anonymity will be protected through not obtaining information about IP addresses accessing the survey website. Furthermore, SurveyMonkey utilizes SSL (Secure Sockets Layer), a protocol developed to create a secure, encrypted, connections. This study has been approved by the Institutional Review Board at Pepperdine University. I really hope that you will consider being a part of this study. I believe that as a pre-doctoral intern, you can offer valuable information and insights that can inform the field of psychology about how to best educate and train reflective practitioners. I would greatly appreciate your assistance with my study. Participation in this study is entirely voluntary and is expected to take no more than 15-20 minutes. Participation is open to all current pre-doctoral psychology interns. Please feel free to forward this invitation to any psychology interns you know. A link to the web address of the surveys can be found below this message. Upon completion of this study, you will have the opportunity to be entered into a drawing for one of three $25 gift certificates to Amazon.com.

Thank you in advance for your assistance with the completion of this study.

Sincerely,
Rachel Fried, M.A.
Clinical Psychology Doctoral Student
Pepperdine University

https://www.surveymonkey.com/r/reflectivepracticeinterns

APPENDIX F

Follow-up Letter to Training Directors

Dear Training Director,

A few weeks ago I sent you an invitation for study participation to be forwarded to your interns. If you have not forwarded this invitation to your interns, I hope that you will consider forwarding this invitation so your interns may have the opportunity to inform the education and training of future trainees in reflective practice. If you have already forwarded this invitation to your interns, I truly appreciate you taking the time to do so. Information about the study sent in my previous correspondence can be found below.

I am a doctoral student in clinical psychology at Pepperdine University. As part of my dissertation, I am studying the construct of reflective practice. My study includes an examination of the following: interns' engagement in reflective practice, the extent to which supervision facilitates reflective practice, and the reflective practices that are believed to contribute to clinical effectiveness. Finally, the study asks participants to comment about perceived barriers to reflective practice and how reflective practice is useful to clinical practice. I am contacting all APPIC-member internship sites and requesting their assistance with my study. It would be much appreciated if you would kindly forward this e-mail to your interns. The Institutional Review Board at Pepperdine University has approved this study. Information regarding participant demographics and program type will also be collected, although no personally identifying information will be collected. Completion time for this study is approximately 15-20 minutes.

If you have any questions or comments, please do not hesitate to contact me, at Rachel.fried@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, at eshafran@pepperdine.edu or Dr. Thema Bryant-Davis, Chairperson of the Pepperdine University Graduate and Professional Schools Institutional Review Board, at (310)568-2389.

Thank you in advance for your assistance with the completion of this study.

Sincerely,
Rachel Fried, M.A.
Clinical Psychology Doctoral Student
Pepperdine University

https://www.surveymonkey.com/r/reflectivepracticeinterns

APPENDIX G

Follow-up Letter to Participants

Dear Psychology Intern,

A few weeks ago I sent you an invitation for study participation. If you have not completed this brief survey, I hope that you will consider participating in this opportunity to inform the education and training of future trainees in reflective practice. If you have completed the survey, I truly appreciate you taking the time to do so. The link to access the survey and information about the study sent in my previous correspondence can be found below.

I am a clinical psychology doctoral candidate at Pepperdine University conducting a study, as part of my dissertation, under the supervision of my dissertation chairperson, Edward Shafranske, Ph.D., ABPP. I am conducting a study on the construct of reflective practice, and how interns in training are being trained to think critically about their practice. Participation in this study entails completing an online survey about the following: interns' engagement in reflective practice, the extent to which supervision facilitates reflective practice, and the reflective practices that are believed to contribute to clinical effectiveness. Finally, the study asks participants to comment about perceived barriers to reflective practice and how reflective practice is useful to clinical practice. The survey is on the website SurveyMonkey. Information about your demographics and program type will also be collected; however, no personally identifying information will be collected. Participant anonymity will be protected through not obtaining information about IP addresses accessing the survey website. Furthermore, SurveyMonkey utilizes SSL (Secure Sockets Layer), a protocol developed to create a secure, encrypted, connections. This study has been approved by the Institutional Review Board at Pepperdine University. I really hope that you will consider being a part of this study. I believe that as a pre-doctoral intern, you can offer valuable information and insights that can inform the field of psychology about how to best educate and train reflective practitioners. I would greatly appreciate your assistance with my study. Participation in this study is entirely voluntary and is expected to take no more than 15-20 minutes. Participation is open to all current pre-doctoral psychology interns. Please feel free to forward this invitation to any psychology interns you know. A link to the web address of the surveys can be found below this message. Upon completion of this study, you will have the opportunity to be entered into a drawing for one of three $25 gift certificates to Amazon.com.

