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Novice clinicians and the experience of transcendence in clinical training and supervision

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NOVICE CLINICIANS AND THE EXPERIENCE OF TRANSCENDENCE IN CLINICAL TRAINING AND SUPERVISION

A clinical dissertation submitted in partial satisfaction
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Doctor of Psychology

by

Alberto Luis Ibarra

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Joan Rosenberg, Ph.D. – Dissertation Chairperson

This dissertation, written by

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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

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DEDICATION

Por la fuerza que nos dan los que nos protegen del cielo, y el amor que se siente con los que seguimos en la tierra.

ACKNOWLEDGEMENTS

This journey has been a gauntlet of trials that many have faced before me, and many more will face once I am done. Along the way there have been many individuals that have maintained me afloat as I ventured into the perils of writing a dissertation. This is a trial of love, a trial of commitment, and a trial of patience forged and measured by the pen. A few words here will never do justice to the guidance, support, and influence so many have had during this time.

Without the love of my family I would not be the man I am today, nor would I be standing where I am. The support from my wife, the love and lessons from my parents, and the laughs and smiles from my sister, brother-in-law, and nephews.

Over the past few years I would have been lost without the encouragement of my wife who endured hundreds of hours of me gazing into oblivion in front of a book, article or screen, somehow always at my side to encourage me when I was at my best, and motivate me when I was at my worst.

My parents were my first teachers, and the first ones to guide my emergence as a whole human being. They were the first to highlight the importance of family and hard work – with compassion and love for myself and for others. It was their love for each other, and their love for me, that inspires me every day.

The laughs and joy came from my nephews, my sister, and brother-in-law, who were there to help me feel the joy of the world. I could always count on them to be there for me. They reminded me that sometimes I needed to stop, laugh, and be silly.

Dr. Joan Rosenberg was a mentor across my professional journey, at times poignantly reminding me of the delicate intersection between personal and professional development. The guidance, late hours, and caring redirection even when I made (big) mistakes taught me that love and kindness are always gateways to learning opportunities. My committee members stumbled through this process with me, providing an image of professionalism and support that I aspire to, even when I precariously fumbled and failed. Their dedication and flexibility inspired me to pay it forward with future students that come to me seeking guidance.

It was my colleagues that stared into the abyss for four years with me, venturing straight into the wild to see what fate held for us. We survived, mostly intact, and I could never have done it without the laughs, the tears, and everything in-between.

And looking towards the beyond, and to all that I have crossed paths with, both brief or lasting, in some small way we have influenced each other's path for better or worse and I will always cherish that.

VITA

Alberto Ibarra

EDUCATION

Bachelor of the Arts, **Psychology**, 2009
California State University, Long Beach
Emphasis: Clinical Psychology

Master of the Arts, Psychology, 2011
Pepperdine University Graduate School of Education and Psychology, Los Angeles
Emphasis: Clinical Psychology

Doctor of Psychology, Clinical Psychology, Anticipated February 2017
Pepperdine University Graduate School of Education and Psychology, Los Angeles

LANGUAGE SKILLS

English and Spanish (*Fluent: Speaking, Reading, and Writing*)

DOCTORAL-LEVEL CLINICAL EXPERIENCE

09/2015 – 09/2016 ***Zuckerberg San Francisco General Hospital and Trauma Center***
Child and Adolescent Services - Clinical Doctoral Intern

- Supervision specializing in multicultural competency and trauma recovery under Betsy Wolfe, PhD
- Average case load of 10-12 patients in outpatient settings with a wide range of clinical diagnosis, focused primarily on domestic trauma and medical trauma.
- Subspecialty in pediatric consultation-liaison through continuity clinic, resident continuity clinic, urgent care, asthma clinic, and intensive care unit.
- Subspecialty in outpatient administration and clinical program development.
- Treatment planning, psychological intakes, outpatient therapy and psychology assessments.
- Systems used include Avatar, CANS, RedCap, and eClinicalWorks.
- Treatment planning, psychological intakes, outpatient therapy, neuropsychology assessments.

09/2015 – 08/2016 ***Zuckerberg San Francisco General Hospital and Trauma Center***
Child Trauma Research Project - Clinical Doctoral Intern

- Supervision in Child Parent Psychotherapy (CPP) under Laura Castro, PhD and Alicia Lieberman, PhD

- Specialty in trauma recovery and evidence-based practice.
- Focus on overlap between clinical work and clinical research.
- Psychological assessments, individual psychotherapy, and child-parent psychotherapy.

2014 – 2015 ***CHOC – Children's Hospital of Orange County***
*Neuropsychology Practicum Extern***:**

- Supervised in Neuropsychology and General Assessment in a medical setting by Grace Mucci, PhD
- Pediatric medical rotation (inpatient and outpatient)
- Treatment planning, intakes, medical modifications
- Bilingual (English/Spanish) assessment
- Administered: VMI-6, WAIS-IV, RCFT, CVLT, Grooved Pegboard, Trails, D-KEFS, TOMAL-2, CPT, CELF, WIAT-III, ROWPVT-4, EOWPVT-4

2013 - 2014 ***CHOC – Children's Hospital of Orange County***
Psychotherapy Practicum Trainee:

- Supervised in Latino Family Therapy and Individual Therapy with Latino/a patients in a medical setting by Alfonso Bustamante, PsyD
- Bilingual (English / Spanish) therapy
- Integrative family systems, CBT, and existential treatment modalities
- Patient age ranges from 4-22
- Training: 1-hour individual supervision, 1-hour case conference, 1 hour of bilingual training weekly.
- Treatment emphasized psychosocial factors related to medical conditions which included medical non-adherence, familial conflict, selective mutism, depression, anxiety, and the management of complex medical conditions.
- Additional training included one day a week in the pediatric hematology specialty clinic approaching treatment with an integrative team of physicians and nurses.

2012 – 2015 ***Pepperdine University Community Counseling Center***
Psychotherapy Practicum Trainee:

- Supervised in individual psychotherapy by Joan Rosenberg, Ph.D.
- Bilingual (English / Spanish) therapy
- Integrative biological neuroscience, humanistic, existential, cognitive-behavioral and psychodynamic approaches
- Patient age ranges from 18-65+
- Conducted formal intakes, treatment planning, provided individual, couples and family therapy.
- 1 hour of supervision, 1 hour of peer supervision, 2 hours of case conference and 4 eight-hour training programs.

- Treatment focused on outpatient populations including local college students and local community residents. Primarily addressed depression, anxiety, substance abuse, suicidal ideation and domestic disputes.

MASTER'S-LEVEL CLINICAL EXPERIENCE

2011 - 2012 ***Los Angeles County Department of Mental Health***
Neuropsychological Extern:

- Supervised in neuropsychological assessment by Brian Betz, Ph.D.
- Bilingual (English / Spanish) neuropsychological assessment
- Rotation emphasizing neuropsychological, psychoeducation, receptive and expressive language, and personality testing.
- Administered, scored, and interpreted measures including the WAIS-IV, WISC-IV, WPPSI-3, WJ-III-NU, CELF-4, TAPS-3, MMPI-A
- Rotation included administration, scoring testing data, generating preliminary case conceptualization, a weekly presentation and formal report writing detailing the assessment results
- 1 hour supervision, 1 hour didactic, 1 hour case conference

2011 - 2012 ***Long Beach Community Hospital***
Behavioral Health Worker:

- Inpatient psychiatric unit located within Community Hospital Long Beach, operated by MemorialCare.
- Managed day-to-day interactions with patients
- Facilitated group therapy, included art therapy, substance abuse groups, and music therapy
- Participated in behavioral rapid response team to respond to hospital-wide behavioral situations which extended beyond the behavioral health unit.

2007 - 2010 ***Therapy Dogs International***
Animal-Assisted Therapist:

- Training included time in Metropolitan State Hospital, California
- Applied AAT techniques to late stage schizophrenic patients which were adapted for use at Orange Coast Memorial Hospital with the launch of its Therapy Dog Volunteer program for high-functioning patients

TEACHING EXPERIENCE

2011 ***Pepperdine Graduate School of Education and Psychology, Los Angeles***
*Teaching Assistant**:***

- Directly worked with graduate level students at the Masters level psychopathology course.
- Assisted in the development of the class syllabus, grading material, developing criteria design, writing exams, proctoring classes, tutoring students on specific course topics, and guest lecturing in the class.

- Created, maintained, and updated course database for grade documentation and student progress.

2010 ***Pepperdine Graduate School of Education and Psychology, Los Angeles***
Teaching Assistant:

- Directly worked with graduate level students at the Masters level social psychology course.
- Assisted in the development of the class syllabus, grading material, developing criteria design, writing exams, proctoring classes, tutoring students on specific course topics, and guest lecturing in the class.
- Created, maintained, and updated course database for grade documentation and student progress.

2009 ***Pepperdine Graduate School of Education and Psychology, Los Angeles***
Teaching Assistant:

- Directly worked with graduate level students at the Masters level theories of learning course.
- Assisted in the development of the class syllabus, grading material, developing criteria design, writing exams, proctoring classes, tutoring students on specific course topics, and guest lecturing in the class.
- Created, maintained, and updated course database for grade documentation and student progress.

COMMUNITY OUTREACH EXPERIENCE

2014 ***Pepperdine Graduate School of Education and Psychology, Irvine***
*Panelist***:**

- Presented to Master's level students on how to apply to doctoral programs
- Engaged in panel discussion on self-care, professional development, and establishing goals as a clinician in the field of Psychology.
- Discussed effective techniques in time management and productivity

2013 ***Pepperdine Graduate School of Education and Psychology, Irvine***
*Panelist***:**

- Presented to Master's level students on how to apply to doctoral programs
- Engaged in panel discussion on self-care, professional development, and establishing goals as a clinician in the field of Psychology.

May 2013 ***CSP: Community Service Programs Adolescent Shelter***
*Presenter***:**

- Presented to staff members and to current adolescent residents
- Discussed topics of safe environments, engaging in productive dialogue, training for effective and best-practice supervision, and the development of open communication.
- Population consisted primarily of displaced adolescents experiencing emotional challenges, traumatic histories, and depressive symptoms.

RESEARCH EXPERIENCE

2014 ***Children's Hospital Orange County***
Researcher
- Conducted research and interviews under David Buchbinder, M.D.
- Research focused on the psychosocial factors in long-term oncology cases with pediatric patients and their families.
- Interviews were conducted in English and Spanish

2013 ***Pepperdine University, Irvine***
Lead Researcher
- Lead author and researcher on a meta-analysis to understand, identify, and define concepts of aggression and violence as it relates to violent media, specifically video games.

2013 ***Pepperdine University, Los Angeles***
Researcher
- First author and investigator on a research project addressing personal and professional development in supervision
- Emphasis is on early career psychologists and novice clinicians currently in training.

PSYCHOLOGICAL TESTING

Proficiency in the following Psychological and Neuropsychological Assessment Tools

- Wechsler Adult Intelligence Scale 4th Edition (WAIS-IV)
- Wechsler Intelligence Scale for Children 4th Edition (WISC-IV)
- Wechsler Individual Achievement Test 3rd Edition (WIAT-III)
- Wechsler Preschool and Primary Scale of Intelligence 3rd Edition (WPPSI-III)
- Minnesota Multiphasic Personality Inventory 2nd Edition (MMPI-2)
- Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)
- Rorschach Test
- Thematic Apperception Test (TAT)
- Woodcock Johnson Test of Achievement (WJ-A)
- Beery-Buktenica Developmental Test of Visual-Motor Integration, 6th edition (VMI)
- Wide Range Achievement Test 4 (WRAT-4)
- Rey-Osterrieth Complex Figure (RCFT)
- California Verbal Learning Test (CVLT)
- Grooved Pegboard
- Delis-Kaplan Executive Function System (D-KEFS)
- Test of Memory and Learning: 2nd Edition (TOMAL-2)
- Conners' Continuous Performance Test II (CPT-II)
- Clinical Evaluation of Language Fundamentals 4th Edition (CELF-4)
- Receptive One-Word Picture Vocabulary Test 4th Edition (ROWPVT-4)
- Expressive One-Word Picture Vocabulary Test 4th Edition (EOWPVT-4)
- Woodcock Johnson (WJ)
- Test of Auditory Processing Skills 3rd Edition (TAPS-3)

OTHER EXPERIENCE

2009 ***Pepperdine University, Los Angeles***
Graduate Assistant: Provided psychological assessment and testing material to students and faculty. Coordinated and organized assessment system, database, and tutored students in the use and scoring of various assessments. Organized new student orientation and introduced new students into the psychology program.

PUBLICATIONS

American Psychological Association Posters

Presented

Ibarra, A., Armstrong, L., Dubs, W., Faith, A., Markowitz, S., Walker, A. (2013) *Call for a Paradigm Shift in Clinical Training: The Personal Transformation of Novice Clinicians*.

Books

In Progress

Ibarra, A. (2017) *Impact of Living a Digital Life*

Editorials

Published

Ibarra, A. (2013) *Deconstructing Video Game Research*

Ibarra, A. (2013) *The Psychology of the Tatau*.

Ibarra, A. (2013) *An Analysis of Brothers*

AFFILIATIONS

2013 – Current	American Psychological Association, Division 17, *Student Affiliate*
2010 – Current	Psi Chi Honors Society, *Member*
2007 – Current	American Psychological Association, *Student Affiliate*
2007 – 2010	Therapy Dogs International, *Animal Assisted Therapist*
2004 – Current	Orange Coast Memorial Gala Foundation, *Sponsor*
2000 – Current	Komen's Race for the Cure, *Volunteer*

HONORS & AWARDS

Student Poster Award: APA Division 17 - 2013
Psi Chi Honors Society, 2009

OTHER SKILLS AND HOBBIES

Fluent	Spanish (Castellan): Speaking, Reading, Writing
Proficient	Photography, Marketing and Design
Fluent	Marketing and Business Consultation
Hobby	Video Games, Recreational Ice Hockey

ADDITIONAL TRAINING

09/2015	Healthcare Provider Basic Life Support, Updated
09/2014	Healthcare Provider Basic Life Support, Updated
01/2012	Healthcare Provider Basic Life Support
3/2012	Management of Assaultive Behavior, *MemorialCare*

ABSTRACT

This autoethnographic study, from the perspective of novice clinicians, used a directed, or deductive, qualitative content analysis to explore the presence of transcendent experiences, as one aspect of personal growth for three first year clinical psychology doctoral students. A total of fifty-three journal entries describing critical moments during their first-year clinical training and supervision experience were used for this study. Coding categories for transcendence that reflected the quality of "being more" were drawn from existing literature. In descending order of frequency, results from this exploratory study found that transcendence was experienced by these trainees, centered first and predominantly on capacity (or competence), followed by themes involving: the pursuit of truth, the emergence of altruism, the development of self-identity, reflections beyond the self, awe and spirituality and finally, growth through peak experiences. The findings are discussed as they relate to current literature, along with limitations, implications and recommendations, and this author's personal reflections.

Chapter I – Overview of the Study

The role of psychologists has shifted over time from researchers and academicians to direct service providers, yet throughout this transition clinical training and education approaches have struggled to adequately identify and respond to the needs of their trainees (Abt, 1992; Farreras, 200; Routh, 2000). Initially, clinical training as a psychologist utilized the medical model approach, one that involves competency based training firmly rooted in ethics, knowledge, skill acquisition, and self-reflection as the primary measures of evaluation (Falender & Shafranske, 2012a; Fouad et al., 2009; Ibarra et al., 2013; Kaslow et al., 2004; Rodolfa et al., 2005; Rubin et al., 2007). However, this competency based medical model is lacking in effectiveness; the personal development needs of trainees are not fully addressed and trainees often remain unaware of how the self plays a role in both their professional and personal development (Edwards, 2013; Falender & Shafranske, 2012; Saito, 2005; Watkins, 2011; Watkins, 2012; Wilcoxon, Norem, & Magnuson, 2005).

The focus for trainees and professionals alike has relied on American Psychological Association (APA) benchmarks and competency-based training where the expectation is to develop, nurture, and grow self-awareness and self-reflection, which are keystones of personal development (APA, 2002a; Eva & Regehr, 2008; Falender & Shafranske, 2012a, 2012b; Fouad et al., 2009; Watkins Jr., 2012). Development of the self is considered an aspect of resilience throughout vulnerable clinical experience, and is also a measure of a novice trainee's capacity to learn (Ellis, Hutman, Chapin, 2015; Warren, Morgan, Morris, & Morris, 2010).

Yet, educational and training models continue to struggle with how to incorporate attention to personal factors (e.g., curiosity, presence and self-awareness) within curricula, due to the objective needs of academic programs (Epstein & Hundert, 2002; Kaslow et al., 2007). The

current emphasis remains firmly on theoretical orientations within training models, and does not focus on the development of the person (Wilkins, 2006). The high resource cost of attending to personal factors within clinical training, inconsistent established guidelines, and fear of cultural and ethical repercussions remain the most significant barriers for these programs (Jacobs, et al., 2011; Kaslow, et al., 2007; Shen-Miller, Forrest, & Burt, 2012; Veilleux, VanderVeen, January, Felice Reddy, & Klonoff, 2012). The reluctance to address the personal needs and development of a trainee then shifts the responsibility from the program to the trainee, adding undue burden to an already stressful environment (Rosenberg, et al., 2005; Veilleux et al., 2012).

Role of Personal Development

Much earlier, Freud (1912) and Rogers (1961) identified personal development as an important element that helped facilitate change in another. Rogers (1961) recognized that counselors were able to maintain the growth of others (the client), only as far as the counselor themselves could grow. Likewise, Falender and Shafranske (2012) have noted that personal growth is necessary for effective clinical work. However, training programs are not required to incorporate personal development, or actively engage in, train, or educate students about the value of self-reflection nor on personal and professional growth.

Calls for more and meaningful additional research that focuses on interpersonal skills, self-care, self-reflection, and self-awareness have been made (Grafanaki, 2010, p. 81). Researchers have called for more studies that identify the importance of personal development, the use of the self in training programs, and how to implement personal growth throughout training programs (Cain, 2007; Ellis, 1991; Folkes-Skinner, Elliott & Wheeler, 2010; Grafanaki, 2010; Heppner & Roehlke, 1984; Hill, Sullivan, Knox, & Schlosser, 2007; Ladany, 2007; Luke

& Kiweewa, 2010; Mathers, 2012; Orlinsky & Rønnestad, 2005; Rabinowitz, Heppner, & Roehlke, 1986).

There are, however, limited frameworks that currently integrate both personal and professional development within academic settings (Horner & Youngston, 2009; Wilkins, 2006). Only one very specific framework, the person-of-the-therapist (POTT), has attempted to develop a structure for exploring the self within a training setting (Aponte et al, 2009).

The importance of personal factors (known through aspects of an individual such as one's attitudes, beliefs, emotions, values, etc.) has been described in various studies including treatment outcomes (Nissen-Lie, Havik, Høglend, Monsen, & Rønnestad, 2013), the development of greater expertise (Hill et al., 2007), and the continuation of treatment through the reduction of dropout and client dissatisfaction (Roos & Werbart, 2013). As noted in a personal communication with Dr. C. Falender (September 17, 2014), despite the psychology field's shift of focus towards personal factors, there are an infinite range of personal factors that are relevant to the therapeutic process to consider, which simultaneously poses a concern, challenge and an opportunity. Such variability makes personal factors difficult to measure, but also allows for a broader, more culturally appropriate understanding of personal development throughout the field. One aspect of personal development, that of personal growth, as described through the experience of transcendence, or "being more", is the focus of this dissertation.

Transcendence

Transcendence is a term that has emerged with a wide range of definitions throughout history, and Westphal (2004) identified the biggest challenge to scholarly definitions in that, only through one's own reflections, can the term itself develop meaning. The term transcendence was conceptually understood as an emergence towards becoming greater than one is, to connect to

something greater than one is, or the pursuit towards becoming "more." Peterson and Seligman's (2004) re-definition of this concept marked a turning point in the view of transcendence.

'Emergence' is recognized as transformation, and this idea can be tracked back to 570 B.C. where ancient literature references self-transformation and understanding the self. In more recent time, transcendence has been interpreted as a spiritual pathway towards a greater power or being. For instance, Maslow (1968) and Frankl (1959) have emphasized the journey and growth of an individual to become something greater than he or she currently is. This concept of growth has often been associated with Rogers (1956), who suggested that a therapist can only take his or her client or patient as far as her or she can go, thus often eliciting a desire in the self to become something greater so one can elicit that something greater in others as well.

However, in 2004, this definition of transcendence shifted with Peterson and Seligman, who guided a movement towards defining transcendence through individual categories in positive psychology that focused on the appreciation of beauty, gratitude, hope, optimism, playfulness, humor, and spirituality. While their refinement captures the essence of growth as a whole, their definition of transcendence fails to capture the concept or essence of "becoming more".

Gaps in the Literature

Despite the discussion of transcendence occurring throughout history, whether ancient to modern, there is a glaring absence of discussion of transcendence in research literature, as it relates to clinical training and supervision of novice clinicians. For example, a review of literature conducted in October 2016, revealed through the PsycARTICLES search engine the following results using these broad key terms: (a) "Transcendence," 99 results, (b) "Transcendence" and "Training," 5 results, (c) "Transcendence" and "Supervision," 0 results.

Using a secondary search engine PsycINFO yielded the following: (a) “Transcendence,” 2,675 results, (b) “Transcendence” and “Training,” 103 results, (c) “Transcendence” and “Supervision,” 8 results.

As previously noted, clinical training programs have directed few resources and a very limited focus on personal development and personal growth within the programs themselves. Instead, there has been a shift towards the medical model, one that emphasizes competence in training with limited attention to personal development (Kaslow, et al., 2004). Training programs are encouraged though they are not required to incorporate such training, leading several authors to call for additional research on the effect of personal development and personal factors on one’s professional development (Grafanaki, 2010; Rønnestad and Skovholt, 2001; Rønnestad and Ladany, 2006; Skovholt & Rønnestad, 2003; Truell, 2001).