Thank you in advance for your assistance with the completion of this study.

Sincerely,
Rachel Fried, M.A.
Clinical Psychology Doctoral Student
Pepperdine University

https://www.surveymonkey.com/r/reflectivepracticeinterns

Pepperdine University IRB Submission

PEPPERDINE IRB
Application for a Claim of Exemption

Date: 2/9/15   IRB Application/Protocol #:

Principal Investigator: Rachel Fried
        ☐ Faculty   ☐ Staff   ☒ Student   ☐ Other
School/Unit: ☐ GSBM   ☒ GSEP   ☐ Seaver   ☐ SOL   ☐ SPP
              ☐ Administration   ☐ Other:
Street Address:
City: State: Zip Code:
Telephone (work):   Telephone (home):
Email Address:

Faculty Supervisor: **Edward Shafranske** *(if applicable)*
School/Unit: ☐ GSBM   ☒ GSEP   ☐ Seaver   ☐ SOL   ☐ SPP
              ☐ Administration   ☐ Other:
Telephone (work): (   )   -
Email Address:

Project Title: The Use of Reflective Practices By Psychology Interns
Type of Project (Check all that apply):
         ☒ Dissertation   ☐ Thesis
         ☐ Undergraduate Research   ☐ Independent Study
         ☐ Classroom Project   ☐ Faculty Research
         ☐ Other:

Is the Faculty Supervisor Review Form attached? ☒Yes   ☐No   ☐N/A

Has the investigator(s) completed education on research with human subjects? ☒ Yes   ☐ No
Please attach certification form(s) to this application.

Investigators are reminded that Exemptions will NOT be granted for research involving prisoners, fetuses, pregnant women, or human in vitro fertilization. Also, the exemption at 45 CFR 46.101(b)(2), for research involving survey or interview procedures or observations of public behavior, does not apply to research with children (Subpart D), except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

1.   Briefly summarize your proposed research project, and describe your research goals/objectives.

The purpose of this dissertation is to explore and better understand trainee engagement in reflective practice, within the field of psychology. Reflective practice can be defined as using focused inquiry to increase personal and professional self-awareness. The goal is for the professional to attain a comprehensive understanding of his or her work and to increase competency in practice (Skovholt, Ronnestad, & Jennings, 1997; Fouad et. al., 2009; Nelson & Neufeldt-Allsetter, 1998). Within the field of psychology there has been increased attention placed on reflective practice in the context of training. This came about through a series of conferences focused on developing professional competencies for psychologists in training (Epstein and Hundert, 2002; Kaslow et al., 2007; Rodolfa et. al., 2002; Fouad et al., 2009). Through the work of dedicated workgroups, reflective practice came to be recognized as a foundational competency for psychologists in training. It is a marker of readiness at various levels of training, including readiness for practicum, internship, and entry into practice (Fouad et al., 2009). Much of the discussion on reflective practice within the field of psychology occurs within the context of clinical supervision (Orchowski et. al; 2010, Moffet, 2009; Ward & House, 1999; Neufeldt, Karno, and Nelson, 1996). Supervision is where habits of practice are developed and thus it is the most advantageous context to foster reflective practice (Neufeldt et al., 1996).