The APA ethics code has historically addressed the need and implied support for personal growth throughout various documents (APA, 2000; 2002b; 2007; 2013), where it references personal development as an aspect of clinical training that measures effectiveness, emphasizes self-awareness, and the expectation that self-reflection must be applied to prevent conflicts of competence in clinical care. In a similar manner, California statutes regarding the practice of psychology also recognizes interpersonal and personality implications for clinical work. For example, section 1396.1 states that psychologists will not undertake any activity where personal factors may result in “inferior professional services or harm to a patient or client” (Dept. of Consumer Affairs, 2012, p. 115). Even though the American Psychological Association at a national level and the State of California at a state level have addressed personal factors and personal growth by extension as important in the practice of psychology, this focus is largely absent in clinical training programs.

Definitions

This author has identified various terms throughout the research and historical pieces of literature that often overlap, are used interchangeably, or are recognized to have similar concepts and/or meanings. The following ideas are discussed throughout and the definitions provided below address a few that are most relevant to this research.

Being Human: The idea of "being human" is a self-reflection on an individual's purpose in life, with the goal of moving towards understanding growth and personal meaning in our personal and professional lives (Dean, 2002; Rogers, 1961).

Critical Incidents: A critical incident is defined as a significant event, activity, or situation that could be systematically described, observed, or elicited retrospectively and through which performance-related behaviors could be categorized and interpreted (Flanagan, 1954)

Novice Trainee: The terminology *novice trainee, novice clinician, novice counselor, novice therapist, trainee, student, extern, practicum trainee, early career psychologist, and intern* have been used interchangeably in the literature to identify a full-time student enrolled in a psychology training program, or early career professional receiving clinical supervision and the guidance of mentors. The difference between a novice trainee in their first year of practicum training compared to trainees with more experience (2nd year through internship) are minimal (Howard, Inman, & Altman, 2006).

Transcendence: Transcendence across the literature has been revised, understood, and reflected upon using a wide range of definitions. After extracting and summarizing definitions found in the research literature, transcendence, as used in this dissertation can be considered: ***as a meaningful and purposeful movement towards growth, and a greater connection to the self and towards others in an effort to become more*.** This definition coalesces the ideas that

transcendence: emerges out of the individual rising above the self and seeking meaningful self-existence and self-identity (Rychlak, 1980); the potential to go beyond the self at any given moment (Summers, 2012); the pursuit of truth over being right (Hora, 1987); the exploration and connection to higher powers beyond the self (Torrance, 1994); the sense of identity that extends beyond the self and connects to others (Clark, 1998); and the quality with which one brings awareness to the self and to those around us (Vago & David, 2012).

Growth: Growth as defined by Carl Rogers, is also known as growth tendency, a drive toward self-actualization, or forward-moving directional tendency (1961, Pg. 35). "[Growth] is the urge which is evident in all organic and human life – to expand, extend, become autonomous, develop, mature – the tendency to express and activate all the capacities of the organism, to the extent that such activation enhances the organism or the self" (Rogers, 1961, Pg. 35).

Purpose of this Study

The field of psychology has called for meaningful additional research that focuses on interpersonal skills, self-care, self-reflection, and self-awareness (Grafanaki, 2010, p. 81). Existing research that focuses on these skills and development describes the perspective of veteran clinicians who reflected on their previous needs and growth; it occurred through retrospective analysis rather than identifying these same factors in novice clinicians during and throughout their training experience (Carlsson, Norberg, Schubert, & Sandell, 2011; Rønnestad & Skovholt, 2001; Trotter-Mathison, Koch, Sanger, & Skovholt, 2010). The emphases of this retrospective analyses remained on the importance of competence, over the needs of the trainee as they adjusted into the field of clinical work (Folkes-Skinner et al., 2010).

Researchers clearly recognize the importance of personal development and how it directly impacts a clinician's capacity for facilitating change (Freud, 1912; Rogers, 1961; Warren

et al., 2010). Although personal development has been cited as a key element of a training experience and overall professional development (APA, 2002a; APA, 2002b), as well as an important tool in the development of culturally appropriate responsivity in supervision and training (Ancis & Ladany, 2001; Tinsley, 2015), novice trainees' personal development has been largely ignored. Despite earlier calls to address personal factors in the clinical training process (APA, 2002b; Eva & Regehr, 2008; Falender & Shafranske, 2012a; Falender & Shafranske, 2012b; Watkins, 2012) the focus on developing these aspects of the self remains limited in scope (Falender & Shafranske, 2012b; Grafanaki, 2010; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2001; Rønnestad & Ladany, 2006; Skovholt & Rønnestad, 2003; Truell, 2001). The need for such reflective practice then becomes an essential component of one's own development (Falender & Shafranske, 2012).

Across two decades, several researchers have emphasized the need for research in the area of personal growth and from the perspective of a trainee who is engaged actively in their own development (Auxier, Hughes & Kline, 2003; Bennett, 1986; Borders, 1989; Coleman, 2006; Ellis, 1991; Gibson, Dollarhide & Moss, 2010; Grafanaki, 2010; Hanna, Bemak & Chung, 1999; Hill et al., 2007; Matthews, 2012; Rønnestad & Ladany, 2006; Rønnestad & Skovholt, 2001; Skovholt & Rønnestad, 2003; Taubner, Zimmermann, Kachele, Moller & Sell, 2013; Thaeriault & Gazzola, 2010; Trotter-Mathison et al., 2010; Truell, 2001). However, personal growth of the novice clinician from his or her perspective has remained largely absent as a research focus.

As a first step in understanding the personal growth of a novice clinician, this qualitative dissertation explored the experience of transcendence from the perspective of three first year doctoral students engaged in clinical training and supervision, while enrolled in a clinical

psychology doctoral program. Content analysis of 53 personal journal entries completed by and collected from first-year novice trainees comprised the data set. Across a period of seven months, these three participants voluntarily completed one journal entry that, on average, were written approximately every two weeks. The journal entry described experiences throughout their training that reflected moments of personal growth.

The goal of this study was to identify experiences of transcendence as one element of personal growth from the perspective of novice clinicians as they occurred during clinical training and supervision. The author of this dissertation was one of the three participants contributing journal entries reflected in this study. This study was centered on the following research question:

1. Through self-reflection on critical incidents and moments in clinical training and supervision, do novice clinicians experience moments of transcendence as one element reflecting personal growth?

Chapter II – Literature Review

Academic literature studying the experience of transcendence in clinical training and supervision is limited in scope. In multiple literature searches using only the term "transcendence", PsycARTICLES pulls 99 results, PsycINFO pulls in 2,675, and 73,613 were identified on ProQuest Dissertations & Theses in 2016. In comparison, when the terms "Transcendence" and "Training" are searched together, the results shift. In PsycINFO there were 103 results, PsycARTICLES had 5, and ProQuest Dissertations & Theses was reduced to 50,409. When the terms "transcendence" and "supervision" are combined, PsycINFO yields 8 results, PsycARTICLES pulls in 0 results, and ProQuest Dissertations & Theses drops to 19,142, and this last number drops to 44 results when the terms "Transcendence," "Supervision," and "Training" are all searched together. Although more citations appear with dissertations and theses are considered, very few results address transcendence as it relates to clinical training and supervision as the focal point of their study.

Emphasis of Clinical Training

Over the years, psychologists have served in such roles as scholars, consultants in the recruitment and intelligence testing of American military personnel, and direct service providers (Abt, 1992; Farreras, 2001; Routh, 2000). Clinical training, especially to become a direct service provider, has been influenced by the medical model, where the training emphasis is predominantly on the development and achievement of key competencies (Falender & Shafranske, 2012a; Kaslow et al., 2004). Based on this competency emphasis, evaluations of clinical training for novice clinicians are rooted in the development of ethics, knowledge, skill, and a capacity for self-reflection; these are important aspects of individuals whose character is considered congruent with the practice of mental health (Fouad et al., 2009; Ibarra et al., 2013;

Rodolfa et al., 2005; Rubin et al., 2007). This competency-based approach has been the pinnacle of supervisory work and the means of training and evaluating trainees (Falender & Shafranske, 2012a). These competencies, as reflected by the benchmark model, have their own inherent conflicts and there have been a variety of measures utilized over the years (Rodolfa et al., 2014).

The competency based approach leads to a triage of priorities as the clinical training model begins to unfold, in which the needs of the client take precedence, primarily because licensure of supervisors is involved (C. Falender, personal communication, September 17, 2014). This triage often results in clinical training that is less effective, with the personal development needs of trainees remaining unmet (Wilcoxon et al., 2005). Competencies required to achieve academic success supersede the clinical development needs of trainees (Saito, 2005).

The triage order itself in supervision (academic transcending clinical competencies), is an obstacle in trainees' development of clinical competencies and their trajectory towards becoming effective professionals (Edwards, 2013; Falender & Shafranske, 2012; Watkins, 2011; Watkins, 2012). Trainees may be unaware of how personal factors, specifically how unique aspects of the self, play a role in their clinical training and professional journey, especially when compared to other professions (Falender & Shafranske, 2007; 2012b). Yet it is this supervisory experience that stands at the forefront of critical development for trainees (Hill et al., 2007).

Broadly speaking, the challenge training models face is in the relationship between personal factors and competence. Behaviors, attitudes, beliefs, curiosity, motivations, self-perceptions and a variety of other personal characteristics are influenced by an individual's life experiences (Kaslow et al., 2007). The development of these personal competencies remain fluid and contextual, posing a challenge to training programs that require more objective structure (Epstein & Hundert, 2002; Kaslow et al., 2007). As a result, programs consistently lack training

in these areas due to the significant costs in time and energy required; this problem increases in complexity as cultural factors and fear of ethical repercussions relative to established guidelines are considered (Jacobs et al., 2011; Kaslow et al., 2007; Shen-Miller et al., 2012; Veilleux et al., 2012).

Further, the complication of bias and cultural factors is recognized in the interaction between supervisors and supervisees (Jacobs et al., 2011; Shen-Miller et al., 2012). The importance of attending to personal factors is magnified when behavior influenced by cultural factors is either misunderstood or mislabeled and also missed by clinical supervisors (Gizara & Forrest, 2004; Miller, Forrest, & Elman, 2009; Shen-Miller et al., 2012; Vacha-Haase, Davenport, & Kerewsky, 2004). The inability to intervene can and often does interfere with a trainee's development, and often inappropriately places the onus of awareness and discomfort on the supervisee (Rosenberg, et al., 2005; Veilleux et al., 2012).

Trainee Vulnerability

Throughout a trainee's clinical development there is exposure and vulnerability to professional stress that may include vicarious trauma, fatigue, and burnout (Elman & Forrest, 2007; Epstein & Hundert, 2002; Johnson, Elman, Barnett, Forrest, & Kaslow, 2013; Johnson et al., 2014; Norcross & Guy, 2007). This professional stress or provider fatigue impacts personal relationships, interpersonal factors, psychological distress, and mood disorders (Johnson & Barnett, 2011). It is the intensity of clinical work that includes exposure to prolonged, highly charged emotional content that often results in practitioner burnout (Canfield, 2005; O'Donovan, Halford, & Walters, 2011; Weiss, 2004). Provider fatigue may also result from personal aspects of the practitioner being ignored (Adams, Boscarino, & Figley, 2006; Cheung & Chow, 2011; Cieslak et al., 2013; Goode, 1960; Newell & Macneil, 2011; Stamm, 2010).

Clinical trainees are a particularly vulnerable population and they report abnormally high levels of stress and anxiety throughout their work, which are often correlated to psychological disorders (Dennhag & Ybrandt, 2013; O'Donovan et al., 2011; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2003; Scott, Pachana, & Sofronoff, 2011; Stafford-Brown, 2010). It is this distress that has influenced others to highlight the importance of personal development and self-care (Johnson et al., 2013).

For many trainees, the lack of attention to personal development and self-care leads directly to burnout, fatigue, and other psychological distress. This distress is often seen as a measure of the trainee's performance and degree of competence that may later directly impact the trainee's opportunity for educational and occupational success (O'Donovan et al., 2011). A stigma is attached to personal development efforts and many training programs and potential employers continue to see these efforts as unprofessional (Veilleux et al., 2012).

The American Psychological Association (2013) attempted to combat burnout by requiring accredited programs to address issues of trainee competence. However, the APA allowed programs to self-assess, and it did so without recommending or requiring any preventative measures, leaving training programs free of accountability; suggested remediation for identified students often involved a recommendation for personal therapy (Falender & Shafranske, 2007; Johnson et al., 2014; Kaslow et al., 2007; Lamb, Cochran, & Jackson, 1991).

For example, limited insight may itself be an indicator of possible clinical incompetence. Though training programs are free to respond in whatever manner they choose to address this trainee challenge, these situations also provide an opportunity to integrate and develop a culture of personal development through self-assessment and reflection (Hays et al., 2002; Kaslow et al., 2007).

A measure of professional competence is identified through understanding the trainee's life stressors, individual characteristics and personalities, and self-care strategies (Kaslow et al., 2007). The needs of the trainee will likely be better understood by exploring the academic and clinical training culture and evaluating its role in the work of clinicians (Johnson et al., 2014). By utilizing the training community rather than placing the onus of personal development on an individual trainee, one's professional competence is able to flourish (Johnson et al., 2013).

The trainee and training professionals can monitor both personal and professional factors that can interrupt one's emotional well-being and health through collaboration (Johnson et al., 2013). Trainees, similarly, can be encouraged to use their peers and the academic support system to develop both personal and professional competencies as well as attend to self-care and well-being (Johnson et al., 2013). The humanistic approach to clinical training is a representative example of one such collaborative environment (Elkins, 2009).

The humanistic model. The medical model in psychology remains the dominant model to describe and define clients, their problems, and the process of psychotherapy (Elkins, 2009). The psychology field's predisposition to favor the medical model is observed through the selection of randomized clinical trials over the personal dimensions of therapy (Baker, McFall & Shoham, 2008; Elkins, 2009; Schneider & Längle, 2012; Wampold, 2007). Despite this concern, the public, media, and a large segment of the professional practice community continues to favor the medical model over the personal dimensions of therapy (Baker et al., 2009; Elkins, 2009; Wampold, 2007). Carl Rogers' elaborations of his approach to clients and person-centered therapy influenced several away from the medical model and towards promoting the development of the individual (Kirschenbaum & Jourdan, 2005; Rogers, 1951, 1959).

The focus on personal dimensions of therapy emerged as the humanistic model gained influence in the 1950's and 1960's (Elkins, 2009). In an attempt to shift away from the medical model, Abraham Maslow developed and described a theoretical framework for achieving self-actualization by measuring objective traits of healthy humans which included: (a) a clearer, more efficient perception of reality, (b) more openness to experience, (c) increased integration, wholeness, and unity of the person, (d) increased spontaneity, expressiveness, full functioning, and aliveness, (e) a real self; a firm identity, autonomy, uniqueness, (f) increased objectivity, detachment, transcendence of self, (g) recovery of creativeness, (h) ability to fuse concreteness and abstractness, (i) democratic character structure, and (j) ability to love (Maslow, 1968, p. 189). Maslow's belief was that these traits included the ability to experience love, to have self-worth, being comfortable with seeking truth, and continued growth in order to achieve their full potential (Feist & Feist, 2009; Maslow, 1968).

Concerted efforts to understand the person as a whole became another driving force behind the humanistic model (Buhler, 1971). Thus, the development of the person was seen as a core requirement for providing effective therapy (Maslow, 1968; Teegen, Frassa, & Honiger, 1979). More recent approaches to the integrated humanistic-existential model were discussed by Schneider and Krug (2010), who described personal involvement, genuineness, support and understanding as the most important traits of a therapist's personal and professional development. Schneider and Längle (2012) also suggest that humanistic practice is based on the foundational principles that include empathy, alliance, receptivity to client feedback, and meaning making.

Rogers (1992) stated that a humanistic approach involved experiential learning, and he argued for the benefits of such learning as an essential element of professional training; this

emphasis meant experiential learning would take precedence over teaching intellectual information. Rogers (1969) also believed the best results were seen when an individual became a self-learner capable of self-reflection and self-actualization. Likewise, he suggested that a mentor or teacher must be capable of feeling and understanding the student's experience (Rogers, 1969).

The humanistic-existential model is a therapeutic approach built on core therapeutic ideals that are geared towards individual growth (Bracke & Bugental, 2002; Cain, 2002; Cooper, 2007; Schneider & Krug 2010). At the core of humanistic theory is the liberation of one's own interpersonal process so it is fully available to facilitate and support client growth, thus helping clients develop the capacity to solve their own problems, as opposed to the medical model approach of producing cures to pathology (Elkins, 2009).

Cooper (2007) suggests that good psychotherapy is undergirded by a basic capacity for valuing and respecting the client, skill in collaboratively exploring the client's experience, and the ability to relate genuinely in the service of the client's growth. He notes that the humanistic-existential psychotherapy supervision model parallels this vital capacity with goals that include meaningful attempts to adapt to life challenges and fully understanding individuals as a whole (Farber, 2012).

These reflective practices then become a gateway towards experiencing a full range of emotions with other individuals outside of therapy and supervision. It is accomplished by creating reciprocal dialogue and shifting the conversation from a problem focus to the dynamics of dialogue and the relationship between the clinician and the trainee (Smyth & Cherry, 2005). In this model, both the client and psychotherapist are the essential elements in that dynamic relationship (Farber, 2012).

The training model for humanistic-existential psychotherapy emphasizes the development of basic knowledge acquisition, fundamental professional conduct, reflective practice, scientific knowledge and methods, relationships, individual and cultural diversity, ethical and legal standards and policy, and interdisciplinary systems (Fouad et al. 2009; Rodolfa et al. 2005; Rubin et al. 2007). These competencies were designed to measure a novice clinicians' relative level of mastery and to guide training and evaluation (Donovan & Ponce, 2009; Fouad et al. 2009).

The emphasis is centered on the development of the person of the psychotherapist, in which the supervisor guides and promotes mastering skills in experiential awareness, while also promoting the trainee's capacity to utilize self-awareness to understand and empathize with the client (Farber, 2010). The development of a reflective practice, self-reflection, and self-knowledge in the service of the client then becomes a core competency in humanistic theory (Cain, 2002; Farber, 2010; May, 1983; Yalom, 1980).

Although a humanistic-existential supervision model has yet to be fully articulated, key competencies found within this framework have moved towards conceptualizing the integrative humanistic-existential model as an evidence-based practice in supervision (Farber, 2012; Rodolfa et al., 2005; Rubin et al. 2007). This leaves proponents of the humanistic model facing difficulties engaging in genuine dialogue with proponents of other evidence-based traditions who are predisposed to follow the medical model (Hayes, 2012).

This particular model offers a lens for understanding what it means to be human through the experience of creating meaning beyond the self (Frankl, 1959). The field of psychology has long suggested that a desire for experiencing meaning and identifying one's purpose are factors that often compel an individual towards psychotherapy (Fromm, 1963; Yalom, 1980).

What often emerges through the therapy experience is an openness to one's own organic experience and a willingness to live and learn in the fluid and ongoing process of growth and self-reflection (Rogers, 1961). By questioning the self, and sometimes agonizingly asking what one's purpose is in life, one comes closer to understanding the concept of being human (Rogers, 1961). Being human then involves selecting goals to pursue, identifying the purpose one wishes to follow, and the consistent move towards growth and being more (Rogers, 1961). This idea of being more intersects with those involving the pursuit and search for personal meaning in one's personal and professional lives (Dean, 2002).

Role of Personal Development

Ethical practice in the field of psychology is framed within the APA ethics code (APA, 2002a); over time supplemental documents have appended older documents to incorporate recommended changes (APA, 2000; 2002b; 2007; 2013). These supplemental documents highlight what has been largely ignored in the research, specifically, that personal development is one aspect of clinical training that contributes to effectiveness as a clinician.

The ethics code emphasizes self-awareness (ACA, 2005; APA, 2002a) with an expectation that clinicians will engage in self-reflection as a prevention measure against incompetent clinical care (APA Ethics Code, Standard 2.06). California statutes (section 1396.1) regarding psychological practices require clinicians to recognize interpersonal and personality implications in their clinical work. This latter law guides a psychologist not to undertake any activity where personal factors may result in "inferior professional services or harm to a patient or client" (Department of Consumer Affairs, 2012, p. 115).

The importance of personal development has also been noted in *The Guidelines on Multicultural Education Training, Research, Practice, and Organizational Change* (APA,

2002b), which encourages mental health practitioners to recognize their own cultural identity, attitudes, and beliefs and how these elements influence one's interactions with others. A distinction is made between life experiences that include diversity and formal education and training even when a multicultural approach to racial and ethnic issues in supervision has been recognized as an overall contributor to personal development (Ancis & Ladany, 2001; Tinsley, 2015).

Personal development is strongly supported as: a) a means of facilitating change in clients (Freud, 1912; Rogers, 1961; Warren et al., 2010); b). necessary for effective clinical work (Falender & Shafranske, 2012b; Freud, 1912; Pope-Davis & Coleman, 1997; Sue & Sue, 2003), and c) a relevant and important research focus (APA, 2002b; Eva & Regehr, 2008; Falender & Shafranske, 2012a; Falender & Shafranske, 2012b; Watkins, 2012). It has been suggested that professional growth and development may depend on elements tied more directly to factors under personal development (Falender & Shafranske, 2012b), even if it is limited in scope (Falender & Shafranske, 2012b; Grafanaki, 2010; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2001; Rønnestad & Ladany, 2006; Skovholt & Rønnestad, 2003; Truell, 2001).

However, clinical training programs are not required to incorporate training that addresses personal development nor actively promote education, training or practices of self-reflection; these practices remain notably absent from the *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (APA, 2013). Clear support is obvious when states provide continuing education credit for skills and behavior they wish to develop in their practitioners. In contrast to the statute stating that psychologists must be aware of personal factors impeding service delivery, the State of California notes psychologists are ineligible for

continued education credits that facilitate personal growth (section 1397.61 of the Department of Consumer Affairs, 2012).

The person, the therapist. Academic programs have been challenged to integrate the self as a therapist into school curricula as a formal style of training (Watson, 1993). The framework of the "person of the therapist" (POTT) calls for the mastery of the self by meeting personal challenges and achieving technical mastery in the therapeutic relationship (Aponte et al., 2009). The POTT model does not focus on only the broad sense of self, but emphasizes self-knowledge in psychological, cultural and spiritual aspects as well (Aponte et al., 2009). The focus of the self in the POTT model sees an integrated self; this approach is distinctly different from multicultural competence training that focuses on skills, attitudes and behaviors as if they were entities separate from the individual (Ancis & Ladany, 2001). Current models of supervision do not have an adequate framework integrating an individual's gender, sexuality or culture (Singh & Chun, 2010).