Although the field of psychology has acknowledged the importance and need to train critically thinking practitioners, little is actually known about trainee engagement in reflective practice. Furthermore, it is suggested that reflective practice can be an overwhelming and anxiety provoking experience. Fears of appearing incompetent and the discomfort associated with looking at personal vulnerabilities can be an impediment to engaging in reflective practice (Scaife, 2010; Orchowski, Evangelista, & Probst, 2010). Moreover, a sizable body of research demonstrates that supervisees often fail to disclose information to their supervisors (Coburn, 1997; Ladany, Hill, Corbett, & Nutt, 1996), or choose to discuss topics that produce only positive impressions of their work, as opposed to negative ones (Ward, Freidlander, Schoen, & Klein, 1985). This would limit the potential of engaging in effective reflective practice within the context of supervision. This dissertation has as its aim to survey psychology interns in order to assess the following: psychology interns' frequency of engagement in reflective practice and how this may differ based on clinical challenge and perceived competency; the extent to which reflective practice is being encouraged in clinical supervision; how reflective practice relates to clinical effectiveness; and barriers that are believed to prevent engagement in reflective practice.

The Reflective Practices Survey was created specifically for this study and developed in three primary stages. First, a critical review of the literature on reflective practice within psychology was undertaken. This was done in order to identify the behavioral practices that psychology discusses as being central to reflective practice. In the second stage, an expert panel reviewed the survey to determine the validity of the survey (i.e. face, content, and construct validity). In the third stage a small pilot study was done with 12 third year Pepperdine doctoral students, in a psychology practicum course, to ensure that the survey items were clear and understandable. Based on feedback from students and further consultation with the expert panel, the survey was further refined.

In order to study the aforementioned research questions, the proposed study will utilize a survey approach to the collection of both qualitative and quantitative data. The quantitative analysis portion will utilize descriptive statistics in order to study the following: behavioral practices of reflective practice being utilized and the frequency of engagement in these practices; the reflective practices currently being encouraged in supervision; and the reflective practices viewed as enhancing clinical effectiveness. Qualitative analysis will be used in order to understand how interns believe reflective practice enhances their clinical effectiveness, as well as, the barriers to engagement in reflective practice. This will be done through a content analysis searching for common themes in participant's answers. Finally, correlational analysis and regression analysis will be used to look at the relationship between participant characteristics and frequency of engagement in reflective practice (please see attached Demographic Questionnaire for relevant questions). Correlational analysis will also be used to look at whether supervisor encouragement of supervisee engagement in reflective practices relates to frequency of supervisee engagement in these practices.

The hope is that this dissertation will lay the groundwork for the development of a functional model of reflective practice for psychologists in training.

2.   Using the categories found in Appendix B of the Investigator Manual, list the category of research activity that you believe applies to your proposed study.

The proposed research involves survey procedures with a non-protected adult population. No identifying information is being collected through the survey, and the study presents no more than minimal risk to participants. Disclosure of the data outside of the study would not place participants at risk of criminal/civil liability, or damage to their financial standing, employability or reputation, and no deception is being used. Therefore, the study appears to be exempt based on 45 CFR 46.101 (b) (2).

3.   Briefly describe the nature of the involvement of the human subjects (observation of student behavior in the classroom, personal interview, mailed questionnaire, telephone questionnaire, observation, chart review, etc):

Participants recruited for this study will be interns participating in clinical, counseling, school, or combined psychology APA accredited internship programs. This population was chosen, in particular, because the purposes of this dissertation is to better understand how the field of psychology is training its students to be reflective practitioners. Given that the internship year represents the transition from student to professional psychologist, understanding how interns are approaching reflective practice will take into account the overall training practices of the field.

Participants will be recruited from internship sites with membership in the Association of Psychology Postdoctoral and Internship Centers (APPIC). The training directors at these sites will be contacted via email through the email list set forth in the APPIC directory. Training directors will be asked to forward to their current interns a link to the secure web-based instrument, which will be housed on SURVEYMONKEY.com. Invitations to participate in the study will also be posted on APPIC listservs, which are widely used by

doctoral interns. These announcements will also ask recipients to forward the invitation to any pre-doctoral intern who meets eligibility for the study. In order to incentivize participation and provide compensation, research participants will be given the opportunity to enter a drawing to receive one of three 25 dollar Amazon gift cards for their participation (Hoonakker & Carayon, 2009).