The British Psychology Society has historically called for additional exploration into this overlap of personal and professional development within its coursework (Horner & Youngston, 2009), and Wilkins (2006) has noted that Humanistic and Psychodynamic orientations place more importance on the development of the person, and the self, than the Cognitive-Behavioral training model. More recently, there have been increased efforts to attend to and implement personal factors and the person-of-the-therapist training as an educational directive (Buchanan, 2002; Ellis, 1991; Folkes-Skinner et al., 2010; Grafanaki, 2010; Heppner & Roehlke, 1984; Hill et al., 2007; Ladany, 2007; Luke & Kiweewa, 2010; Orlinsky & Rønnestad, 2005; Rabinowitz et al., 1986). Despite criticisms, personal development training using the Multicultural Supervision Competencies is being implemented. It is one of the few models to directly and intentionally

address elements (rooted in race and ethnicity) of the self, yet lacks a focus on the whole self (Ancis & Ladany, 2001).

Personal factors are always elements of the therapeutic environment; therapists or clinicians and are viewed as having stronger influence than theoretical orientation, clinical diagnosis, the experience of the therapist, and the style of training (Benish, Imel & Wampold, 2008; Beutler et al., 2004; Blatt, Zuroff, Quilin, & Pilkonis, 1996; Cain 2007; Castonguay & Beutler, 2006; Duncan & Moynihan, 1994; Dunkle & Friedlander, 1996; Goldfried, Greenberg, & Marmar, 1990; Hanna et al., 1999; Huppert et al., 2001; Lambert, 1992; Lambert, Shapiro, & Bergin, 1986; Livesley, 2007; Mathers, 2012; Nissen-Lie & Havik, 2013; Norcross, 2011; Sandell et al., 2007; Sexton & Whiston, 1994; Skovholt & Jennings, 2004; Strupp & Hadley, 1977; Wampold, 2007; Whiston & Sexton, 1993). Researchers have called for increased attention on the personal factors of the trainee in an effort to more systematically foster the personal growth and development of trainees while engaged in their respective training programs (Cain, 2007; Ellis, 1991; Folkes-Skinner et al., 2010; Grafanaki, 2010; Heppner & Roehlke, 1984; Hill et al., 2007; Ladany, 2007; Luke & Kiweewa, 2010; Mathers, 2012; Orlinsky & Rønnestad, 2005; Rabinowitz et al., 1986).

Some training programs have incorporated a focus on personal growth (Ieva, Ohrt, Swank, & Young, 2009; Lennie, 2007; Luke & Kiweewa, 2010), personal growth training (Batten & Santanello, 2009; Geller, Farber, & Schaffer, 2010; Norcross, 2005; Wiseman & Shefler, 2001) and also integrated this focus into clinical supervision (Batten & Santanello, 2009; Geller et al., 2010; Norcross, 2005; Wiseman & Shefler, 2001) by developing clinician self-awareness and the awareness of how issues in a trainees personal life affects his or her training.

However, this type of training is quite limited in scope and is one in which most programs currently do not participate (Falender & Shafranske, 2004; Rosenfeld, 2008).

Calls to increase a focus on personal development defer to the current emphasis on learning techniques and measuring competence in trainees (Falender & Shafranske, 2012a). The emphasis of most training models has been primarily on skill and knowledge acquisition; ethical and professional behavior; stages of growth in training; and identity development with a glaring deficit of training on personal growth in novice trainees (Ibarra et al., 2013). This widely accepted model is influenced by the APA Benchmarks, which emphasizes the development of competence above all else (APA Benchmarks: Fouad et al., 2009). As a consequence, clinical training has continued to focus primarily on a competence based model to training and supervision, even though many of these competencies focus on the importance of the trainee's independent growth through self-awareness and self-reflection (APA, 2002a; Eva & Regehr, 2008; Falender & Shafranske, 2012a; 2012b; Watkins Jr., 2012).

In contrast to the APA Benchmarks, the pursuit of the "person" and the factors that make us human have been discussed in the research by Nissen-Lie and Havik (2013) who found that interpersonal skills, empathy, responsiveness, affirmation, interpersonal functioning, and maintaining boundaries played significant roles in a therapist's efficacy (Anderson, Ogles, Pattersen, Lambert, & Vermeersch, 2009; Bohart, Elliott, Greenberg, & Watson, 2002; Dunkle & Friedlander, 1996; Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009; Najavits & Strupp, 1994; von der Lippe, Monsen, Rønnestad, & Eilertsen, 2008), and on the therapists' well-being, such that a better sense of self translated into a positive therapeutic experience. Likewise, the emphasis to change clinical training has been explored, albeit limited at this time

(Nissen-Lie & Havik, 2013; Rogers, 1956, 1961; Rosenzweig, 1936; Strupp, 1958; Taubner et al., 2013).

Interpersonal factors have been investigated in other aspects of the field. Epstein and Hundert (2002) explored attentiveness, curiosity, self-awareness, and presence, while Falender & Shafranske, (2012b) discussed the importance of interpersonal and intrapersonal factors as a pinnacle of a therapist's ability to empathize, attend, and track emotions through verbal and nonverbal behaviors, in a manner of response that is congruent with the therapist.

Trainee Self-Care

However, the inclusion of personal development in training programs is not as simple as making a swift change to curriculum due to the trainee's potential for experiencing a disturbing personal journey (Folkes-Skinner et al., 2010). It is through this journey that the new trainee will emerge, the new-self will emerge, one that is influenced through both clinical work and supervision (Folkes-Skinner et al., 2010).

The act of therapeutic work is one of sitting in and participating in the telling of painful stories that can often be processed differently by different providers, leading to the potential for compartmentalization in the effort to protect the self (Warren et al., 2010). In an effort to counteract this compartmentalization, there must be efforts put forth to both accept and experience the emotions associated; connecting to vulnerability, helplessness, frustration and insecurity to create genuine safety (Kornfield, 1993; Warren et al., 2010). For trainees, an increase of anxiety is disruptive to clinical supervision and impedes a novice clinician's capacity to learn (Ellis et al., 2015).

The emphasis and importance of self-care in clinical work is important, as burnout and distress have been experienced by a significant percentage of psychological therapists

(Hannigan, Edwards, & Burnard, 2004) and medical providers (Dyrbye et al., 2006). Trainee risk is seen in the 25-41% of individuals in the field of psychology that report significant problems with anxiety, depression, low self-esteem and adjustment (Brooks, Holttum & Lavender, 2002; Kuyken, Peters, Power & Lavender, 1998; Moore & Cooper, 1996; Skovholt & Rønnestad, 2003), and the 45% of medical students that endorse depression and increased alcohol use (Dyrbye et al., 2006).

The American Psychological Association (2012) identifies self-care as a competency benchmark, yet the American Psychological Association of Graduate Students noted that 70% of graduate students have reported impaired functioning due to at least one stressful event, including financial, academic, relational and health-related circumstances (El-Ghoroury, 2011). Most graduate-level reports on mental health, however, have originated by studying medical students (Dyrbye et al., 2006; Ey, Henning, & Shaw, 2000; Midtgaard, Ekeberg, Vaglum, & Tyssen, 2008;). Levey (2001) identifies similarities in the stressors between medical students and psychology students that include stress due to time constraints, sleep deprivation, financial limitations, limited free time, and responsibility for patient care.

Although the benchmark established by the APA emphasizes the importance of self-care, there is no vehicle by which graduate students and clinical psychologists are able to actualize the ethical responsibility to address one's own personal development throughout the entirety of their training and career (American Psychological Association, 2012; Youngson & Green, 2009).

Effect of a clinician's personal growth on clients. The trainee's personal growth has been profoundly understated. A counselor's ability to support another individual [the client] is limited to the level that the counselor (him or herself) has maintained his or her own growth (Rogers, 1961). Like Rogers, other theorists have noted the importance of personal development

and its relevance to treatment outcome (Benziman, Kannai, & Ahmad, 2012; Nissen-Lie & Havik, 2013; Warren et al., 2010). For instance, personal growth benefits and influences a trainee's therapeutic work by contributing to greater expertise (Csikszentmihalyi, 1990; Hill et al., 2007; Scardamalia & Bereiter, 1993; Winne, 1995).

Personal factors of the therapist and trainee has been considered a self-development factor (Anderson et al., 2009) and correlates with the client's commitment to the therapeutic process (Roos & Werbart, 2013). The importance of this personal relationship with the client is seen by identifying a strong correlation between client dropout and self-reports of dissatisfaction (Roos & Werbart, 2013). When the therapist is viewed as unsympathetic, hostile, unsupportive, invalidating, passive or indifferent the rates of dropout increased; whereas therapist's personal factors including experience, training, education, flexibility, accommodation, personal experience, and genuine emotional support predicted lower dropout rates (Roos & Werbart, 2013).

As noted previously, in a personal communication with Dr. C. Falender (October 1, 2014), she noted that "the field is moving toward a focus on personal factors, and there are an infinite range of personal factors which are relevant to the therapeutic process." This shift poses a concern, challenge and an opportunity. The variance in personal factors may make them (1) difficult to measure within the research, yet (2) simultaneously allow for a broader, more multiculturally appropriate understanding of personal development throughout the field. Clearly, gaps in our knowledge about personal growth and development of novice clinicians exist and researchers are issuing calls for more research in this area (Grafanki, 2010; Rønnestad & Ladany, 2006; Rønnestad & Skovholt, 2001; Skovholt & Rønnestad, 2003; Truell, 2001).

Despite personal development being described as an ideal for trainees, the inclusion through supervision and training is largely absent. (Anderson et al., 2009; Bohart et al., 2002; Cain, 2007; Dunkle & Friedlander, 1996; Falender & Shafranske, 2012b; Fauth & Williams, 2005; Folkes-Skinner et al., 2010; Hill et al., 2007; Ladany, 2007; Najavits & Strupp, 1994; Nissen-Lie & Havik, 2013; Orlinsky & Rønnestad, 2005; von der Lippe et al., 2008).

Transcendence

To understand what it meant to "be more", in my own personal and professional experience, required a pursuit to understand what it meant to "be", sans the pursuit of growth. The recognition became a personal journey that overlapped a spiritual exploration, an understanding of my own personal growth, and the recognition of professional development in the field of psychology. This led me to this concept of transcendence, a term unfamiliar in colloquial speech, but recognized across modern literature and media as an ideal that it is to become something greater, again, to "be more." As such it makes it difficult to quantify the term itself, for the psychology field has used it sparingly. To understand transcendence one must recognize its origin and how the concept has evolved over time.

The scholarly definitions of transcendence vary, and it is only through the course of reflection that the term itself can develop meaning (Westphal, 2004). The term has been traced to 570 B.C. with references to self-transformation and understanding the self within the continuum of the universe (Tzu, 1963). Philosophy and theology hold transcendence at their core as a virtue that spans across culture and religion, encompassing Buddhism, Hinduism, Christianity, Judaism, Confucianism, Taoism, Athenian philosophy, and Islam (Dahlsgaard, Peterson & Seligman, 2005). The bond between the spiritual side of transcendence and the scientific understanding of the concept was captured in the concept of rising above oneself through the use

of art and science (Einstein, 1940). It has also been influenced heavily by the humanistic movement through Maslow's self-transcendence, and the purposeful act of self-actualization (Maslow, 1954; Frankl, 1975).

Maslow (1954) popularized the idea of self-transcendence in his description of an individual who seeks to further a cause beyond the self and to move beyond the boundaries of the self through peak experiences. As humanistic theory gained prominence, one could see a parallel rise in the interest of experiential learning, the pursuit of peak experiences, and mystical or unexplainable phenomena (Berger, 1979; Dupré, 1976; Murdoch, 1970). Frankl (1975) exemplified these pursuits through a purposefully led life of self-actualization as a means to achieve a transcendent state within the self. This development led to further exploration of the self through existence and identity (Rychlak, 1980) and the shift towards spiritual journeys guided by transformation (Torrance, 1994).

Transcendence: Peterson and Seligman

Peterson and Seligman (2004) argued for the commitment to the transcendent aspects of life, regardless of what they are called; whether the universal, the ideal, the sacred, or the divine. The frequently cited definition of transcendence comes from Peterson and Seligman (2004) who re-introduced and popularized the term within the scientific community, by identifying individual character strengths as categories or traits that understand how one connects to life and the transcendent self. These traits include: Appreciation of beauty, which connects someone directly to excellence; gratitude, which connects someone directly to goodness; hope and optimism, which represent a means by which to connect someone directly to the dreamed of future; playfulness and humor which connects someone directly to troubles and contradictions in a way that produces not terror or anger but pleasure; and spirituality, the belief in the unity and

purpose of life, a connection to others, and the extent of emotional support one experiences as a result of spiritual pursuits, such as prayer and meditation (Piedmont, 1999). Each of these categories of transcendence are held together by a common theme that allows "individuals to forge connections to the larger universe and thereby provide meaning to their lives" (p.519).

Appreciation of beauty and excellence [awe, wonder, elevation]. The appreciation of beauty is reverence in its purest form, allowing one to profoundly appreciate and notice excellent (Peterson & Seligman, 2004). This sense of awe is a facilitation of cognitions that go beyond treatment, diagnosis or illness (Büssing et al., 2014). It is an emotional perception of astonishment and admiration with an overwhelming emotion that is accompanied by a sense of vastness (Bussing et al., 2014). There is suggestion that awe is also involved in a diminished sense of self, and the presence of a higher power (Maslow, 1964). While it is a mixture of sensation and feelings at its peak, there is something powerful associated with the feeling of submission, confusion, surprise, and wonder (Keltner & Haidt, 2003).

Gratitude. Emmons and McCullough (2004) understand gratitude as an emotion that at its core is a pleasant feeling about a freely bestowed benefit or gift. It is the willingness to recognize unearned increments of value in one's own experience (Bertocci & Millard, 1963) and the measure of well-being (McCullough, Emmons, & Tsang, 2002). Gratitude enhances the subjective quality of an individual's life by generating positive feelings about the self with the cohesion and support of others (Büssing et al., 2014; Caprara & Steca, 2005; Moen, Dempster, McClain & Williams, 1992). In medical settings, gratitude becomes a stepping stone that reinforces confidence and hope (Büssing et al., 2014).

Hope [optimism, future-mindedness, future orientation]. Lu Xun once stated, "I could not blot out hope, for hope belongs to the future." (Lu, X., 1995, p. 39). Hope is an aspiration

and pursuit that facilitates positive therapeutic change (Coppock, Owens, Zagarskas, & Schmidt, 2010; Flesaker & Larsen, 2010, O'Hara & O'Hara, 2012). It is the "stance toward the future and the goodness that it might hold" (Peterson & Seligman, 2004, p. 526). Hope is a common factor within the change process (O'Hara & O'Hara, 2012) that has been explored in nursing as a significant predictor of self-acceptance. In palliative care hope is the concept of wanting to live (Haugann, 2014) and in counseling it is illness that brings with it a need for hope (Edey & Jeyne, 2007). Hope is about including a direction towards success and having the capacity to achieve goals by being in the realm of being, rather than doing (Edey & Jeyne, 2007). Unrealistic goals however, lead to hopelessness (McGee, 1984). Hope is achieved through positive reappraisal, self-worth, meaning and humor (Haugan, 2014).

Humor [playfulness]. An individual skilled at laughing, capable of making others smile, and being playful as one injects humor into situations at the right moment is one capable of humor (Peterson & Seligman, 2004). It is an instrument for positive change (Scott, Hyer, & McKenzie, 2015). It provides insight and the capacity to observe life through different perspectives which leads to personal growth (Gladding, 1995; Goldin & Bordan, 1999; Ricks, Hancock, Goodrich & Evans, 2014). Intentional and spontaneous use of humor in therapy and healthcare improves interpersonal relationships with patients by sharing positive emotional experiences (Franzini, 2001) and has been found to be a positive intervention to reduce symptoms of depression (Konradt, Hirsch, Jonitz & Junglas, 2013). The interdisciplinary American Association for Therapeutic Humor (AATH) provides guidelines for laughter clubs to achieve idealistic goals, personal health, happiness and world peace (Franzini, 2001). Humor provides empathy, the experience of compassion, and caring as a bidirectional interaction that is genuine, congruent, and consistent with one self by embracing that humor is not for the

gratification of the sender, but for the receiver (Sultanoff, 2013). Humor is a conscious and purposeful action that guides positive therapeutic change in an individuals' feelings, behaviors, thoughts and physiology (Sultanoff, 2013).

Spirituality [religiousness, faith, purpose]. *"The highest and most beautiful things in life are not to be heard about, nor read about, nor seen but, if one will, are to be lived." Soren Kierkegaard (p. 139).* Spiritual transcendence is the connection to something beyond the self (Drescher et al, 2004). It is the "subjective experience of the sacred that affects one's self-perception, feelings, goals, and ability to transcend difficulties" (p. 441). It is the strength of higher meaning and purpose in the universe and one's place within it (Peterson & Seligman, 2004). Religion and spirituality are often intertwined for many individuals through purpose, meaning, ritual, beliefs, relationships and motivation (Eriksson et al., 2015).

Spirituality is the belief in the unity and purpose of life, a sense of connection to others, and the extent of emotional support one experiences as a result of spiritual pursuits such as prayer and meditation (Piedmont, 1999). It is the relationship with the larger, transcendent realities with God or the universe (Piedmont, Ciarrochi, Dy-Liacco, & Williams, 2009). Spirituality has been linked, and strongly associated, with improved health behavior habits and an increased likelihood of medical improvement (Aldwin, Park, Jeong, & Nath, 2014). Spiritual fitness has been implemented by the United States Army as "the capacity to: (a) identify one's core self and what provides a sense of purpose and direction; (b) access resources that facilitate the realization of the core self and strivings, especially in times of struggle; and (c) experience a sense of connectedness with diverse people and the world" (Pargament & Sweeney, 2011, p. 59). It was incorporated to proactively address concerns of high rates of posttraumatic stress symptoms and suicide amongst soldiers (Cornum, Matthews, & Seligman, 2011).

Transcendence and psychology. Although the term transcendence has been defined in various ways across the literature, it continues to be a developmental pathway built on individual virtues of being more and personal growth (Levenson, Aldwin, & Cupertino, 2001; Levenson, Jennings, Aldwin, & Shiraishi, 2005). The two historical foundations begin with Maslow (1971) and Frankl (1975). Maslow (1971) described self-actualized people as a direct parallel to the "transcendence of self, the fusion of the true, the good and the beautiful, the transcendence of selfish and personal motivations, the giving up of 'lower' desires in favor of 'higher' ones, the easy differentiation between ends (tranquilly, serenity, peace) and means (money, power, status), the decrease of hostility, cruelty and destructiveness and the increase of friendliness, kindness, etc. (Maslow, 1968). This self-actualization then became a measure of growth (Maslow, 1987; Winston, 2016).

Transcendence, as it is applied, is a means by which to understand the actualization of human potential by defining self-actualizing persons as being: self-determined, self-organized, and self-directed (Maslow, 1971). Self-actualization then becomes a link to transcendence through its measure of human potential (Collins, 2010). Transcendence must be understood as an exploration of developmental experiences that precede the transcendent moment (Levenson, Aldwin, & Cupertino, 2001) and it is likewise the bond between human behavior and personality as it connects to both psychology and spirituality (Koltko-Rivera, 2006). This linkage created a path for an individual to move towards growth and motivation, in the attempt to realize his or her true potential (D'Souza & Gurin, 2016).

The hierarchy of needs was one of the most prominent motivational movements in the field of psychology by addressing five major needs prior to adding self-actualization and self-transcendence in his later revisions (Maslow, 1943, 1973). Maslow identified this pursuit

towards self-actualization and self-transcendence as beneficial to society because it would lead one towards solidarity, compassion, care, problem-solving, and altruism (D'Souza & Gurin, 2016). Maslow made the process of self-actualization popular by identifying the path individuals follow towards growth and motivation in order to realize their true potential (D'Souza & Gurin, 2016).

Similar to Maslow, Frankl identified self-actualization as individuals who had the capacity for, and who pursued self-transcendence (Frankl, 1975). He argued that happiness could not be sought as an end in itself, but rather as the side-effect of the normal pursuit of meaningful activities (Frankl, 1967, 1986; McLaffery & Kirylo, 2001). By integrating the three dimensions of human existence: soma (the physical); the psyche (emotions); and noetic (spirit), one could aim towards harmonious integration and cooperation between the self and higher spiritual energies (Assagioli, 1965; Frankl, 1967, 1986).

Self-actualization as experiential living persisted as transcendent characteristics of flow, peak experiences, and mystical experience (Kohls, 2014). Self-actualization would lead one towards authentic living, a break away from the norm, and striving towards one's dreams through the pursuit of bliss (Rahilly, 1993; Cooperstein, 1985; Campbell, 1988). More recently, researchers have recognized that transpersonal experiences are encountered and integrated into daily life as reflective of self-actualization (Collins, 2010).

In Buddhist psychology, these transpersonal experiences are seen through the lens of the "loss of the self," which is viewed as a developmental goal in transcending (Levenson, Aldwin, & Cupertino, 2001). Transcendence is also viewed through neurotheology (Newberg, D'Aquili, & Rause, 2001; Piedmont & Leach, 2002) which understands spirituality as a basic element of our natural world (Piedmont & Leach, 2002). This bridge between the self and the spiritual has

become a dynamic of spiritual transcenders and non-transcenders by identifying peak experiences and achievement (McLaffery & Kirylo, 2001). The fundamental perspective on self-transcendence becomes either a rational explanation without reference to God, referred to as the naturalist view, or the belief that self-transcendence reflects our spiritual nature to yearn for oneness with God and with others, known as the supernaturalist view (Batthyany & Russo-Netzer, 2014). Although these transcendent experiences through spirituality are identified as variables of health and treatment, they have been incorporated into the education and clinical training for psychologists in a very limited way (Shafranske, 2016).

Other authors have described transcendence as a human being's capacity to stand toward one's own thoughts and rise above them to find meaningful self-existence and self-identity (Rychlak, 1980) and the potential for going beyond the realized self at any given moment (Summers, 2012). It is an experience that occurs when a human being becomes more interested in the truth than in being right (Hora, 1987). Through profound exploration and a connection to higher powers one becomes conscious that a higher part of the self, also becomes a higher part of the universe outside of the self (Torrance, 1994). It is this exploration that is viewed as a state in which the sense of identity of the self "extends beyond (trans) the individual or personal to encompass wider aspects of humankind, life, psyche, or cosmos" (Clark, 1998, p. 351). Transcendence is understood as the "quality with which one brings awareness to oneself and those around us" (Vago & David, 2012).

Beyond psychology. Beyond the field of psychology transcendence is viewed as the embodiment or pursuit of self-actualization (Maslow, 1987), self-transcendence (Frankl, 1975; Koltko-Rivera, 2006), intrinsic motivation (Lickel, Kushley, Savalei, Matta, & Schmader, 2014), human drive (Sacks, 1991), growth (Yeager et al., 2014) and self-complexity (Niedenthal,

Setturlund, & Wherry, 1992; Sosik & Cameron, 2010). This movement towards growth becomes the production of new ideas and protects that leads one in the pursuit and movement towards something greater (Amabile, 1996; Forgeard & Mecklenburg, 2013).

Motivation itself as a driving force arises when the "self" experiences sudden or profound change (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007; Lickel et al., 2014; Robins, Noftle, Trzesniewski, & Roberts, 2005). This change is often interpreted as a precipitating event that an individual personally played a role in bringing about (Heatherton & Nichols, 1994; Lickel et al., 2014). As a drive towards identifying explicit differences one pursues "universal human drive" as a means to transcend the self towards increased life satisfaction and Maslow's self-actualization (Black, 1965; Sacks, 1991).

Motivation and growth is not always rooted in the positive side of experiential life; with happiness often comes self-transcendence through despair (Kierkegaard & Lowrie, 1941; Winston, 2016). Despair or negative experience is viewed as a successful or unsuccessful episode of self-change, and profound change out of despair leads one towards growth (Heatherton & Nichols, 1994; Lickel et al., 2014). This self-complexity out of despair is linked to personal meaning and the expression of personal values (Sosik, 2000; Sosik et al., 2009). When one experiences growth out of this despair, it is a drive towards development and learning through the pursuit of purpose (Yeager et al, 2014). Growth can be fostered by regulating attention, emotion and behavior when presented with alternatives (Duckworth & Carlson, 2013; Mischel, Shoda & Rodriguez, 1989; Yeager et al., 2014;). Drive towards learning and growth emphasizes self-transcendent motives through the creation of personal meaning and prosocial purpose (Brophy, 2008; Yeager et al., 2014).

This pursuit towards purpose is driven by the "feeling that one's own actions are important for the world" (Frankl, 1963, p. 80). It is rooted in the importance of not throwing away one's own life (Yeager et al., 2014). This pursuit of purpose becomes a dual-paradigm of intrinsic motivation and the movement towards self-actualization in a need towards self-transcendence as a means to distinguish between the "means" and the "ends" in gratification (Koltko-Rivera, 2006; Maslow, 1987, p. 47).

This continued drive towards growth is an assembly of personal traits, responsibilities and actions that lead towards character strength for psychologists, philosophers, and theologians (Sosik & Cameron, 2010). The importance of drawing on thousands of years of philosophical reflection to build a theoretical framework in psychology and a reflection on the virtue of transcendence is rooted in building meaning for not only the self, but for others (Sosik & Cameron, 2010). Merging these three fields allows the exploration of self-transcendence through the lens of religiosity and spirituality as an individual difference (Piedmont et al., 2009); the pursuit of growth through the recognition of conscious and biological aliveness (DeCarvalho, 2000); and challenging the research to examine personal attributes over cognition or behavior (Sosik & Cameron, 2010).

The transcendent therapist. Transpersonal and existentially grounded clinicians are less likely to experience burnout and instead exhibit personal growth as a result of their work with human suffering (Linley & Joseph, 2007). When a therapist is only capable of taking their clients as far as he or she is capable of going (Rogers, 1956), then the personal and professional growth a clinician experiences becomes an intimate, depth-oriented and reflective practice (Schneider & Krug, 2010). However, achieving this level of critical thinking requires a caring relational supervisory environment (Hernandez & Rankin, 2008). To develop in this manner means a

therapist must bring into his or her own training attributes that include personal involvement, genuineness, support, and understanding (Schneider & Krug, 2010). The role of supervision, then, is to facilitate personal growth in the trainee (Hernandez & McDowell, 2010). For a budding clinician, the role becomes an existential emphasis on liberation by penetrating a new perspective on the self, the world, or a problem, which falls into the core of self-reflection and self-actualization, and self-transcendence (Hanna, Giordano, Dupuy, & Puhakka, 1995; Schneider & Krug, 2010). In the review of transcendence, two threads emerge, one that seems to be more personal-trait oriented (Peterson & Seligman, 2004) and the pursuit of individual growth towards something greater or becoming more (Clark, 1998; Hora, 1987; Rychlak, 1980; Summer, 2012; Torrance, 1994). It is the latter thread that is the focus of this dissertation.

Statement of the Problem

Calls for research on interpersonal skill, self-care, self-reflection, self-awareness (Grafanaki, 2010), and personal factors in the clinical training process from the perspective of novice trainees' have been made, albeit largely ignored (APA, 2002b; Eva & Regehr, 2008; Falender & Shafranske, 2012a, 2012b; Watkins, 2012). Yet, existing research is predominantly retrospective in nature, capturing the viewpoint of senior professionals or master clinicians, who described their personal and professional development needs and experiences as trainees (Carlsson et al., 2011; Rønnestad & Skovholt, 2001; Trotter-Mathison et al., 2010). They described the influence of work stress and satisfaction, the impact of conducting therapy on their own life, personal motives to become a therapist, and professional development (Nissen-Lie et al., 2013).

One major study centered on the personal distress and its impact on psychologists used 749 practicing psychologists, however, no trainees participated in this study (Guy, Poelstra, &

Stark, 1989). Similar measures of personal development from the veteran clinician perspective have also been explored through the development of the psychotherapist, or their personal therapy (Orlinsky, 2013). Likewise, other studies focused on the personal development of experienced psychotherapists to understand six domains: (a) importance of personal therapy for therapists; (b) impacts on the professional self-identity; (c) impact on one's being in the session; (d) experiences in previous and current therapy; (e) self in relation to the personal therapists; and (f) mutual and unique influences of didactic learning, supervision, and personal therapy (Wiseman & Shefler, 2001).

Personal growth and development has been recognized as having direct impact on clinical work (Freud, 1912; Rogers, 1961, Warren et al., 2010). This growth has also been recognized as a key element of training by the American Psychological Association (APA, 2002a; APA, 2002b). Despite research calls to address its implementation into clinical training, the focus on personal growth remains limited in scope (Falender & Shafranske, 2012b; Grafanaki, 2010; Hardin, Weigold, Robitschek, & Nixon, 2007; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2001; Rønnestad & Ladany, 2006; Skovholt & Rønnestad, 2003; Truell, 2001). Recruiting volunteers for these studies has been identified as one of the challenges to studying personal growth of novice clinicians (van Dierendonck, Garssen, & Visser, 2005).

Jorgensen and Weigel (1973) noted a great disparity between training practices in personal growth and the professional training opportunities presented to students; only 2 of 98 programs included any aspect of personal development in their curriculum. One example of this disparity was shown when 76% of APA affiliated psychologists in a randomly selected study reported that their graduate programs inadequately addressed training related to the spiritual and religious aspect of personal growth in their work with patients (Crook-Lyon et al., 2012).

Trainees' have expressed uncertainty about the role of personal factors and measures of competence as part of their training program (Shen-Miller et al., 2015). As a result, Shen-Miller et al. (2015) called for research to explore the engagement, involvement, and perception of clinical training programs by their trainees (Shen-Miller et al., 2015).

While the bulk of graduate education and training focuses on competencies, 70% of graduate students have endorsed feeling negatively impacted by personal factors or events throughout their graduate education (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012). The response of the programs has been inadequate because it has been difficult to pinpoint the actual needs of the trainees (Abt, 1992; Farreras, 2001; Routh, 2000). As a result, clinical training programs have both underemphasized and failed to adequately address the personal needs of the trainee, and trainees remain confused or unaware this lack of response may have on their overall development (Edwards, 2013; Falender & Shafranske, 2012; Saito, 2005; Watkins, 2011; Watkins, 2012; Wilcoxon et al., 2005; Zeddies, 1999)

The focus on competencies emerged out of the medical model that utilizes a competency-based style of training rooted in ethics, knowledge acquisition, skill acquisition, and self-reflection (Falender & Shafranske, 2012a; Fouad et al., 2009; Ibarra et al., 2013; Kaslow et al., 2004; Rodolfa et al., 2005; Rubin et al., 2007). The competency-based model of training relies on American Psychological Association (APA) benchmarks for both trainees and professionals (APA, 2002a; Eva & Regehr, 2008; Fouad et al., 2009; Falender & Shafranske, 2012a; 2012b; Watkins Jr., 2012). However, training models have struggled to implement a focus on personal factors into their curricula due to objective needs of academic programs (Kaslow et al., 2007; Epstein & Hundert, 2002). These limitations are often due to the emphasis on theoretical orientation over the development of the person (Wilkins, 2006), the high resource cost of

attending to personal development, and the fear of cultural and ethical repercussions (Jacobs et al., 2011; Kaslow et al., 2007, Shen-Miller, Forrest & Burt, 2012; Veilleux et al., 2012). As a result, the responsibility of developing personal growth is placed on the individual, not the program, adding additional burden to an already stressful environment (Rosenberg et al., 2005; Veilleux, 2012).

Across two decades, several researchers have emphasized the need for research in the area of personal growth and from the perspective of a trainee who is engaged actively in their own development (Auxier et al., 2003; Bennett, 1986; Borders, 1989; Coleman, 2006; Ellis, 1991; Gibson et al., 2010; Grafanaki, 2010; Hanna et al., 1999; Hill et al., 2007; Matthews, 2012; Rønnestad & Ladany, 2006; Rønnestad & Skovholt, 2001; Skovholt & Rønnestad, 2003; Taubner et al., 2013; Thaeriault & Gazzola, 2010; Trotter-Mathison et al., 2010; Truell, 2001). However, personal growth of the novice clinician from his or her perspective has remained largely absent as a research focus. Likewise, there is no literature that discusses the experience of transcendence from the perspective of novice clinicians over the course of their supervision and training experience.

Given these gaps, and as a first step, there is a need for understanding the personal growth of novice clinicians from their perspective. This qualitative dissertation explored the experience of transcendence from the perspective of three first year doctoral students engaged in clinical training and supervision, while enrolled in a clinical psychology doctoral program.

Chapter III – Research Methodology

Introduction

This chapter presents the research methodology used in this qualitative study and includes a discussion and rationale of the study design, description of the data, procedures for how data was collected, descriptions of participants, research bias, limitations and potential contributions to the field.

Rationale

Research literature addressing the personal growth and development of psychologists is: (a) often discussed from the viewpoint of senior professionals or master clinicians (Rønnestad & Skovholt, 2001); (b) predominantly retrospective in nature (Carlsson et al., 2011; Trotter-Mathison et al., 2010); (c) relatively narrow in its focus, emphasizing the use of journals as a means of self-reflection about personal growth (Lutz & Irizarry, 2009; Tryssenaar & Perkins, 2001); (d) focused on learning through achieving specific clinical skill competencies (Folkes-Skinner et al., 2010) as opposed to the overall development of the person of the therapist; (e) primarily centered on personal growth as it relates to multicultural or diversity aspects of individuals (APA, 2002a); and (f) almost absent any discussion of the experience of transcendence as it relates to the personal growth of novice clinicians.

Although calls for additional research on personal growth and development have been made, any discussion of the training process and its impact on a trainee's overall development and experience during the formative years of education is relatively new and a needed area of study (Grafanaki, 2010; Rønnestad and Skovholt, 2001; Rønnestad and Ladany, 2006; Skovholt & Rønnestad , 2003; Truell, 2011).

Given these gaps in the research literature, the original intent of this study was to explore and understand the experience of transcendence as one aspect in the personal and professional

growth of novice trainees; a secondary intent was to supplement current literature as it relates to the supervision and training and personal growth of novice clinicians (Morrow, 2007). The research question was framed as exploratory in nature (Elo & Kyngäs, 2008). Additional research will be needed to overcome any shortcoming of this data, though results can offer a contribution to support theory development (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005).

Research Design

Qualitative research methods support the generation of theory for specific concepts where the research is limited (Bradley, Curry, & Devers, 2007). The current literature on transcendence in clinical training and supervision is almost non-existent. Consequently, this researcher used a qualitative approach to further understand and interpret the phenomena of clinical training through the lived experiences of the novice clinicians participating in this study (Ritchie, Lewis, Nicholls, & Ormston, 2013). In this case, this researcher used vignettes from novice clinician's journal entries about the first year of their clinical training experiences.

The specific style of qualitative analysis used in this study was content analysis; a technique that is used to analyze objective and systematic manifestation of written content (Berelson, 1952). This style of content analysis allows the researcher to describe specific phenomena when the existing literature is limited, such as understanding the experience of transcendence in training and supervision (Hsieh & Shannon, 2005; Kondracki & Wellman, 2002).

This use of content analysis also allows for both inductive and deductive analysis of the data provided, which, in this study consisted of long-format vignettes that were original journal entries completed by three novice clinicians (Elo & Kyngäs, 2008). This style can also be used to further develop the research question itself, by enhancing the depth of the research as

issues arise through the analysis (Elo & Kyngäs, 2008).

Within content analysis, there are various techniques that one could approach the data. This study used directed content analysis through the use of predetermined codes to capture all possible occurrences of a phenomenon (Hsieh & Shannon, 2005). Directed content analysis, also recognized as deductive content analysis, is guided through the use of predetermined codes as opposed to an inductive approach that allows the data to emerge independently (Moretti et al., 2011). More specifically, the use of previous research literature, in this case, definitions of transcendence suggestive of "being" or "becoming more", allowed this researcher to identify experiences of transcendence, as described in the vignettes, themselves (Moretti et al., 2011). The use of these superimposed predetermined codes allowed this researcher to remain closer to the data and increase validity (Rourke & Anderson, 2004).

A qualitative approach was used for this research for its ability to explore conceptual phenomena within health services. A secondary benefit of using this approach involves the contribution it can make to health policy, including the possibility of influencing change in training programs (Sofaer, 1999).

However, content analysis has been criticized for variable statistical analysis and is not always considered immersively qualitative in nature (Elo & Kyngäs, 2008; Morgan, 1993). The strength of the research and data then relies on what the researcher identifies and determines to be both the research question and the classification and purpose of the data (Elo & Kyngäs, 2008). This method requires the re-interpretation of analytical text narratives that counter traditions of inquiry through one's own culturally conditioned understanding (Krippendorff, 2004). Lastly, the widely-generated content that could be generated through analysis, often

referred to as a "moving target" (p. 5) of data, makes it challenging to narrow the focus on a specific question (Neuendorf, 2002).

Autoethnography: Participants as Researchers

Autoethnography as a method of research seeks to identify aspects of research that cannot be documented through traditional research methods. Autoethnography is the systematic analysis of personal experience to further understand a cultural experience through complex and meaningful research that is designed to accommodate the influence of the researcher (Ellis, Adams, & Bochner, 2011). As an introspective method, it is used to identify data that cannot be easily observed, providing a perspective or insight into a part of the human experience that is not easily tapped into (Stanley, 2015; Wambura, Ngunjiri, Hernandez, and Chang, 2010). This method of research repositions the researcher as an object of inquiry, depicting areas of interest that include personal awareness and introspection regarding experience to understand events, experiences, and emotions as they are evoked from the self (Crawford, 1996). Berry & Patti (2015) also found that autoethnographic stories, "open up possibilities for broadening a sense of connection, while deepening appreciation for the ultimate uniqueness and complexity of any life as lived and narrated" (p. 267).

Stanley (2015) offers further support for the use of autoethnography, using the example of completing a Ph.D. as being like a black box: "While inputs, outputs, and milestones are visible, there is a sizeable gap in our understanding of candidates' lived experiences. These experiences may cause some academic advisors to erroneously assume their students' experiences are comparable to their own and to proceed accordingly" (p. 143). An autoethnographical approach to the current study allows the researcher to most directly review the lived experiences of individuals undergoing clinical training.

The primary participants and subject of the current study involve journal entries completed by this researcher and two of his doctoral colleagues. Although not common practice, there is a precedent for researchers' own observations to be data for a given study; research involving case studies have often employed similar methods. Selby (2003) identified several major researchers as having used themselves to contribute to their research in some way, including Jung's analysis of his own dreams and Wundt's use of introspection. Selby further notes that the field of psychology is largely built upon a foundation of personality theories, which were developed with theorists' personal life experiences as data. Thus, the tradition of using researcher as the subject has a longstanding precedent in the field.

Participants / researchers. The researchers, who also served as participants for this study, consist of three clinical psychology doctoral students who were each responsible for coding the collected data (Coders 1, 2, and 3). A clinical psychologist served as an auditor for the study and supervised the research team throughout the data collection, coding, and analysis process. The inclusion of multiple researchers and an auditor assisted in providing different perspectives, minimizing individual biases and helping to sufficiently capture the complex nature of the data (Hill, Thompson, & Williams, 1997). The following is a personal description (e.g., background, professional views) provided by each of the coders and auditor in an effort to identify potential areas of bias.

Coder 1: Coder 1, a researcher and this author, is a 32-year-old, Latino-multiracial, male clinical psychology doctoral student. He was born and raised in an upper-middle class family in the western part of the United States. Coder 1 was raised in a Catholic family and currently affiliates himself spiritually with Buddhism and the Catholic Church. Coder 1 generally conceptualizes and treats clients from an existential approach including acceptance-based

cognitive-behavioral techniques, person-centered therapy, and purpose-centered therapy. More specifically, he believes that the growth and recovery of an individual stems from focusing on purpose-driven personal goals, increased awareness of human limitation and inevitable death, and forging meaning within the context of the lived human experience the individual had encountered up until that point in their life, while enacting a willingness to embrace and overcome the challenges presented to shift towards personal growth and self-actualization.

Coder 2: The second researcher, Coder 2, is a 28 year-old, white, female clinical psychology doctoral student. She was born and raised in an upper-middle class family in the southwestern part of the United States. Coder 2 was raised in a Christian family, and self identifies as spiritual and non-religious. Coder 2 generally conceptualizes and treats clients from an existential-humanistic approach; including the use of cognitive behavioral techniques, acceptance, and mindfulness. More specifically, she believes that therapeutic change often emerges from a strong therapeutic alliance, relying on the therapist's' level of attunement and ability to meet the client where they are while challenging them to become more. In order to do this, a therapist must be willing to reflect upon his or her own process and be willing and open to continuously grow.

Coder 3: The third researcher, Coder 3, is a 28-year-old, white, married, female clinical psychology doctoral student. She was born and raised in an upper-middle class family in the Midwestern part of the United States. Coder 3 was raised in a Catholic family and self-identifies as a non-practicing Christian. Coder 3 generally conceptualizes and treats clients from a humanistic perspective; including acceptance-based cognitive-behavioral techniques. More specifically, she believes that clients gradually experience healing in therapy as their self-awareness increases, and is contingent upon their willingness to embrace such awareness without

denying or distorting the truth of who they are and their experiences in the world. The therapist's role in producing such a shift is that of a metaphorical mirror, in that the therapist experiences the client as they present in therapy and reflects back to them what is observed. This coder believes this process of reflection must take place without judgment of what is observed or experienced. Further, the therapist must be active in their use of empathy in order to both fully recognize all aspects of the client's difficulties, and to validate the client's experience as one that is or could potentially be experienced by all humans. Thus, an additional element of treatment deemed necessary by coder 3 is that the therapist themselves must maintain congruence so as not to collude with the client's denial or distortion, and to model healthy psychological processes. The elements of reflection, non-judgment, empathy, and congruence are believed to be reliant upon the therapist's commitment to his or her own personal development. Accurate reflection, for example, can be influenced by the therapist's personal biases and overall life experiences. Thus, ongoing self-awareness and congruence on the part of the therapist precede the use of accurate reflections in therapy. Further, non-judgment and empathy are both effortful processes that may require the therapist to confront their personal biases, thoughts, behaviors, and overall sense of self as it has been shaped by their own unique experiences.

Auditor: The auditor of the study, who is also the dissertation chair and the licensed clinical supervisor of the participants/researchers, is a European-American, Jewish single female. She has a doctoral degree in psychology and is senior level / master clinician and lecturer / professor of psychology. She teaches applied psychotherapy courses and uses an integrative theoretical approach combining principles from four theoretical positions as part of the clinical training provided to six novice clinicians. First, she uses psychodynamic as a theoretical foundation, understanding that one's past history affects and contributes to present-day

functioning. Second, she finds that first through third wave cognitive-behavioral theories help individuals move out of the strictures of the past and help them change their perspective and ability to function in the present. Third, she maintains an overall positive view of the self, emphasizes self-responsibility, and uses the "here and now" of therapeutic sessions, elements which are drawn from a humanistic/existential perspective. Fourth, all of this is ground in an understanding of how the brain functions, information drawn from neuroscience, and more specifically, interpersonal neurobiology. Finally, her work is informed by systems, developmental and strength-based approaches. Her teaching approach highlights the use of psychotherapy process. She greatly enjoys mentoring the individuals she has the opportunity to teach and has a strong belief in personal growth, ideas threaded throughout humanistic / existential and neuroscience literature. Accordingly, she supports the exploration and use of research on personal and professional development, and believes that such emphases contribute to the overall professional development of clinicians.

Participant Demographics

Six first year clinical psychology students (and their respective journal entries) comprised the initial possible pool of participants. Actual participants of this study included three first-year doctoral students, who as clinical psychology trainees, were trained under the supervision of a licensed psychologist (Ph.D.), who identifies as a white female with 28 years' experience in training and supervision. The three first-year doctoral students include; 1 multiracial male and 2 white females, with a mean age of 28 (SD: 2.71) who had completed two years of graduate education and were in their first year of a clinical psychology doctoral program at a major Southern California private university, accredited by the American Psychological Association.