In order to ensure that participants do not complete the survey multiple times due to receiving the invitation to participate more than once, the web-program housing survey will allow each computer IP address to access the survey once. IP addresses will not be recorded in order to protect participant anonymity. This will be ensured through turning off the function within SurveyMonkey that collects IP addresses, prior to the collection of any survey responses (screen shot of this attached). This function is called 'Make Anonymous' and ensures that respondent IP addresses are not stored. Furthermore, SurveyMonkey utilizes SSL (Secure Sockets Layer) which is a protocol developed for transmitting private documents or information via the Internet. SSL creates a secure connection, encrypting sensitive information being transmitted through the web page. The survey is expected to take no longer than 15-20 minutes. In order to assess whether engagement in reflective practice differs based on clinical challenge and perceived competency, participants go through the survey items three separate times, each time answering the questions based on a different patient (i.e. (1) a case in which the therapeutic work is going well, (2) a clinically challenging case in which the therapeutic work is going well, and (3) a clinically challenging case in which the therapeutic work is not going well and you feel ineffective). Participants are also asked to answer all questions based on what they have done in the past month. A time limit was imposed on the survey given research on the limits of personal recall in retrospective self-report surveys (Pearson, Ross, and Dawes, 1992).

The survey has three sections. The first section of the survey consists of 20 self-report survey items. Each item represents a behavioral element of reflective practice (e.g. "I devote time to examine my personal beliefs and values "; "I devote time to the self-assessment of my clinical skills"). Participants are asked to endorse how often they engaged in each item, over the course of the past month, choosing from, never, once per month, more than once per month, or every week. The second part of the survey lists the reflective practices and participants are asked to check-off the practices that have been strongly encouraged in their supervision, over the course of their internship year. Finally, in the third section, participants are asked to identify one to three reflective practices, from a list of all the reflective practices, which they believe have had the greatest impact on their clinical effectiveness as psychotherapists. The final part of the survey has a qualitative component. It is intended to gather more detailed and in-depth information about the intern's beliefs about reflective practice, which is not easily captured through a quantitative approach. The two questions presented deal with the participants' beliefs about how reflective practice is helpful to clinical practice and whether there are perceived barriers towards engagement in reflective practice.

APPIC reports that 3,326 students matched through the Phase I and Phase II match process in the 2013-2014 training year (APPIC November 20, 2013

http://www.appic.org/Match/MatchStatistics/MatchStatistics2013Combined.aspx).
Based on the number of individuals in the actual population, it is believed that 353
participants is a sufficient sampling, in order to achieve adequate power, to run statistical
analysis (Israel, 1992). However, there is no way to determine how many potential study
participants will actually receive the web-based instrument. Therefore an exact number
of desired participants cannot be determined. Furthermore, given that the current study is
not based on any prior research, it is difficult to establish an aspirational quantity for the
number of participants hoped to be recruited to this study.

4. Explain why you think this protocol should be considered exempt. Be sure to address all
known or potential risks to subjects/participants.

It is believed that this protocol should be considered exempt, as this study poses no more
than minimal risk to participants. Identifying information is not being collected and the
study items should not cause anything more than minimal distress, if any at all (discussed
below). Furthermore, participant anonymity will be fully protected by not obtaining
information about IP addresses accessing the survey website. This will be ensured
through turning off the function within SurveyMonkey that collects IP addresses, prior to
the collection of any survey responses. This function is called 'Make Anonymous' and
ensures that respondent IP addresses are not stored. Furthermore, SurveyMonkey utilizes
SSL (Secure Sockets Layer) which is a protocol developed for transmitting private
documents or information via the Internet. SSL creates a secure connection, encrypting
sensitive information being transmitted through the web page.
Also, participants will be fully informed about study's purpose and procedures prior to
taking the survey (i.e. estimated completion time, how participant confidentiality will be
protected, potential risks and benefits in participation, the voluntary nature of
participation, and that participation can be discontinued at any point).
In regard to potential risks, the study's risks include: inconvenience due to time spent in
participation (approximately 15 minutes-20 minutes), fatigue, boredom, and the potential
for distressing reactions related to feelings of disappointment or incompetency for not
being exposed to the idea of reflective practice or using reflective skills in practice.
Potential risks will be minimized by making the study as user-friendly and convenient as
possible, through not asking for any identifying information and by suggesting that in the
event of a distressful reaction to the study, participants should seek assistance to deal
with the distress. Participants will be given the name and contact information of the
researcher and the study advisor. They will also be advised to contact a clinician if they
experience distress as a result of their participation in the study. If the researcher or study
advisor is contacted, a psychotherapy referral will be given through contacting the local
psychological association in the participant's areas.