One of the three is the researcher of this study, while the two remaining individuals served as coders for this study.

All three trainees had previously completed a master's degree in psychology prior to this training year and were placed in community counseling center settings for their first-year clinical practicum experience. The participants self-selected through convenience sampling with the following criteria: (a) Participants were first-year doctoral students in a clinical psychology program, (b) the participants trained under the supervision of one licensed supervisor. There was no exclusion due to gender, age, clinical experience or culture. At the time the participants generated journal entries, they were completing their clinical training with the same supervisor and received approximately 140 hours of supervision across the clinical training year.

The journal entries were generated across a period of seven months, four months after a full day educational training experience that had occurred in the first two weeks following entrance into their doctoral program. The full day training emphasized: understanding 15 basic premises of psychotherapy; 6 listening skills that were drawn from the work of Allen Ivey (Ivey, Normington, Miller, Morrill, & Haase, 1968); 9 aspects of enhanced attunement to the client (J. Rosenberg, personal communication, November 14, 2012); the discussion of "therapy as choreography" involving moving back and forth between content and process and the six basic skills; introductory concepts of interpersonal neurobiology including neuroception, and neuroceptive challenges (J. Rosenberg, personal communication, November 14, 2012); safety, emotional window of tolerance, somatic experience, affect tolerance, and a core of unpleasant feelings that guide emotional congruence. This researcher, along with the two coders and three other doctoral students, attended one hour of supervision and two hours of case conference weekly, for a period of one year (140 hours) with the psychologist mentioned above.

Procedure

Sampling procedures. Purposive sampling was initially used on the final data set of 53 journal entries (one journal entry incomplete and unusable) to address the stated research question (Merriam, 2014).

The body of data consisted of reflective journal entries that were generated by students within one supervision group at a major Southern California university. All six students enrolled as first-year doctoral students in a clinical psychology program who were also members of this supervision group were considered for inclusion in the study. There were no exclusion criteria based on age, gender, clinical experience, theoretical orientation or culture. Journal entries from three students comprised the data pool; one student never responded to email or phone contact and the remaining two students indicated that they could not locate their own generated journal entries.

The archival data set consisted of 53 journal entries (54 submitted, one incomplete and unusable), representing three viewpoints. Data collection and storage and all related procedures relative to participant involvement were approved by the university's Institution Review Board (IRB) prior to accessing the archival data.

Critical Incidents

The critical incident approach has been previously utilized in clinical psychology research and closely parallels the type of journal entries generated for this study (Fraser & Hunt, 2011). A critical incident is defined as a significant event, activity, or situation that could be systematically described, observed, or elicited retrospectively and through which performance-related behaviors could be categorized and interpreted (Flanagan, 1954). Flanagan (1954)

defined critical incidents as a systematic system of coding complex experiences that were identified as conflicts, processes, and/or values.

Heppner and Roehlke (1984) developed the Critical Incident Technique (CIT), instructing participants to "describe any critical incidents (i.e., major turning points) within the supervision process that resulted in change(s) in your effectiveness as a counselor" (p. 124). This method is especially salient to supervision research as it has been used to describe and understand the meanings that people attach to significant events in training or organizational life (Fraser & Hunt, 2011; Kain, 2004). The critical incident technique (CIT) uses modified questions to describe and understand an experience, such as a supervision session, and clarifying questions asking what made an experience a critical incident for the individual (Ellis, 2006; Heppner & Roehlke, 1984).

The Critical Incident Technique is a behaviorally driven task-analysis method with the critical incident as the unit of analysis itself, as reflected in Flanagan's original implementation with Air Force pilots, where he explored conflict resolution, systemic issues and problem solving (Fraser & Hunt, 2011). Problem solving allowed researchers to map the content domains of effective and ineffective responses and outcomes, and produced a heightened awareness in participants of the tasks, routines, norms, and expectations inherent in their work (Butterfield, Borgen, Amundson, & Maglio, 2005; Chell, 1998; Clamp, Gough, & Land, 2004; Fivars & Fitzpatrick, 2001).

Borders (1989), Holloway (1987), and Stoltenberg (1981) noted: "there is a need for descriptions of the thoughts, feelings, and behaviors of supervisees at various developmental stages" (Borders, 1989, p. 17). Using a critical incident approach within the context of supervision, supervisors tend to identify more critical incidents as they relate to relationship

issues, while novice clinicians more often recount critical incidents that involve competence, autonomy, purpose, and direction (Ellis, 2006; Fine & Fenell, 1985).

Within the therapeutic environment, critical incidents have been used in supervision to explore supervisory relationships, competence, emotional awareness, autonomy, and personal issues; although not theoretical identity issues as noted by Sansbury (1982; Ellis, 1991). More specifically, the Critical Incident approach has been used to: conceptualize significant learning events that define counselor development (Furr & Carroll, 2003; Howard et al., 2006; Smith-Adcock, Shin & Pereira, 2015); explore therapeutic impacts (Kivlighan, Multon & Brossart, 1996); reduce novice clinician anxiety so difficult topics that promote growth can be broached (Nelson, Oliver, & Capps, 2006; Sommer et al., 2009).; identify ethical issues in supervision (Goodyear, Crego & Johnston, 1992; Kitchener, 1984); describe developmental shifts in the attitudes and beliefs of novice clinicians (Arrendondo et al., 1996; Delsignore et al, 2010); and explore experiential learning (Smith-Adcock, Shin & Pereira, 2015).

Critical incidents and the current study. The use of critical incidents as an analytic approach in qualitative data has been used across the counseling and psychology field (Angelides, 2001; Cormier, 1988; Delsignore et al., 2010; Furr & Carroll, 2003; Leong & Kim, 1991; Mwaba & Pedersen, 1990; Skovholt & McCarthy, 1988). Journal entries utilized in this study parallel others who have also used the Critical Incidents Questionnaire (CIQ) approach, as first described by Heppner and Roehlke (1984). Individuals participating in this investigation documented “critical moments” that were defined as visceral reactions, cognitive reframes or major turning points which resulted in increased (a) self-reflection, (b) insight, (c) therapeutic effectiveness, and/or (d) personal awareness, personal growth, and self-agency. For this study, a

critical moment must have also resulted in the experience of being challenged, inspired or invited to be or do more than they had prior to what they just learned or experienced.

A critical moment could be recognized as a personal life experience that was now more fully understood or faced more directly based on a discussion of conceptual or client case material; or deeper reflection on some element of supervision of training that impacted either one's personal or professional activity. Setting and focus were not relevant to the learning (e.g. one-day training vs. case conference or supervision for a peer or for oneself).

In this case, personal and professional development is seen as emerging from (a) supervision without a related personal experience; (b) supervision and a related personal experience following supervision; and / or (c) supervision and a related personal experience following supervision and self-reflection of integrated material.

Using this critical moment approach, at the end of their first semester, all six novice clinician's began journaling approximately twice per month for a period of seven months to describe and summarize situations, events or experiences where they were inspired to be or do more. Individual journal entries were, on average, one double-spaced page in length.

Data Collection and Management

The data set that was used in this study is phenomenological in nature and is a representation, through their self-report of the lived experience of the three participants (Moustakas, 1994). All six trainees, of which three were participants in this study (Coders 1, 2 and 3), recognized they were experiencing significant changes, as a result of their clinical training and supervision experience, particularly in their personal lives as well as professional lives. The frequency of the conversations among the six trainees that reflected ongoing personal changes prompted documentation of these changes. These were the "critical moments". The

collection of data was initiated at the end of the first semester of the first academic year and spanned approximately seven months till the end of the spring semester.

This particular research study was proposed after the journal entries were completed; the journal entries themselves represent an organically lived experience by the trainees that was not influenced or modified based on inclusion or criteria of this study. It is important to note that each of the individuals completing journal entries and participating in the study represents a notable bias relative to their respective interests in the training, supervision, personal and professional growth of novice clinicians. The design of this study is influenced by this bias.

The self-selected participants in this study submitted a total of 54 journal entries that were voluntarily written biweekly, on average, over the course of seven months, in settings that included their offices, home, and other selected spaces they felt comfortable writing about their experience. The variance in settings may have influenced the authors' participation and willingness to journal about the sensitive subject matter.

Journal entries were voluntarily submitted by the three first-year clinical psychology doctoral students at a private university in Southern California. The data set included 54 journal entries, with one excluded due to being incomplete, which is an average of 18 entries per student participant. These student-participants had been encouraged to journal and document "critical moments" (i.e., critical Incidents), over the course of their first-year practicum training experience. As noted, these self-identified moments could include experiences like a shift in perspective or turning points, or involve an experience where the individual gained more insight, self-awareness or a greater sense of confidence or self-efficacy, all ultimately leading to personal growth or development.

Data collection involved utilizing an individual unknown to the participants. A volunteer was recruited to assist specifically with data collection and de-identification of the same. The dissertation chair announced the opportunity in a first-year doctoral class. The neutral third party was a master's level student who was not familiar with either the researcher, participants, or content of the research study. This individual signed a confidentiality agreement that outlined the proper handling of the data (see Appendix C).

The student volunteer communicated with Coder 3 for instructions related to the consent process and to acquire, de-identify and disseminate data. Coder 3 provided the research volunteer with a recruitment script, which was sent via email to all potential participants (see Appendix D); she was responsible for all communication efforts to help maintain the anonymity of participants. Individuals who provided consent and journal entry data were asked to complete a demographic form (see Appendix H) in an effort to further recognize areas of bias in accordance with content analysis strategies (Elo & Kyngäs, 2008). The participants were provided informed consent that included the nature of the study, their participation and role in the study, how the data will be kept confidential and the handling of the data which includes potential risks, benefits, questions, and concerns (see Appendix B).

Once recruitment efforts and the informed consent process was complete, journal entries were sent digitally to the research volunteer; each journal entry data was then de-identified using established parameters as outlined in Appendix E. Once all the data was de-identified, each journal entry was electronically copied and transferred to a password protected flash drive that contained the entire data set. The dissertation chair received that flash drive, made four hard copies of the data set and sent one hard copy each to Coder 1, 2 and 3, while also keeping one copy for herself for use in auditing the coding process. Signed consent forms were kept apart

from the data in a separate locked drawer. Data used in this study will be maintained in locked drawers for a period of 5 years before destroying it. These data sets are stored in a locked drawer in the dissertation chair's professional office at the private university in Southern California.

Coding and Data Analysis

Interrater reliability was established prior to individual coding efforts through the use of five randomized journal entries that each coder and auditor coded independently, followed by a comparison of coding to identify the similarities and variation in coding structure. The researchers addressed coding discrepancies until there was a consensual agreement of 80% throughout the coding (Miles & Huberman, 1994). This researcher engaged in biweekly conference calls with the auditor and Coders 2 and 3 to ensure reliability and consensual agreement in the coding. Discrepancies were re-coded until a consensual agreement was met.

The dissertation chair of this research project served as the auditor to examine the results of this study. The auditor challenged incongruent or inconsistent coding data initially as it related to the overall approach to the data set and secondarily to content category coding. Coding involved consistently returning to the raw data to confirm the accuracy of content codes.

In order to monitor the reliability of data throughout this process, a team of three coders consisting of Coders 1 (primary researcher), 2 and 3. Coder 1 analyzed the initial set of data, which consisted of a three arc system of analysis. Coders were asked to identify the following: Arc I, the pursuit of truth, what is the journal entry about?; Arc II, the greater meaning, what is the dissonance or change in the individual's field (experience)?; and Arc III, the deeper connection, what is the learning drawn from the reflection? Throughout the coding process, including consensual agreement, the 53 journal entries were coded using this three arc system by the coders, resulting in 162 categorical codes per arc. In an effort to narrow the focus on themes

of personal growth and transcendence (Edgar & Miller, 2001), the third arc became the central focus of this research, where the 162 codes were then separated into 237 data points; the additional data points resulted from identifying distinct ideas (learnings) in the coded data. Additional auditing throughout each step of the coding process was completed by the auditor.

The analysis of the data began as open coding, categorization, and abstraction (Creswell, 2009; Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). The first stage began with (a) a sweeping look at the journal entries as a whole to identify the emergence of major themes; (b) a meaningful coding system that used a three-step exploration of each journal entry as follows; (1) the overall theme of the entry, (2) the moment, event, or act that led to change; and (3) the result (learning) of the moment, event, or act. This framework for reviewing the data emerged from understanding human drive involves movement towards growth; growth itself involves the production of new ideas, and the pursuit or movement towards something greater (Amabile, 1996; Forgeard & Mecklenburg, 2013; Sacks, 1991). This universal human drive as a move towards transcending the self is built upon Maslow's ideas of self-actualization (Black, 1965; Sacks, 1991).

What the research attempted to capture was either a moment of profound change (Hayes et al., 2007; Lickel et al., 2014; Robins, Noftle, Trzesniewski, & Roberts, 2005), personal growth (Koltko-Rivera, 2006; Yeager et al., 2014) or self-transcendence through despair (Heatherton & Nichols, 1994; Kierkegaard & Lowrie, 1941; Lickel et al., 2014; Winston, 2016) or peak experience (Maslow, 1954).

It is often at the discretion of the researcher to identity key themes as they relate to the field in which they hold expertise (Creswell, 2007; Lichtman; 2006; Wolcott, 1994). To identify moments of growth, the three coders were first asked to review each journal entry and discern

what the reflection represented. During the first audit involving all three coders, it became apparent that the focus of the task as a whole was too broad, and did not adequately capture the thematic narrative described in the journal entry. The primary researcher then asked the coders and auditor to follow a trajectory reflected in the transcendence literature. This arc consisted of three separate elements and was identified by answering the following questions:

- Arc I: What is the reflection about? This is referred to as the "pursuit of truth."
- Arc II: What is the dissonance or change? This is the "pursuit of greater meaning"
- Arc III: What is the learning drawn from this experience? This is the "moment or experience of transcendence" or one of "deeper connection."

The three coders re-examined the journal entries with these questions in mind, and their coded responses were compiled into an Excel spreadsheet. The data was then examined for agreement across codes and then reviewed by the auditor. The focus of the next auditing session involved reviewing the coded data and establishing the clearest manner for responding to the original research question, which asked whether novice clinicians experienced transcendence . . . was transcendence present? Given multiple definitions of transcendence and the nature of the data set, a determination was made that a content analysis approach would best answer the research question, allowing the coding to be sorted using pre-existing content categories. More specifically, definitions of transcendence that conveyed the qualities of being and doing more were selected to evaluate the data.

Data analysis, using a content analytic approach, centered on the third arc (the result [learning] of the [transcendent] moment, event, or act); this arc most adequately captured and described the moment(s) of growth reflecting transcendence. In addition, the separation of distinct ideas within the coding of the third arc allowed for further exploration, which was

completed by the researcher and verified by the auditor. As content coding was being accomplished, the researcher consistently returned to the journal entry raw data to clarify meanings as they related to differing expressions of transcendence. This process was also audited.

The content categories best reflecting transcendence involved: (a) a self-reflection to rise above meaningful self-existence and self-identity (Rychlak, 1980), which is understood operationally as: self-reflection or awareness that leads to greater clarity with establishing or knowing one's self-identity; (b) going beyond the realized self at any given moment (Summers, 2012), which is understood operationally as: the concept of "going beyond" is recognized as a measure of capacity or limits/limitation of one's experience, reflecting also learning, growth, being more, and measures of competence; (c) the pursuit of truth over being right (Hora, 1987), which is understood operationally as; an emphasis on the pursuit of truth over being right and involves a specific self-reference or acknowledgement that truth is more important than rightness; (d) a higher part of the self, connecting to a higher part of the universe (Torrance, 1994), which is operationally understood as the higher part of the self and the universe are recognized through awe, inspiration, or moments of spirituality; (e) a connection to elements beyond the self (Clark, 1998), which is operationally understood as: the connection beyond the self is externalized, broad, and/or not-specific to the individual's growth nor are these identified elements a target or reflection of the individual's behavior; (f) an awareness of the self and those around us (Vago & David, 2012), which is operationally understood as: highlighting moments of teaching for others, with more specificity, or where there is an emphasis on the altruistic nature or intent of the individual; and (g) furthering a cause beyond the self and moving beyond the

boundaries of the self through peak experiences (Maslow, 1954); which is operationally understood as: there is a self-growth through an identifiable peak experience.

Human Subjects/Ethical Considerations

Ethical standards and confidentiality were upheld for the research participants through the use of an external reviewer unknown to participants. This individual communicated with all potential participants and followed an established protocol to de-identify journal entry data. Prior to accessing journal entry data, this researcher completed the IRB certification course and the "Health Insurance Portability & Accountability Act (HIPAA) course (see Appendix D) to ensure adherence to ethical standards regarding confidential health information in participant research. All participants releasing their data signed informed consents. Data is and will be kept stored in locked key cabinets during the investigation through submission of the dissertation and then remain in the dissertation chair's locked cabinet on campus for a period of five years following completion of the dissertation.

Proposed Contributions

This researcher may have developed more insight as he generated journal entries, a self-reflective process that involved experiential learning and may have generally enhanced self-reflection and increased emotional awareness (Cornish & Cantor, 2008; Ghaye, 2007; Lauterbach & Hentz, 2005; O'Connell & Dyment, 2011; Thorpe, 2004). Personal and professional growth emerging from continual self-reflection was inherent in the process. No additional direct benefits to the author were identified.

The results of this study contribute to the understanding of clinical training and supervision of novice clinicians, particularly in the area of personal growth and development and the experience of transcendence. The intent is to highlight those elements that can be integrated

into academic, clinical or professional training programs, especially those that can foster such growth and development for these clinicians. Results from this study will be utilized to help develop novel training approaches that may include valued training personal development (Miles & Huberman, 1994).

Researchers Grafanki (2010), Rønnestad & Ladany (2006), Rønnestad & Skovholt (2001), Skovholt & Rønnestad (2003), and Truell (2001) have previously called for these aspects of personal growth to be addressed; it is believed that this data begins to answer these calls.

Chapter IV - Results

The goal of this study was to identify experiences of transcendence as one element of personal growth from the perspective of novice clinicians, as they occurred during clinical training and supervision. The author of this dissertation was one of the three participants contributing journal entries reflected in this study. This study was centered on the following research question:

> Through self-reflection on critical incidents and moments in clinical training and supervision, do novice clinicians experience moments of transcendence as one element reflecting personal growth?

This chapter is organized to explore whether these transcendent moments appear within the supervisory relationship, as identified through the journal entry reflections. The following includes: The data itself including a description of critical incidents or moments of transcendence. Per the data analysis description, 162 codes were identified and then separated into 237 data points; the additional data points resulted from further identifying distinct ideas (learnings) in the coded data. Using thematic categories drawn from accepted definitions of transcendence reflecting the notion of "being or doing more", data was categorized from these 237 data points into 7 categories described below.

Category 1

Pursuit of truth. This category was drawn from the definition of transcendence described by Hora (1987), that is an experience that occurs when a human being becomes more interested in the truth, than in being right. This was operationalized as an emphasis on the pursuit of truth over being right, and involves a specific self-reference or acknowledgement that truth is more important than rightness. The pursuit of truth category yielded fifty-five coded entries.

These entries emphasized the pursuit of truth, over the individual being right or correct, in a reflection of self-reference or acknowledgement. Elements of the pursuit of truth varied, and as put by one of the participants found in vignette 1 (code 1a), lines 27-29:

> "Bravery is facing the truth of your life, and then setting down a path towards the truth of what you want in life, with certainty that you will hit many bumps along the way."

The pursuit of truth becomes the emergence of self-exploration and the recognition of struggle along the way. That aspect of truth is also seen in the reflection of recognition through truth-seeking, as stated in vignette 8 (code 8a), lines 7-8:

> "Having this ability to bring to light something that the client is not, for whatever reason, is an invaluable tool."

This recognition also, at times, emerges out of the novice trainee's reflection on accepting that not all is known, or will be known as found in vignette 19 (code 19a), lines 6-8:

> "This taught me a lot about myself and my tendencies to doubt myself, and helped me to combat these thoughts because I knew that there was no evidence for the client thinking I was incompetent…because it was just silence."

Table 1

Theme 1: Pursuit of Truth, definition of transcendence by Hora (1987)

Category	Key terms	Response
1a	Self-growth, teaching	Committing to self-growth process in order to know [the] self-more truly, and then [I] can begin to teach clients.
2a	Learning	Learning that it is okay and normal to not know everything.
3a	Change, support	Identifying the need to change in order to support our clients.
3b	Learning	Learned that labeling emotions as you experience them makes them feel more manageable.
3c	Learning	I learned to embrace uncomfortable emotions that come up when making mistakes or struggling, in order to learn.
4a	Comfort	Developing comfort with own ability

(continued)

Category	Key terms	Response
4b	Confrontation, uncomfortable feelings	Confronting uncomfortable feelings in order to be a better therapist
4c	Past experiences, stagnation	Past experiences can lead to therapeutic stagnation if unaddressed
5a	Negative impact	Recognizing negative impact of history and past on clinical work.
5b	Recognizing past habits	Realizing aspects of my past and habits from the past freed me to make a different choice about how to approach therapy.
6a	Learning, gratitude	Learned how difficult this can be for so many people, and [I] felt a sense of gratitude for having learned what I learned, that allowed me to stay present with my experience.
6b	Failing, learning	Failing is an important part of learning.
8a	Learning, thoughts and feelings, effort	Learning to attune with client's thoughts and feelings is a worthwhile endeavor, and requires more effort on the part of the therapist than simply physically being in the room.
9a	Helplessness	Helplessness is a feeling to endure and as therapists, we can't create movement without acknowledging it.
10a	Success, failure	Success versus failure
10b	Failing, learning	Failure is an important part of learning
10c	Mistakes, development	Making mistakes is part of the process and necessary to development
10d	Learning	Learning is always taking place, and is an ongoing process.
12a	Knowledge, family, boundaries	It's best to not apply psychological knowledge to family, boundaries
14a	Movement, challenge	[I] learned that I'm not challenging this client and I could be, or can, create movement in the client by approaching it differently
17a	Recognition, learning, roles	Recognizing and learning role of counter-transference on own tone and expression

(continued)

Category	Key terms	Response
17b	Learning, countertransference, awareness	Learned the importance of being conscious of countertransference reactions in session, and that it involves engaging in self-reflection and increased awareness, and contact with unresolved feelings.
18a	Learning, teaching	Learning from this and teaching it to clients out of personal understanding.
19a	Learning, value	learned that silence is not an indication that I've done something wrong, but rather is a valuable tool to be used in treatment
21a	Learning, confidence, competence	Better understanding and experiential learning of the confidence/competence loop
24a	Recognition, experience, connecting to clients	Recognizing experiencing frustration with inability to connect to client.
24b	Distraction, personal life	Recognizing client [is] distracting, and finding [myself] distracting in personal life outside of sessions.
24c		
25a	Past, present, future	My past has dictated my present, but doesn't have to dictate my future
27a	Adapting	Adapting in therapy
28a	Ownership, behavior	Taking ownership of the frustration as belonging to the writer of this story and not coming from the client's behavior.
28c	Frustration	Understanding that frustration is about [the] self, not [the] client
29a	Productivity, growth	Productivity isn't everything, there are different ways of defining and valuing productivity. It takes time and energy to help clients with their growth
30a	Control	Recognizing loss of control
30b	Experience	Opportunity to experience an experience
33a	Sensory acuity, content, process	Attending to sensory acuities leads to deepening session, shifting from content to process.
34a	Review	Reviewing tape led to understanding of session and emotion
34b	Fear, Disconnection	Recognized fear was disconnection
34c	Dread	Dread
34d	Awareness, review	Watching taped sessions help to gain awareness into processes in session that we may not be aware of
35a	Discomfort	Discomfort not disclosing the issue initially

(continued)

Category	Key terms	Response
35b	Recognition	Recognizing mistakes
35c	Vulnerability	Allowing self to be vulnerable, and make voice heard.
36a	Exploration, negative behavior	Exploring the reason for engaging in the negative behavior
36b	Awareness, behaviors	Gaining awareness by exploring difficult behaviors and feelings of myself.
43a	Experience, expression, feelings	Experiencing feelings and expressing them leads to congruence.
43b	Ownership, experience	Feeling true to oneself by taking ownership of own experience.
44a	Speaking your mind, expression, context	Speaking your mind and the truth with others, creates a sense of safety in relationships, in which you feel at ease expressing yourself in whatever context this takes place
47a	Confrontation, understanding, experience	Asking direct questions and making confrontations in clinical work and in daily life to increase understanding of personal and friend's experiences
49a	Decision making	Making better decisions in my dating life
49b	Experiencing feelings, decision making	By experiencing my feelings, I was able to know myself better, and make more informed decisions.
54a	Recognition, emotion, insight, relationships	Allowing yourself to recognize and experience an emotion leads to increased use of knowledge and emotion for good, to benefit one's life, increased insight, increased safety in interpersonal relationships, increased clarity about wants and needs.

Category 2

Self-reflection and self-identity. This category was developed using Rychlak's (1980) definition of transcendence who described it as a human being's capacity to stand toward one's own thoughts, and rise above them to find meaningful self-existence and self-identity. Operationally, this idea was defined as a self-reflection or awareness that leads to greater clarity with establishing or knowing one's self-identity. There were thirty-eight entries that were associated with this category identifying the pursuit towards self-identity.

These reflections or moments that lead to greater clarity about one's self-identity can be recognized in examples such as the following from vignette 7 (code 7a), lines 17-19:

> "I realized that it was very unlikely that my next attempt at therapy would be as bad as the first. So I walked into my next session with little to no fear, and every session after that. It was like an experiment in exposure. I had built up this fear and anxiety about my performance as a therapist, and then experiencing it as being completely different in the room confirmed that I would never need to feel that fear again."

Self-identity is not always reflected in the self; it is in turn, a moment or experience that one recognizes as the development of self-identity through the impact or effect of others, while simultaneously retaining the identity of the self. It is the primary focus of the vignette 1 (code 11a), lines 14-18.

> "My parents taught me that I should be able to deal with [emotions] by not dealing with them, and maintain a positive attitude in life despite negative things happening. And I wasn't able to do this, so I felt shame. I internalized feelings of shame. They became a part of me. Shame. It's one word. That's how I feel. Shame."

It is also seen in the reactions towards others as seen in vignette 14 (code 14a), lines 12-17:

> "I also realized that I was reacting to the person in fear in the same way I had forever reacted to my parents when I experienced sadness in their presence… I was always afraid I would be "found out" and get in trouble because I had a negative emotion. In the same way, I felt the person's sadness in the room but I was afraid the person would find out. I was afraid to admit the depth of the person's sadness to the person, as if the person was reprimanding me for it."

Table 2

Theme 2: The pursuit of self-identity as defined by Rychlak (1980)

Category	Key terms	Response
1a	Self-awareness	Gaining self-awareness
1b	Listening to thoughts, behavior	Learned to not listen to negative thoughts about [individual], or let those thoughts guide my behavior, but that I could be my own guide.
3a	Learning	Recognizing it is a learning process

(continued)

Category	Key terms	Response
4a	Reflection, emotional distress	Reflecting on the emotional distress
4b	Recognition, emotional growth	Recognizing need for emotional growth
4c	Past patterns	Addressing the past patterns
4d	Identification, feelings	Identifying own feelings and emotions
4e	Learning, trust	Personal learning to trust myself
7a	Experience, professional, fear	Fear is worth experiencing to get what I want out of my professional goals
10a	Learning	Learning can be tiring and exciting
10b	Learning	Shift towards learning
11a	Shame, ability, feelings	Internalization of shame through past experiences impact daily ability to feel my feelings
12a	Responsibility, emotion	Sensation of responsibility and power, internalizing emotions and knowledge, family role, and responsibility.
13a	Reflection, boundaries, love	Reflecting on importance of self-care, setting boundaries at home, with family and loved ones, recognizing passion and dreams we pursue and the importance of loved ones in that growth.
14a	Learning	Learning that my response to client was influenced by my family history, and that I can respond differently now.
15a	Learning, validation	Learned the importance of self-validation for being successful in life and as a therapist.
17a	Experience, disappointment	Experiencing disappointment after reviewing session in supervision
18a	Learning	Learned that we can apply what we learn to ourselves; it helps to understand stuff we are doing in session at a personal level
19a	Learning	Learning about the self, recognizing doubt, and acknowledging silence
21a	Recognition, confidence, competence	Recognizing a need to view the self differently, importance of increasing confidence to feel competent
21b	Awareness, competence, confidence	New awareness of competence and confidence

(continued)

Category	Key terms	Response
22a	Understanding, values	Increased understanding about what it takes to behave congruent to values
22b	Emotional experience	Recognizing increased exposure to emotional experience, finding it difficult not to comment on racist jokes, standing up for the self, for one's belief, whole-heartedly, congruent life.
25a	Process, experience	Greater understanding of own processes and tendencies based on past experience
30a	Learning	We have to apply everything we are learning to ourselves first, to fully understand how to help others.
37a	Growth, confidence	Realizing that being brave leads to growth and feeling confident
39a	Change, acculturation	Recognizing something was wrong, making a change, experiencing acculturation
39b	Learning, culture	Learning to mesh one's own cultural background with the therapist culture to develop one's approach in therapy
41a	Bravery, vulnerability	It takes bravery to be vulnerable, and being vulnerable gives you strength as a therapist, bravery or brave acts make us congruent with what we ask of our clients
46a	Knowledge, self-awareness	Application of knowledge to personal life has led to increased self-awareness, better decision making, and greater awareness and understanding of others. More adaptive to hanging moods and feelings with clients (professionally) and with personal relationships
48a	Voice, confidence	Using my voice helped me to feel more confident
50a	Growth	Growth in the program has led to becoming braver, wiser, and more attuned to the self and others. These changes can happen relatively quickly under the right circumstances. Helping others furthers own growth and development
51a	Skill, bravery	Identifying new skills and relationships as a benefit of being brave
51b	Bravery, growth, feelings	Being brave has facilitated my growth in several areas, facing difficult feelings, using my voice, becoming happier, deeper relationships

(continued)

Category	Key terms	Response
51c	Skills, relationships	Approaching new things or things that I'm hesitant about with bravery has resulted in developing new skills and creating new relationships, meaning being brave in both my personal and professional lives has been beneficial in a variety of ways (happier, more well-rounded, increased support, bolder in trying new things, learning new skills, new relationships).
52a	Flexibility	Flexibility in planning activities and social life leads to less concern about planning
54a	Change, emotion, relationships	Changed to actively feel anger, emotion, feeling that led to insight into myself, especially in romantic relationships, and navigating out of toxic relationships.

Category 3

Individual capacity or limitation. The third category used Summers (2012) definition of transcendence that emphasized the potential for going beyond the realized self at any given moment. Operationally, this concept of "going beyond" was understood or recognized in the journal entries as a measure of capacity, or limits and limitation of one's experience, reflecting also learning, growth, being more, and measures of competence. There were sixty-five entries under this category.

Examples of individual capacity or limitation include moments where the trainee is questioning themselves as noted in vignette 12 (code 12a), lines 7-11:

> "This puts you as the trainee in an interesting position… you don't really know what you're talking about just yet but you want to help. But then when you try and help [others], it can become disastrous…opening up doors that have never been opened and that they didn't realize they were opening when asking for your help."

At times it also emerges out of the exploration of the self through the other as seen in vignette 24 (code 24a), lines 8-11:

> "Their [the client] refusal to address their pain means that it stays with me after session, and it does not feel good. I can understand why the person distracts from it, because I find myself doing the same after our sessions."

These entries also presented as an attempt at recognizing one's own capacity and limitation in the work that is being done, within the context of therapy and mental health, as seen in vignette 42 (code 42a, 42b, 42c), lines 7-11:

> "This means that you worry about these feelings in order to have control over them, because you do not feel capable of handling the feelings. Once I learned this, I was able to realize that I am able to handle my feelings as I have been practicing doing so for several months."

Table 3

Theme 3: An individual's capacity or limitation as described by Summers (2012)

Category	Key terms	Response
1a	Understanding	Moving towards understanding what one is capable of
1b	Bravery, embrace	Have to embrace bravery, which means embracing hardship, recognizing truth, having awareness of self, and of what it takes to succeed
3a	Growth	Moving towards growth
3b	Control, learning	Letting go of control and allowing myself to make mistakes while learning
5a	Growth	Moving towards overcoming the negative impact and moving towards growth
6a	Learning	Learning takes time
6b	Gratitude, learning	Feeling gratitude for knowledge, learning leading to emotional strength
6c	Learning	Learning won't happen if you don't try new things
7a	Reframe, anxiety	Reframing anxiety into excitement
7b	Fear, excitement	Understanding fear in a different way, as excitement in this case, and something worth facing.
7c	Fear, reframe	Reframing fear as excitement
7d	Willingness	Willingness to try again
8a	Skills	Identifying necessary basic skills
10a	Learning	Integrating new learning as knowledge

(continued)

Category	Key terms	Response
10b	Learning	Learning won't happen if you don't try new things
12a	Learning	Learning how to maintain professional and ethical boundaries with family members
15a	Learning	Learning to confront the client with truth, learning to trust the self in the room, understanding full range of emotions
16a	Learning, empathy	Learned what true empathy is and how it can be expressed, how empathy results in increased awareness of emotional strength
18a	Awareness, change	Awareness of patterns makes it possible to change them
18b	Learning	Learning to identify patterns, understand patterns, recognize them, and reverse them
19a	Awareness	Awareness of discomfort with silence and ability to work through that discomfort.
20a	Validation, listening	Listening, validating, and sitting with client's uncomfortable feelings is how to approach treatment and silences
20b	Comfort, experience, feelings	I have to be comfortable myself with unpleasant feelings, in order to sit with the client's experience instead of trying to fix it
20c	Recognition, validation, growth	Recognizing comfort with experiencing helplessness, recognizing need to listen and validate, use discomfort for purposes of growth in the room
20d	Learning	Learned to become comfortable with silence and difficult feelings that come up in silence
22a	Congruence, change	That living a congruent life can be difficult as perspective changes, but it [is] ultimately well worth it.
23a	Teach, improvement	Ability to teach clients what we are able to improve on ourselves, difficulty teaching clients what we are afraid to do
23b	Learning	Experiential learning of therapeutic concepts is important to our success in using them
24a	Empathy, feelings	When feelings aren't addressed or "owned" in session, they can be experienced as lingering discomfort within the therapist, which helps to increase empathy for client's experience
25a	Frustration, anger, reflection	Experiencing frustration and anger and reflecting on need to diffuse unpleasant feelings

(continued)

Category	Key terms	Response
26a	Acceptance, change	Acceptance leads to change or makes change possible
26b	Acceptance, change	Acceptance can lead to change
27a	Adapt	Our ability to adapt is what makes the chaos of life manageable, and is almost evidence that we are supposed to live in this ever changing chaos
27b	Adapt	Recognizing that adapting is crucial in effective therapy
29a	Growth	Recognizing growth
29b	Productivity	Feeling productivity
29c	Growth	Directing energy into fewer things can create focus, calm, and more growth
30a	Growth	Need to engage in personal growth in order to help clients
31a	Change	Adjusting to changes based on treatment planning
31b	Adapt, flexibility	Remaining adaptive, prepared but flexible, keeps us in the dance" or able to work effectively as clinicians
31c	Adapt, flexibility	Importance of adapting and being flexible while holding the treatment plan in mind
31d	Adapt, flexibility	Adapting and preparing with flexibility
32a	Growth	Recognizing content versus process to facilitate growth
33a	Acuity	Attending to acuity led to depth in conversation
37a	Bravery, comfort	Using bravery, one can enter situations in which they are not yet comfortable or "ready" per say
39a	Change, competence	Making a personal change for the purposes of increasing therapeutic competency is a gradual process which shifts the whole experience
41a	Vulnerability	Recognizing vulnerability as a therapist, willingness to make myself vulnerable
41b	Growth, competence, strength	Using bravery as a way to face challenges in the growth process, as well as to increase strength and competence
42a	Feelings, experience	Realizing one is able to handle feelings, allowing the self to experience and express an experience
42b	Learning	Learning you can handle your feelings

(continued)

Category	Key terms	Response
42c	Learning	Learning to manage your feelings more effectively
43a	Growth, vulnerability	Gaining personal and professional growth by facing vulnerability
43b	Vulnerability, teaching	Vulnerability helps build strength and resiliency, increase honesty with others, and development of deeper bonds with others. Personal practice accepting and embracing vulnerability leads to greater ability to teach this to clients
45a	Shift, knowledge	Attitude shift impacting clinical work and change in attention, notes, reading, and application of knowledge in personal and professional lives
46a	Attunement	Attuning to others verbal and nonverbal
46b	Understanding	Greater understanding based on intuition
48a	Contribution	Recognizing speaking up leads to contribution
48b	Voice, recognition	Pursuing finding own voice and recognizing challenging myself leads to increased rewards
48c	Voice, truth, vulnerability, depth	Using 'voice' means speaking up about the truth of your experience, adding to your experience and those of others of being in the world. It requires facing potential or perceived embarrassment and vulnerability. Speaking up leads to greater depth in connections with others, increased understanding of others, and increased self-confidence. Increased self-agency
49a	Attunement	Finding space to be more in tune with own process in the moment to moment
49b	Awareness	Greater awareness of emotions as they erupt moment-to-moment leads to, or allows for making better decisions in various areas of life, quicker than if one was not aware of these things. Sometimes allows one to avoid negative experiences altogether (creates increased safety).
52a	Learning, flexibility	Learning to accept change and appreciate calm moments has helped me be more flexible
53a	Support	Seeking out support of colleague to feel "afloat."

(continued)

Category	Key terms	Response
54a	Experience, knowledge, insight, clarity, needs	Allowing yourself to recognize and experience an emotion leads to increased use of knowledge and emotion for good, to benefit one's life, increased insight, increased safety in interpersonal relationships, increased clarity about wants and needs.

Category 4

Critical moments involving others, or altruism. The focus of the fourth category utilizes the definition of transcendence by Vago and David (2012) who understood the concept as the quality with which one brings awareness to oneself and those around us. Operationally, this was defined as highlighting moments of teaching for others, with more specificity, or where there is an emphasis on the altruistic nature or intent of the individual. This category consisted of forty-five entries.

Examples of these moments of altruism were recognized through the self-sacrifice of emotional distress for the benefit of another, as noted in vignette 9 (coded 9a, 9b, 9c), lines 18-22.

> "I believe the first step to opening a door where the client can begin to explore their pain is by sitting with them in their experience of hopelessness, which is truly helplessness that has been endured for so long that they no longer have sight of how they came to be that way. The therapist must endure their own helpless feelings to sit with this client, so that they feel their state of being (or not being) is understood, is not hopeless, and is in fact very sad."

These themes also emerge out of the desire to help others, as noted in vignette 16 (coded at 16a, 16b), lines 20-23:

> "However being empathic is to acknowledge the difficult situation the client is experiencing, recognize it aloud, and sit with the client in their discomfort of experiencing it to demonstrate that it is tolerable, acceptable, and a normal response to what they are going through."

More closely tied to the concept of altruism, there is a sense that a moment of reflection on our own loss or connection to others (e.g. the loss of contact with intimate relationships) is guided by a pursuit towards the other as noted in vignette 38 (code 38a, 38b, 38c), lines 13-14.

"We learn, because it will help our clients. We learn, because it will help someone's life."

Table 4

Theme 4: Moments involving others altruism as defined by Vago & David (2012)

Category	Key terms	Response
1a	Growth, teaching	Shifting towards finding a way to teach others, our clients, how to achieve similar growth
2a	Growth, development	Recognizing growth, development, constant move towards learning more
3a	Change, support	Identifying the need to change in order to support our clients.
5a	Patterns	Past patterns can come up unexpectedly, but I addressed them and was able to adjust my approach with clients
6a	Emotions, feelings	Recognizing others inability to access emotions or feelings
6b	Experience, knowledge	Experiencing a desire to share the knowledge with others
6c	Learning	Learning can be tiring and exciting
8a	Needs	Attending to client needs.
8b	Insight	Providing insight
9a	Experience	Moving client towards emotionally distressful experience, by sitting in the experience with them.
9b	Helplessness	Enduring own helpless feelings to help client move towards growth
9c	Tolerance	Realizing that I need to be able to tolerate client's pain with them
11a	Processing emotion	To help a patient process emotion, they have to feel it, go through it, connect to it.
12a	Learning	Learning how to maintain professional and ethical boundaries with family members

(continued)

Category	Key terms	Response
13a	Change, relationships	As you change, the people around you notice and are affected by it too. It's important to be conscious about what we're learning relative to how it impacts others, our world, our relationships
13b	Presence, support	Be present with your loved ones, and grateful for their support
14a	Learning, experience, emotion	Learning about reaction in parallel process to own experience, identifying sadness, recognizing inability to experience full range of emotion (sadness) with the client
16a	Learning, empathy, distress	Learning role of empathy, reflecting on true empathy, sitting in discomfort with a client as they experience emotional distress
16b	Tolerance, emotions	Tolerating difficult emotions with client helps client learn to tolerate them
17a	Motivation, awareness	Feeling motivation to increase awareness of counter-transference
17b	Awareness, counter-transference	Importance of being aware of, and working through, counter-transference
18a	Awareness, change	Awareness of patterns makes it possible to change them
23a	Experience, confidence	experiencing a concept on a personal level increases ability and confidence to share with client
29a	Growth	Recognizing growth
32a	Content, process, generalization	Differentiating content versus process with clients is valuable for work with that person, and generalizes to work with all clients
32b	Growth, confidence	Experiencing a growth experience in a session with one client, can increase feelings of confidence in my ability to do the same with other clients
33a	Instinct, trust	Realization to follow one's instincts and trust attunement with client as it often has therapeutic relevance
33b	Safety	Developing safe space
34a	Fear, disconnect, challenge	Fearing as a clinician a disconnect relates to fearing an emotional disconnect that doesn't allow you to help the client, which happens when you don't challenge the client to dig beneath the surface

(continued)

Category	Key terms	Response
35a	Experience, value	Always speak up about your experience because there is value in doing so, for yourself and for other
35b	Learning	Realizing that speaking up can lead to learning for both myself and my peers
38a	Shift, learning	Recognizing shift in education towards learning to help clients, help others, and because we want to
38b	Learning, purpose	Learning for intrinsic and altruistic purposes creates true purpose
38c	Learning	"True education" involves learning for intrinsic value and to benefit others, not ourselves
43a	Change, deeper bonds	Establishing deeper bonds with people in my life by changing and modeling behavior in clinical work
43b	Vulnerability, honesty, strength, teaching	Vulnerability helps build strength and resiliency, increase honesty with others, and development of deeper bonds with others. Personal practice accepting and embracing vulnerability leads to greater ability to teach this to clients
45a	Learning	Learning not only for the self, but learning for the client
45b	Learning	Learning in program is to benefit clients, not ourselves
45c	Learning	Learning for the benefit of clients increased my dedication to my education
50a	Contribution, sharing	Desire to contribute to others lives and share and help others
50b	Growth, development	Growing and developing to help others, by furthering and growing and developing
50c	Experience, growth, development	Desire to share experiences with others, and help others experience the same growth and development
50d	Growth, attunement, development	Growth in the program has led to becoming braver, wiser, and more attuned to self and others. These changes can happen relatively quickly under the right circumstances. Helping others furthers own growth and development

Category 5

Externalized reflection towards the other. The fifth category was identified as a sense of identity of the self that extends beyond the individual or personal to encompass wider aspects

of humankind, life, psyche, or cosmos (Clark, 1998). Operationally, this was understood as the higher part of the self and the universe, recognized through awe, inspiration, or moments of spirituality, of vignettes focused on moments of growth and development in association towards others, rather than an inward reflection towards the self. There were a total of eighteen codes in this category.

Examples of this include generalized approaches to learning and recognizing it is an ongoing process, as noted in vignette 23 (coded 23a), lines 18-22:

> "This new-found ability came from learning how to pay attention to my thoughts and feelings, only because I learned how to help clients do this to improve professionally. It was apparent within a week that if I couldn't figure out how to do this on my own, there was no way I was going to teach it to a client. Helping someone else navigate a road you've never been down is nearly impossible."

There is also the recognition of learning and the time it takes to go through this process, as noted in vignette 10 (coded 10a), lines 8-11.