Participants may have no direct benefit from the proposed study. However, it is believed
that this study will give participants information about how to enhance their reflective
practice, which is a foundational competency (Fouad et al., 2009). Furthermore, it is
believed that this study will provide benefit to the training of future trainees in reflective
practice.

5. Explain how records will be kept.

    The data collected will be kept confidential, and will not be linked to any confidential information. As mentioned, data will be collected through a web-based survey instrument, called SurveyMonkey. The data for this study will be stored on an external drive, and destroyed, by the investigator, five years after the completion of this study. In regard to the gift card drawing, participants will provide consent to be contacted by email if they win a gift card and also state understanding that their anonymity may be compromised by entering into the drawing. However, email addresses will not be linked to survey responses and will be destroyed once the certificates have been awarded.

6. ☐ Yes ☒ No   Are the data recorded in such a manner that subjects can be identified by a name or code? If yes:
    - Who has access to this data and how is it being stored?
    - If you are using a health or mental health assessment tool or procedure, what is your procedure for referring the participant for follow-up if his/her scores or results should significant illness or risk? Please describe.
    - Will the list of names and codes be destroyed at the end of the study? Explain your procedures.

    Only the principal investigator will have access to the data for this study. The data will be stored on an external hard drive and destroyed, by the investigator, five years after the completion of the study.

7. Attach a copy of all data collection tools (e.g., questionnaires, interview questions or scripts, data collection sheets, database formats) to this form. Be sure to include in such forms/scripts the following information:
    - a statement that the project is research being conducted in partial fulfillment of the requirements for a course, master's thesis, dissertation, etc. (if applicable)
    - purpose of study
    - a statement that subjects' responses will be kept anonymous or confidential (explain extent of confidentiality if subjects' names are requested)
    - if audiotaping or videotaping, a statement that subject is being taped (explain how tapes will be stored or disposed of during and after the study)
    - a statement that subjects do not have to answer every question
    - a statement that subject's class standing, grades, or job status (or status on an athletic team, if applicable) will not be affected by refusal to participate or by withdrawal from the study (if applicable)
    - a statement that participation is voluntary

    Please note that your IRB may also require you to submit a consent form or an **Application for Waiver or Alteration of Informed Consent Procedures form.** Please contact your IRB Chairperson and/or see the IRB website for more information.

8.   Attach a copy of permission forms from individuals and/or organizations that have granted you access to the subjects.

9.   ☐Yes ☒No Does your study fall under HIPAA? Explain below.

   9.1 If HIPAA applies to your study, attach a copy of the certification that the investigator(s) has completed the HIPAA educational component. Describe your procedures for obtaining Authorization from participants. Attach a copy of the Covered Entity's HIPAA Authorization and Revocation of Authorization forms to be used in your study (see Section XI. of the Investigator Manual for forms to use if the CE does not provide such forms). If you are seeking to use or disclose PHI without Authorization, please attach the **Application for Use or Disclosure of PHI Without Authorization** form (see Section XI). Review the HIPAA procedures in Section X. of the Investigator Manual.

I hereby certify that I am familiar with federal and professional standards for conducting research with human subjects and that I will comply with these standards. The above information is correct to the best of my knowledge, and I shall adhere to the procedure as described. If a change in procedures becomes necessary I shall submit an amended application to the IRB and await approval prior to implementing any new procedures. If any problems involving human subjects occur, I shall immediately notify the IRB Chairperson.

_____   _____
Principal Investigator's Signature   Date

_____   _____
Faculty Supervisor's Signature   Date
(if applicable)

Appendices/Supplemental Material

Use the space below (or additional pages and/or files) to attach appendices or any supplemental materials to this application.