> "The process of taking in new information, letting it sit with you while you identify how it is either in sync with or out of sync with information that you already possess, while you learn what it is like to apply it, and fumbling your way through it… all of this is a process."

It is also about developing the comfort to ask questions of others through a sense of curiosity, as noted in vignette 47 (coded 47a, 47b, 47c), lines 8-11.

> "This has had the biggest impact with my clients, as I am more at ease asking them direct questions or making confrontations, but I have also noticed that by using this approach in my daily life, I am able to acquire much more detail about even my closest friend's experiences, which has been satisfying to both me and them."

Table 5

Theme 5: Externalized reflections towards others as understood by Clark (1998)

Category	Key terms	Response
2a	Growth	Accepted growth as a process and journey
6a	Learning	Learning is always taking place, and is an ongoing process
8a	Presence, connection	Understanding the importance of presence, and being emotionally connected through fundamental skills
10a	Learning	Learning takes time
17a	Feelings	Disregarding the feelings of others
23a	Growth	Growth from experiencing genuine and congruent modeling through supervision and training
24a	Feelings, avoidance	Client's avoidance of feeling in session means the feeling is being held by clinician
32a	Content	Recognizing blank stares as content
36a	Change, shift	In order to understand shifts or changes with us, we need to consider contextual changes (ex: time and timing).
44a	Safety	Creating safety between the self and others
44b	Emotions, safety, connection	By choosing to speak up and face difficult emotions, in doing so, I can create safety in relationships leading to deeper connection to others
46a	Adjustment, relationships	Adjusting mood and feelings in clinical work and in interpersonal relationships
47a	Curiosity, understanding, experience	Curiosity, when coupled with kindness, is likely to be received well and responded to with enthusiasm, and allows for greater understanding of the experiences of others
47b	Comfort, understanding	Feeling comfortable to ask questions and be curious allows me to understand my clients and friends better
47c	Recognition	Recognizing impact of asking questions on clients

(continued)

Category	Key terms	Response
48a	Truth, experience, vulnerability, depth, confidence	Using 'voice' means speaking up about the truth of your experience, adding to your experience and those of others of being in the world. It requires facing potential or perceived embarrassment and vulnerability. Speaking up leads to greater depth in connection with others, increased understanding of others, and increased self-confidence. Increased self-agency
53a	Support, confidence, competence	When struggling, it's effective to reach out to others for support and/or remind myself of the confidence/competence loop (that things will get better again).

Category 6

Moments of growth through peak experience. The sixth category utilized Maslow's (1954) view of transcendence, which involved furthering a cause beyond the self and moving beyond the boundaries of the self through peak experiences. Operationally, this idea was defined as self-growth through an identifiable peak experience. This category had a total of four entries.

Although limited in terms of quantity, moments of peak experiences did emerge, and they include examples such as the emergence of traits of bravery, as noted in vignette 37 (coded 37a, 37b), lines 7-9, and 23-28.

> "We're here to change people's lives, but we have to understand that we will never get more than the tip of the iceberg and hope that it's enough to help them. Is it ever enough?" … "I had an absolute fear that I would be doing something wrong, or that somehow I would ruin someone's life, or not be able to help them, or even worse, not be able to save them from themselves. The prospect of a suicidal client or patient is terrifying. This was where the first application of bravery came into place. It was time to step out of my comfort zone and be brave, and so I was. It was the most liberating experience I could have possibly imagined.

Table 6

Theme 6: Moments of growth through peak experiences (Maslow, 1954)

Category	Key terms	Response
7a	Reflection, distress	Recognizing and reflecting on benefit of experiencing distress and overcoming the challenge
11a	Reframe, feelings, emotions	Reframing psychological disorder as shame, recognizing shame and emotions, internalizing feelings, ownership of emotions
37a	Feelings	Feeling liberated stepping into the room
37b	Experience, bravery	Experiencing moment of bravery.

Category 7

a higher part of the self, connecting to a higher part of the universe (Torrance, 1994), which is operationally understood as the higher part of the self and the universe are recognized through awe, inspiration, or moments of spirituality

Moments of awe and spirituality. The seventh category was represented by Torrance's (1994) definition of transcendence, which described a higher part of the 'self' connecting to a higher part of the universe. Operationally, this idea was recognized as the higher part of the self and the universe, understood through awe, inspiration or moments of spirituality. This category had a total of eight entries. Although brief in mention, the emergence of these moments of awe were present and candid.

One experience shared by a participant included the following, as seen in vignette 6 (coded 6a, 6b), lines 11-12.

> "I sat back in awe, as I listened to my family talk about their state in a rigid, emotionless, matter of fact way."

It also presented through the emergence of living a full experience and gaining insight, as noted in vignette 54 (coded 54a), lines10-11.

> "I was able to understand it more and use it to my advantage. Having access to my feelings of anger gave me much more insight into myself."

Table 7

Theme 7: Moments of awe and spirituality as defined by Torrance (1994)

Category	Key terms	Response
6a	Awe	Sitting in awe listening to family
6b	Gratitude, learning, strength	Feeling gratitude for knowledge and learning leading to emotional strength
26a	Acceptance, gratitude	Accepting bad feelings, moving forward, gratitude.
38a	Learning, purpose	Learning for intrinsic and altruistic purposes creates true purposes
43a	Bravery	Choosing to be brave
52a	Learning	Shifting mindset to learn and embrace new things
52b	Change	Embracing change allows one to enjoy and appreciate moments of serenity and calm, decreases rigidity, and increases spontaneity
54a	Awareness, experience, insight	Being aware of feelings opens you up to living your full experience and gaining insight

Summary

In total there were two hundred and thirty-seven coded statements that emerged out of fifty-three useable journal entries used to answer the question: "Through self-reflection on critical incidents and moments in clinical training and supervision, did the individual experience moments of personal growth as reflected through the experience of transcendence?" More specifically, this writer was interested in the aspect of transcendence that reflected "being or doing more". With this distinction of transcendence in mind, definitions found in research literature conveying this quality of transcendence were used to establish the content coding categories.

More specifically, transcendence, known by the quality of "being more" was framed by definitions that included: the pursuit of truth (Hora, 1987); moments of self-reflection or

awareness that led to elements of self-identity (Rychlak, 1980); the recognition of "going beyond" through capacity, limitation and growth (Summers, 2012); the higher part of the self and universe through awe, inspiration, or spirituality (Torrance, 1994); a connection beyond the self in non-specific reflections (Clark, 1998); the pursuit of teaching others or moments of altruism (Vago & David, 2012); and moments of self-growth through identifiable peak experiences (Maslow, 1954).

Aspects of these definitions of transcendence were identified in the participant's journal entries. Out of the 237 coded statements, the theme that emerged most frequently was the concept of "going beyond" as seen through the lens of capacity, limitation and growth (Summers, 2012), with 65 of the 237 entries. This is the aspect of growth that is most frequently associated with issues of competence. The pursuit of truth over being right was the second most frequent code with 55 entries (Hora, 1987), followed by the emergence of altruism and the pursuit of knowledge for the other with 45 entries (Vago & David, 2012). The exploration of self-identity through these critical incidents was also found frequently and was seen in 38 entries (Rychlak, 1980). The two categories that emerged least frequently included reflections beyond the self with 18 entries (Clark, 1998), moments of awe and spirituality with 8 entries (Torrance, 1994), and self-growth through peak experiences with 4 entries (Maslow, 1954).

Chapter V - Discussion

Overview

This research was designed to further understand the importance of personal growth in conjunction with professional development (Fouad et al., 2009; Rodolfa et al., 2005; Rubin et al., 2007). These moments of growth, both personal and professional, reflect the presence of a transcendent experience. The nature of the existing literature on personal growth as it relates to novice trainees is vastly retrospective in nature (Carlsson et al., 2011; Rønnestad & Skovholt, 2001; Trotter-Mathison et al. 2010). Thus, the more specific purpose of this study was to identify experiences of transcendence as one element of personal growth, from the perspective of novice clinicians, as they occurred during clinical training and supervision. The research question, "through self-reflection on critical incidents and moments in clinical training and supervision, do novice clinicians experience moments of transcendence as one element reflecting personal growth", was answered affirmatively by this investigation. This chapter presents a discussion of the findings described in Chapter IV, including limitations, recommendations for further research and implications for clinical training.

Overall Trend of the Data

Starting first with a broad review of the data, the different aspects of transcendence emerged with the following frequency: issues of capacity (65 entries); pursuit of truth (55 entries); emergence of altruism (45 entries); self-identity (38 entries); reflections beyond the self (18 entries); awe and spirituality (8 entries); and self-growth through peak experiences (4 entries). The order of the data implicitly suggests there are aspects of clinical training that emerge more frequently, with the possibility this order also highlights a level of importance for novice clinicians.

Maslow's hierarchy of human needs suggested that his motivational hierarchy towards self-transcendence was the highest form of motivational development (Koltko-Rivera, 2006). Later revisions of Maslow's hierarchy emphasized less of a hierarchical system, and more of a pursuit towards self-fulfillment, where each level in ascending order referred to: (a) obtaining basic necessities, (b) seeking security, (c) seeking affiliation with a group, (d) seeking recognition or achievement, (e) seeking fulfillment, and lastly (f) self-transcendence, seeking to further a cause beyond the self and experience a communion beyond the boundaries of the self through peak experience (Koltko-Rivera, 2006).

Interestingly, the frequency and order of the coded material, as identified by study participants, loosely parallels Maslow's hierarchy of needs and the data seems to suggest there may either be a developmental trajectory for trainees or a trainee hierarchy of needs where; (a) issues of capacity (65 entries) provide the basic skill development needed for clinical work; (b) the pursuit of truth (55 entries) reflects the theme of security in understanding and pursuing truth, learning, and knowledge; (c) the emergence of altruism (45 entries) reflects a desire to connect or affiliate with others, (d) the development of self-identity (38 entries) reflects the trainees need to reconcile and achieve their goals; (e) reflections beyond the self (18 entries) and awe or spirituality (8 entries) reflect the idea of seeking fulfillment; and lastly (f) self-growth (self-actualization) through peak experiences (4 entries), which reflects the common view of self-transcendence.

Issues of Capacity

Issues of capacity, which emerged with the highest number of coded entries appears tied to a trainee's expected growth and experienced growth. The first thread involves measuring one's own expertise and understanding their training capacity and purpose, and the second is the

issue of competence, a commonly identified benchmark established and used for training novice clinicians. These measures of capacity are likely at the forefront of many trainees' minds as their years of graduate education and clinical practice unfold.

Summers' (2012) definition of transcendence emphasized the potential for going beyond the self at any given moment. Operationally, this concept of "going beyond" was defined as a measure of capacity or limits/limitations of one's experience, reflecting also learning, growth, being more, and measures of competence. This aspect of transcendence emerged with the greatest number of coded entries and there may be several possible explanations for such an occurrence., which include: (a) clinical training is centered on achieving competency benchmarks, (b) measuring self-capacity as it relates to developing expertise, and (c) reconciling comfort in clinical settings.

Issues of competence and technique arise out of the emphasis placed on clinical training as a key measure of professional competence (Falender & Shafranske, 2012a). This emphasis raises questions regarding the actual needs of trainees or whether the study participants' focus on capacity (competence) concerns were more reflective of the training program's influence on them. It is possible that study participants associate growth with competence given the frequency that issues of capacity were raised. The current model using competency benchmarks continues to be the backbone of training and supervision programs in the field (APA, 2002a; Eva & Regehr, 2008; Falender & Shafranske, 2012a; 2012b; Watkins Jr., 2012), yet these benchmarks only capture a small portion of the trainee's experience, needs and wants.

One element reflecting trainees' needs involve perceptions of negative experience and specific incidents that lead to moments of growth and one's own capacity. Examples include code 5a "moving towards overcoming the negative impact and moving towards growth", code 3b

"letting go of control and allowing myself to make mistakes while learning", code 7c "reframing fear as excitement" and code 24a "when feelings aren't addressed or 'owned' in session, they can be experienced as lingering discomfort within the therapist, which helps to increase empathy of client's experience." These entries parallel ideas described in humanistic theory by identifying the importance of supporting client growth through increasing one's own capacity to overcome challenges and conflict (Elkins, 2009).

The expertise literature may help explain why transcendence, as reflected through capacity, was the most frequently coded category. Results from this study were consistent with observations made by Ellis (2006), and Fine and Fenell (1985), who noted that the highest self-critique for trainees are competence, autonomy, purpose and direction issues.

What is highlighted here is the aspect of expertise developed from persistent, goal-directed practice (Ullén, Hambrick, & Mosing, 2016). Expertise addresses the amount of learning needed to thrive (Day, Arthur, & Gettman, 2001) and it is recognized as a knowledge structure that measures skill acquisition and training success for trainees (Day et al., 2001). Thus, as trainees maintain a focus on their knowledge acquisition and skill development, elements of capacity (competence, limitations) likely remain at the forefront of their attention.

A third characteristic of capacity, "comfort", was a recurring theme found in this coding category. Comfort may be another way to express competence. For instance, participants noted in code 19a "awareness of discomfort with silence, and ability to work through that discomfort," and code 20c "recognizing comfort with experiencing helplessness, recognizing (the) need to listen and validate, use of discomfort for purposes of growth in the room," and code 37a "using bravery, one can enter situations in which they are not yet comfortable or "ready" per se". The development of professional experience alone does not create competence, comfort, or learning.

When formal training is interwoven with experience, these measures of competence further develop (Jahn, Quinnett, & Ries, 2016).

The nature of the training environment and graduate education demands may have influenced the frequency a novice clinician would describe thoughts related to competence, or limitations achieving said competence; as a result, capacity was the most frequently coded element of transcendence. It is common for novice trainees to be exposed to information regarding practica placements, internship, and post-doctoral fellowships and the related competency benchmarks that often guide their training. Consequently, competence remains at the forefront of their minds as they both internally and externally, with supervisors, track their own growth.

Pursuit of Truth

The pursuit of truth was understood operationally in this study as an emphasis on the pursuit of truth over being right (Hora, 1987); it involves a specific self-reference or acknowledgement that truth is more important than rightness. The pursuit of truth was observed in the context of embracing knowing and not-knowing, and also in the drive towards recognizing purpose in one's actions.

The pursuit of truth was first reflected in statements where the trainee embraced the idea that they cannot, do not and will not know everything at any given moment. It involved recognizing failure and mistakes, as one sought to further understand the self. Certainly the structure of graduate education and the inherent emphasis on achievement likely influences a trainee's need to recognize, reconcile, correct and learn from mistakes.

Entries coded using this understanding of transcendence involved understanding the self through acceptance and recognition of failure. Examples include code 6b "failing is an important

part of learning", code 24c "experiencing failure as a therapist", 2a "learning that it is okay and normal to not know everything", code 10b "failing is an important part of learning", 1a "success versus failure" and lastly code 10c "making mistakes is part of the process and necessary to development.' Acceptance of failure becomes an important factor in the face of negativity that promotes an investment in energy and a deeper level of processing (Hilbig, 2012).

The experience of failure is subjective (Fazio, Brashier, Payne & Marsh, 2015), yet training programs can train for attitudes and responses to failure. Although some clinical training programs support aspects of personal growth (Ieva et al., 2009; Lennie, 2007; Luke & Kiweewa, 2010), there is rarely formal training to support the trainee through development that parallels failure (Jahn et al., 2016). Consistent with earlier research, what these results suggest is that the trainee exhibits motivation for change and growth, and that growth may be facilitated by the recognition that failure as an experience can be a developmental milestone.

The pursuit of truth was observed in examples of challenging experiences leading to growth as seen in code 4b "confronting uncomfortable feelings in order to be a better therapist." Listening to experience as an element in the pursuit of truth was also recognized as important, as represented by code 24c "experiencing failure as a therapist", code 30b "opportunity to experience an experience," code 43a "experiencing feelings and expressing them leads to congruence," and code 49b "by experiencing my feelings, I was able to know myself better, and make more informed decisions."

Motivation is an attempt towards realizing one's own potential (D'Souza & Gurin, 2016) that leads to growth and realizing self-actualization and self-transcendence (Maslow, 1943, 1973). These latter codes represent a motivation for change and growth influenced by precipitating events (Heatherton & Nichols, 1994; Lickel et al., 2014) and the experience of the

trainee, not the anticipated change of their training environment (Amabile, 1996; Forgeard & Mecklenburg, 2013).

Personal growth and pursuit of truth were also recognized in code 1a “committing to self-growth process in order to know [the] self-more truly, and then [I] can begin to teach clients” , code 28b “identifying impact of own frustration”, code 36b “gaining awareness by exploring difficult behaviors and feelings of myself” and code 49b “by experiencing my feelings, I was able to know myself better, and make more informed decisions.”. These entries reflect the concept of movement towards a purpose (Frankl, 1963). This purpose-driven experience of transcendence distinguishes between the means (awareness) and the ends (informed decisions) and indicates the emergence of the two themes crossing over (Koltko-Rivera, 2006; Maslow, 1987). Applied, this concept provides the trainee with an opportunity for growth in what is otherwise recognized as a negative experience.

Altruism

Altruism involves an awareness of the self and those around us (Vago & David, 2012), which was operationally understood in this study as highlighting moments of teaching for others, with more specificity, or where there is an emphasis on the altruistic nature or intent of the individual.

Vago & David (2012) recognize transcendence as the quality with which one brings awareness to the self, and to those around the self. It is seen through the emergence of altruism, also described as compassion, meaning, enduring something with another person, to put ourselves in someone else’s' shoes, and feeling the pain of the other as our own (Saslow et al., 2013).

There is a striking connection between the pursuit of altruism and the concept of the wounded healer as in vignette 9b "enduring [my] own helpless feelings to help [the] client move towards growth." This journal entry suggests a novice clinician can recognize there are degrees of sacrifice in the conduct of therapy and that he or she can make those sacrifices. The wounded healer archetype suggests that the healer, or in this case a novice trainee, uses his or her own wounds as a curative power for clients (Zerubavel & Wright, 2012).

The wounded healer archetype parallels the novice clinician's pursuit of altruism in the face of adversity; as he or she becomes increasingly aware of the self (healer), there is increasing awareness of the other (the client or patient). These negative experiences can elicit growth in the core self, often accessed during times of struggle (Pargament & Sweeney, 2011). Study results involving altruism support prior research.

The work of the novice clinician is thus grounded in human suffering (Linley & Joseph, 2007). Suffering, painful experience or adversity are the resources of the wounded healer that involve a duality of experience (Zerubavel & Wright, 2012) meaning the therapist must access his or her pain to facilitate growth for clients. Consistent with Rogers (1956) much earlier view, the therapist is only capable of taking their clients as far as they themselves are capable. If the novice clinician has difficulty accessing his or her own experience of suffering and vulnerability, it can fracture the therapeutic relationship (Gelso & Hayes, 2012).

Additional examples of altruism are seen in code 6b "experiencing a desire to share the knowledge with others", code 35a "always speak up about your experience because there is value in doing so, for yourself and for others" and code 38b "learning for intrinsic and altruistic purposes creates true purpose." These journal entries capture the transition towards compassion

and altruism with a developing sense of purpose and meaning; study results are consistent with earlier writing.

Frankl (1963) argued that the purpose of life is to drive towards the feeling that one's actions are important for the world. Yeager, et al. (2014) argued that life was about making use of it, and not throwing it away. The pursuit of altruism has always been rooted in purpose-driven living, in the reflection that the virtue of transcendence in rooted in building meaning for both the self and for others (Palanski & Yammarino, 2007; Sosik & Cameron, 2010). The journey becomes self-exploration through the lens of supporting the other, to experience the full range of capacity that Rogers (1956) emphasized much earlier.

A sub-theme that emerged under altruism was the desire to teach or share knowledge with others. Code 6b "experiencing a desire to share the knowledge with others" and code 1a "shifting towards finding a way to teach others, our clients, how to achieve similar growth" are examples. It is possible this sub-theme emerged based on the very nature of clinical work as it is altruistic and purpose-driven in nature, a field and career designed to understand and help others. Likewise, the heavy emphasis on academia and role models through professors, academic support, supervision, and training environments are likely to influence a trainee's desire to share his or her knowledge.

Self-Identity

Maslow (1968) identifies identity as one emergent trait in the development of the real self, identity, and self-actualization. . Watkins (2012a) further suggested the developing identity of the therapist through self-questioning about one's own capacity and competence is a painful process for trainees. Self-identity was understood operationally as: self-reflection or awareness that leads to greater clarity with establishing or knowing one's self-identity (Rychlak, 1980),

The development of self-identity as a therapist seems tied to the idea that a therapist culture exists and that one is acculturated into it through a combination of coursework (e.g., legal and ethical, multicultural, professional issues courses) and clinical practica. There were attempts to understand the self as seen in vignette 1a "gaining self-awareness," or 4b "recognizing [the] need for emotional growth", and specific to therapist acculturation, as noted in 22a "increased understanding about what it takes to behave congruent to values". This exhibits the drive towards learning and growth that is emphasized in self-transcendent motives by creating personal meaning and prosocial purpose (Brophy, 2008; Yeager et al., 2014). The APA competency benchmarks may also represent elements of acculturation into a professional identity (APA, 2002a; Eva & Regehr, 2008; Falender & Shafranske, 2012a; 2012b; Folkes-Skinner et al., 2010; Fouad et al., 2009; Watkins Jr., 2012).

There were several examples where the participants identified the need to pursue a sense of self-identity as their means of attaining growth. At times, it simply involved growing awareness, as seen in code 4b "recognizing (the) need for emotional growth", code 4d "identifying own feelings and emotions" and, code 4e "personal learning to trust myself".

Beyond the Self, Spirituality, and Peak Experiences.

The last three categories appeared least frequently. These categories include reflections beyond the self (Clark, 1998) with eighteen entries; moments of awe and spirituality (Torrance, 1994) with eight entries; and self-growth through peak experiences (Maslow, 1954) with four entries.

Clark (1998) defined transcendence as the exploration of the self beyond the individual. Operationally, journal entries were coded here when the connection beyond the self is externalized, broad, and/or not-specific to the individual's growth or where identified elements in

the journal entry did not target or reflect the individual's behavior. These entries were broadly associated with an "other". Examples included code 17a "disregarding the feelings of others," code 44a "creating safety between the self and others," and code 23a "growth from experiencing genuine and congruent modeling through supervision and training."

Moments of awe and spirituality involved a higher part of the self, connecting to a higher part of the universe (Torrance, 1994), which was operationally understood as the higher part of the self and the universe recognized through awe, inspiration, or moments of spirituality; Moments of awe and spirituality were identified in code 6a "sitting in awe listening to family" and code 54a "being aware of feelings opens you up to living your full experience and gaining insight." Awe, involves reverence and appreciation (Peterson & Seligman, 2004) and an emotional perception of admiration (Bussing et al., 2014). The experience of awe was infrequently described and coded; perhaps the fast-paced nature of graduate education and its respective demands predominate over awe-inspiring moments for trainees.

Peak experiences involved furthering a cause beyond the self and moving beyond the boundaries of the self through peak experiences (Maslow, 1954). It was operationally understood as self-growth through an identifiable peak experience. Coders captured this peak experience of liberation in code 37a "feeling liberated stepping into the room," and code 37b "experiencing a moment of bravery." Although limited in scope, these few moments reflect a significant experience of growth for trainees.

Journal entries that involve qualities beyond the self, awe, spirituality and peak experiences reflect more traditional views of transcendence. "Beyond the self" experiences are influenced by the concept of learning, teaching, and being more for others. Perhaps the limited number of codes occurring under this last category reflects the predominant focus on capacity

(competence) as the key aspect of training. Trainees are so overwhelmingly focused on exhibiting the skills and knowledge base reflecting competence that peak experiences or experiences of awe and spirituality are either not noticed or minimized.

Research Limitations

Limitations outlined in this study include the use of a limited and small homogenous sample that received training from the same supervisor and training program. Coding qualitative data is inherently difficult and the absence of prior coding experience suggests that some data may have been overlooked or the meaning of data not fully understood. Coding using an autoethnographic approach is implicitly biased. Self-selection bias also applies to the submission of the researchers own reflective journal entries. Dunning, Heath, & Suls (2004) caution the use of accurate self-assessment due to the nature of self-reporting measures being limited and the bias of the researcher authoring some of the journal entries.

This researcher used a data analysis approach that may be limited by its thorough understanding of context and a narrow bias may be reflected in the data (Hsieh & Shannon, 2005), due to this researcher's experience, bias and culture. Additionally, the limited (small) sample size makes the results of this research difficult to generalize given that small samples consistently overestimate rare events (Oeberst & Haberstroh, 2014). This research endeavor was exploratory in nature and researchers are encouraged to use observations from this study as a catalyst for future research.

Implications and Recommendations

This research endeavor sought to identify experiences of transcendence as one element of personal growth, from the perspective of novice clinicians, as they occurred during a first year supervision and clinical training experience. Initial findings show that transcendence, as it is

reflected in multiple iterations (e.g., capacity, altruism, awe, spirituality, peak experiences) is experienced as a result of supervision and clinical training.

The retrospective nature of most research on aspects of personal growth and training makes it difficult to capture more than broad strokes or elements of the emergence of these traits within training environments (Carlsson et al., 2011; Rønnestad & Skovholt, 2001; Trotter-Mathison et al., 2010). Further analysis of the role of transcendence in training should be explored with novice clinicians who are actively engaged in such training.

There have been several calls for additional research and recommendations that clinical training programs implement and expand their focus on aspects of personal growth for novice trainees (Grafanaki, 2010). Increasingly training programs are being encouraged to address aspects of personal growth as part of the overall curriculum (Cain, 2007; Ellis, 1991; Folkes-Skinner et al., 2010; Grafanaki, 2010; Heppner & Roehlke, 1984; Hill et al., 2007; Ladany, 2007; Luke & Kiweewa, 2010; Mathers, 2012; Orlinsky & Rønnestad, 2005; Rabinowitz et al., 1986), yet training programs continue to struggle with the objective needs and process of this implementation (Epstein & Hundert, 2002; Kaslow et al., 2007). Significant barriers to implementing these recommendations exist, including concerns centered on inconsistency between programs (Jacobs et al., 2011; Kaslow et al., 2007; Shen-Miller et al., 2012; Veilleux et al., 2012).

Given study participants' awareness of their own personal growth and experiences of transcendence, this author concurs with prior researchers and likewise suggests a greater emphasis on personal growth throughout clinical training. Recommendations emanating from the results of this study suggest a multipronged approach to address both the needs of the trainee and the needs of academic/clinical training programs.

First, supervisors can draw a closer link between personal and professional growth and development; they can encourage trainees to be more mindful of this link by highlighting such moments and fostering activities that promote trainee self-reflection. At a minimum, this would provide an opportunity for trainees to be intentional about their personal growth, and anticipate challenges they may face throughout their academic and clinical journey.

Second, supervisors can make efforts to create a safe environment between the supervisor and the trainee so he or she may engage in thoughtful conversation and processing of such material. To create such an environment, it is important for a supervisor to be mindful of feedback that is therapeutic, not therapy. The environment would foster the growth of novice clinicians by allowing them to be vulnerable and explore their own experience. The lived experience of the trainee is complex and training programs struggle to facilitate personal growth; consequently, a caring relational supervisory experience in which one is able to achieve the highest level of critical thinking becomes even more valuable (Hernandez & Rankin, 2008) because novice trainees will bring their own personal involvement, genuineness, and understanding to the experience itself (Schneider & Krug, 2010).

Third, clinical training programs can respond to concerns noted by Grafanaki (2010) and others by intentionally addressing personal growth and professional development throughout training programs. Discussions can be facilitated in academic courses (e.g., clinical practica, professional issues or legal and ethical courses), the clinical setting itself and throughout supervision. These discussions could provide the groundwork for trainees to explore, reflect, and document their own personal growth and its impact on their current or anticipated future clinical work. Fourth, clinical training programs can encourage more coordinated efforts to foster

personal growth across multiple practica experiences, including internal university training environments, external practicum, and internship.

Fifth, course instructors and clinical supervisors can ensure that novice clinicians have resources readily available to further understand and explore personal growth independently of their academic or professional training. This could include recommended readings, articles, books, and exercises including journal writing or other activities that promote self-reflection.

Concluding Remarks

For this researcher, these journal entries provided a moment, or opportunity to reflect on what my own needs were at the time of writing. By reflecting on the material, I could recognize that my own needs at the time of writing journal entries, and my needs at the time of this research, varied. It was captivating to recognize moments and experiences that became increasingly present as they were given voice through the writing of critical incidents. It allowed me to understand context and the shared experience of this researcher and his supervisors.

In retrospect, understanding context made issues of capacity and competence seem expected, or anticipated. These journal entries provided insight into the struggles of trainees, especially as the capacity (competence) aspect of transcendence was identified. The field of psychology places a strong emphasis on competence and has entire specialties dedicated to measuring the capacity of trainees at each stage of their training. Given that these capacity (or competence) issues are prominent early in one's training and are likely to remain a focus throughout one's professional career, it seems more research is merited to further understand the impact of a drive towards competence throughout one's professional life, from novice to mid-career to senior clinician.

The presence of altruism, another aspect of transcendence, suggests that individuals have a desire to be something more, to go beyond what they believe they are capable of. The growing research literature emphasizing personal growth and development of trainees suggests that a more intimate and deeper level of training is possible and beneficial to the overall development of a clinician. Consequently, training programs should consider and utilize opportunities to facilitate personal and professional development, by guiding and stimulating the personal growth of novice clinicians.

As noted, researchers have made calls for additional research focusing on the personal growth of the trainee (Grafanki, 2010; Rønnestad & Ladany, 2006; Rønnestad & Skovholt, 2001; Skovholt & Rønnestad, 2003; Truell, 2001). Likewise, personal growth is considered an essential element of professional development, as reflected by its inclusion as one of the APA competency benchmarks (Falender & Shafranske, 2012a; 2012b). Despite stated benefits to trainees, this research has not yet achieved a level of prominence in research literature nor have clinical training programs made significant strides in addressing this competency benchmark. I believe it is time, now, for both to occur.

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APPENDIX A

Institutional Review Board Approval

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

August 19, 2015

Lauren Armstrong, Alberto Ibarra, Whitney Smith
Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive 5th Floor
Los Angeles, CA 90045

Protocol #: P0715D01
Project Title: Personal Growth of Novice Clinicians "PGPD Study"

Dear Ms. Armstrong, Ms. Smith and Mr. Ibarra:

Thank you for submitting your application, *Personal Growth of Novice Clinicians "PGPD Study*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Rosenberg, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

> (b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:
>
> **Category (2) of 45 CFR 46.101**, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Kevin Collins, Manager of the

Institutional Review Board (IRB) at gpsirb@peppderdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Regulatory Affairs Specialist
Dr. Joan Rosenberg, Faculty Advisor

APPENDIX B

Informed Consent

PEPPERDINE UNIVERSITY

Graduate School of Education and Psychology (GSEP)

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Supervision, Clinical Training and the Personal Growth of the Novice Clinician

You are invited to participate in a research study conducted by Alberto Ibarra, M.A., Lauren Armstrong, M.A., Whitney Smith, M.A. (principal investigators) and Dr. Joan Rosenberg (faculty advisor) at Pepperdine University, because you are a doctoral student in clinical psychology that completed supervision under the direction of Dr. Joan Rosenberg during the Spring 2013 academic semester. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for you records.

PURPOSE OF THE STUDY

The purpose of the study is to learn more about the personal development experiences of novice clinicians enrolled in a doctoral program and learning to provide clinical services. The data that is collected is hoped to contribute to the existing literature regarding effective methods for training novice clinicians to provide clinical services.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be asked to complete the following steps for submitting journal entries to the research study:

1. Complete the demographic form to provide context to the journal entries. You will not be asked to provide your name or birthdate anywhere on the form. Additionally, your demographic form will be kept separate from your journal entries and will not be associated with your journal entries so as to maintain the anonymity of your data.
2. Gather all journal entries completed during the Spring 2013 academic semester. Journal entries should be provided in the form of Microsoft Word document(s) only.
3. Copy all journal entries to flash drive. The person obtaining consent will provide a password protected flash drive to you at the time of your consent, and will collect it from you once you have copy and pasted your journal entries.

Participation in the study is expected to take a maximum of approximately 10 minutes.

POTENTIAL RISKS AND DISCOMFORTS

Participation in this study is expected to involve minimal risk or discomfort. It is feasible that participants may experience unpleasant feelings related to awareness that a colleague has read personal journal entries. However, the primary investigators will be unable to identify you as the author; thus, they will be unable to associate any of the personal information disclosed with you as an individual.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Your participation in this research study is not expected to result in any benefits to you directly; however, it is believed that the results made possible by your participation will result in advanced knowledge of the personal development processes of novice clinicians. Thus, it is believed that your participation allows for the potential for improvement in training protocols for clinical psychology doctoral students. Advancements in clinical training ultimately lead to the availability of more effective treatment for society at large.

PAYMENT/COMPENSATION FOR PARTICIPATION

There will be no compensation provided for participation in this research study.

CONFIDENTIALITY

We will keep your records for this study anonymous as far as permitted by law. However, if I am required to do so by law, I may be required to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me about instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

Informed consent will be collected by a third party volunteer (a second-year doctoral student at Pepperdine University), so as to protect you as the participant from any perceived consequences of declining your participation. If you decline participation, the third-party will maintain your confidentiality and the primary investigators will not be informed. If you are to consent to participation, the third-party will collect your signed informed consent, completed demographic form, and flashdrive with all journal entries. The third-party volunteer will then submit your informed consent and demographic form to Dr. Joan Rosenberg to be stored in her office in two separated locked drawers at Pepperdine University Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045.

The third party volunteer will have signed a confidentiality agreement requiring they maintain confidentiality of the data through nondisclosure and secure storage of all documents. Upon receiving the data, they will conduct a thorough de-identification process, removing all potential identifiers from the data prior to it being received by the primary investigators. Upon completion of the de-identification process, the third party will submit all data utilizing the flashdrives to Dr. Joan Rosenberg. Third parties are anticipated to complete the de-identification process by August 5, 2015 5pm PST, at which time they will no longer have access to the data.

Following the de-identification process, Dr. Joan Rosenberg will make ten copies of the data using the Pepperdine University administrative copy machines located on the 5th floor of the West Los Angeles GSEP building. She will maintain one copy in a locked drawer in her GSEP office, and will distribute, in-person, three copies to each of the principal investigators for data analysis. The principal investigators will analyze the data using the qualitative procedure of open coding, and will not make any additional copies or recreate the data in any form.

The data will initially be stored in a locked drawer in the office of Dr. Joan Rosenberg, dissertation chair (Pepperdine University GSEP, 6100 Center Drive, Los Angeles, CA 90045). Data will later be transferred by hand to the locations of each of the principal investigators, and

stored in a locked drawer in each of their individual home offices. A single copy will remain stored in a locked drawer in Dr. Joan Rosenberg's office. Signed informed consents and demographic forms will be stored in a separate locked drawer, also in Dr. Joan Rosenberg's office. The data will be stored for a minimum of five years.

There will be potentially identifiable information obtained in connection with this study. Your name, address, birthdate, and other immediate identifiers will not be collected. However, the demographic form will request that you provide information such as your age, ethnicity, gender, geographic region where you were raised, theoretical and religious orientations, and personal beliefs regarding personal growth. This information will be kept separate from your journal entries, and no links will be made between the journal entries and the corresponding demographic form. If any identifiable information is contained within journal entries, it will be de-identified prior to the principal investigators gaining access to them for review and data analysis.

Three principal investigators will code each journal entry. Upon completion of coding, journal entries will be transferred to the investigator for which the data was coded for final analyses and writing of the results. The investigators will transfer the data in person only.
When data analysis is complete, the principal investigators will illustrate the results in each of their respective written dissertations. This may include the use of direct quotations from your journal entries, unless otherwise specified.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is to not participate. Your relationship with Pepperdine University Graduate School of Education and Psychology staff and students will not be affected whether you participate or not in this study. Additionally, a third party volunteer will be utilized for gathering informed consent, allowing you to decline participation without penalty or risk of disclosure of this decision to the primary investigators.

INVESTIGATOR'S CONTACT INFORMATION

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Joan Rosenberg, by email: joan.rosenberg@pepperdine.edu or by phone: 310-614-0100 (cell phone) or by U.S. mail: Pepperdine University Graduate School of Education and Psychology, 6100 Center Drive 5th Floor, Los Angeles, California, 90045 if I have any other questions or concerns about this research. If you have questions about your rights as a research participant, contact Dr. Thema Bryant-Davis, Chairperson of the Graduate & Professional School Institutional Review Board (GPS IRB) at Pepperdine University, via email at gpsirb@pepperdine.edu or at 310-568-5753.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Thema Bryant-Davis, Chairperson of the Graduate & Professional School Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant Date

SIGNATURE OF INVESTIGATOR

I have explained the research to the participants and answered all of his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

_____

Name of Person Obtaining Consent

_____ _____

Signature of Person Obtaining Consent Date

APPENDIX C

Confidentiality Agreement

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

Confidentiality Agreement

I, _____, individually and on behalf of ___PGPD Study___, do hereby agree to maintain full confidentiality in regards to any and all documents, audiotapes, videotapes, and oral or written documentation obtained for the purposes of this study. Furthermore, I also agree (where applicable):

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of any documents, including audio-taped or live oral interviews, or in any associated documents;

2. To not disclose any information received for profit, gain, or otherwise;

3. To not make copies of any documents, audiotapes, videotapes, or computerized files of the transcribed interview texts, unless specifically requested to do so by Whitney Smith, Lauren Armstrong, or Alberto Ibarra (researchers);

4. To store all study-related documents, audiotapes, videotapes and materials in a safe, secure location as long as they are in my possession;

5. To return all documents, audiotapes, videotapes and study-related documents to Dr. Joan Rosenberg (dissertation chair) in a complete and timely manner.

6. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes, videotapes and/or paper files to which I will have access. I am further aware that if any breach of confidentiality occurs, I will be fully subject to the laws of the State of California.

Study Volunteer Name_____

Study Volunteer Signature_____

Date_____

APPENDIX D

Participant Recruitment Email Script

"Hello,

I am a first year PsyD student who has been recruited by Dr. Rosenberg to assist with the dissertation of three of your colleagues. The title of this study is the *PGPD Study*, for Personal Growth and Personal Development Study. My role is to facilitate the consent and deidentification of data processes for their studies. Please see below a statement from the researchers:

We hope this email finds you well. We're reaching out to you to request that you review the attached consent form and consider participating in our research study. We hope you consider participating, as your involvement would be very useful to our studies. Your role would be brief, requiring no more than 30 minutes of your time. As is stated in the form, if you chose not to participate your decision will remain confidential from us, the researchers. As you can see, an additional attachment is provided, a worksheet, which we would request that you fill out if you chose to participate.

You will note the consent form indicates that I will be providing you a USB flash drive for transporting your data. Given the distance at which some of you may live from the Pepperdine campus, we will be giving participants the option of either password protecting their word document and emailing it to myself or requesting the USB, which would then be mailed to an address you provide. Please specify which option you would like to proceed with if you chose to participate.

Please direct all correspondence related to this study to myself so as to maintain confidentiality of your decision. Your timely response to this request is greatly appreciated.

Thank you,

APPENDIX E

De-identification Protocol

Data Preparation Protocol for Research Study "PGPD Study"

Thank you for volunteering to participate in the PGPD Study data preparation procedures. Please complete the following procedures for each individual journal entry.

De-Identification

1. If journal entries are dated, remove specific dates and number journal entries chronologically.
2. Change all names to the pseudonym "Pat".
3. Change all pronouns (i.e., he, she, him, etc.) to "person".
4. Change all specific geographic locations (i.e., Pasadena) to "place". Nonspecific locations, such as "east coast" or "southern california" do not need to be changed.
5. Change all specific personal events (e.g., marriages, giving birth, death) to "life event".
6. Change all specific professional events (e.g., specified conferences) to "professional event". For example, the word "conference" by itself does not need to be changed, but APA conference is more specific and would thus be changed.
7. Change all gender specific words to be gender neutral (e.g., grandfather → grandparent; boyfriend → partner; brother/sister → sibling).
8. Specific descriptors should be changed to the name of the category in which the descriptor belongs. For example, the descriptor "italian" would be changed to "ethnicity", and the descriptor "blonde" would be changed to "hair color".
9. Change all specific medical or psychological diagnoses in the same manner as you do above for descriptors. Thus, all medical diagnoses would become "medical diagnosis", and all psychological diagnoses would become "psychological diagnosis".
10. Change any specific reference to a mental health clinic to "university community mental health clinic".

Formatting

1. Change all font to Times New Roman, 12 point font.
2. Double space all journal entries.
3. Separate each journal entry by a page break so that no two journal entries are on the same page.
4. Create one long word document with all journal entries (separated by page breaks).

Submission

1. Save document to flash drive provided to you by the investigator.
2. Submit flash drive to the mailbox of Dr. Joan Rosenberg by August 5, 2015 5pm PST.
3. Delete all traces of data from your possession. This includes deleting any copies of data from your computer desktop, as well as from your "trash" folder.

APPENDIX F

HIPAA Certifications

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Alberto Ibarra (ID: 3710113)
- **Email:** alberto.ibarra@pepperdine.edu
- **Institution Affiliation:** Children's Hospital of Orange County (ID: 767)
- **Institution Unit:** CHOC Psychology

- **Curriculum Group:** Course in The Protection of Human Subjects
- **Course Learner Group:** Social and Behavioral Researchers
- **Stage:** Stage 1 - Basic Course

- **Report ID:** 12004373
- **Completion Date:** 01/09/2014
- **Expiration Date:** 01/08/2017
- **Minimum Passing:** 80
- **Reported Score*:** 97

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Introduction (ID:757)	01/03/14
History and Ethical Principles - SBE (ID:490)	01/03/14
Defining Research with Human Subjects - SBE (ID:491)	01/09/14
The Federal Regulations - SBE (ID:502)	01/09/14
Assessing Risk - SBE (ID:503)	01/09/14
Informed Consent - SBE (ID:504)	01/09/14
Privacy and Confidentiality - SBE (ID:505)	01/09/14
Research with Prisoners - SBE (ID:506)	01/09/14
Research with Children - SBE (ID:507)	01/09/14
Research in Public Elementary and Secondary Schools - SBE (ID:508)	01/09/14
International Research - SBE (ID:509)	01/09/14
Internet-Based Research - SBE (ID:510)	01/09/14
Research and HIPAA Privacy Protections (ID:14)	01/09/14
Vulnerable Subjects - Research Involving Workers/Employees (ID:483)	01/09/14
Conflicts of Interest in Research Involving Human Subjects (ID:488)	01/09/14
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID:14928)	01/09/14
Children's Hospital of Orange County (ID:1266)	01/09/14

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Alberto Ibarra (ID: 3710113)
- **Email:** alberto.ibarra@pepperdine.edu
- **Institution Affiliation:** Children's Hospital of Orange County (ID: 767)
- **Institution Unit:** CHOC Psychology

- **Curriculum Group:** Course in The Protection of Human Subjects
- **Course Learner Group:** Social and Behavioral Researchers
- **Stage:** Stage 1 - Basic Course

- **Report ID:** 12004373
- **Report Date:** 06/29/2015
- **Current Score**:** 97

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT
Introduction (ID:757)	01/03/14
History and Ethical Principles - SBE (ID:490)	01/03/14
Defining Research with Human Subjects - SBE (ID:491)	01/09/14
Belmont Report and CITI Course Introduction (ID:1127)	02/21/14
The Federal Regulations - SBE (ID:502)	01/09/14
Assessing Risk - SBE (ID:503)	01/09/14
Informed Consent - SBE (ID:504)	01/09/14
Privacy and Confidentiality - SBE (ID:505)	01/09/14
Research with Prisoners - SBE (ID:506)	01/09/14
Research with Children - SBE (ID:507)	01/09/14
Research in Public Elementary and Secondary Schools - SBE (ID:508)	01/09/14
International Research - SBE (ID:509)	01/09/14
Internet-Based Research - SBE (ID:510)	01/09/14
Research and HIPAA Privacy Protections (ID:14)	01/09/14
Vulnerable Subjects - Research Involving Workers/Employees (ID:483)	01/09/14
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID:14928)	01/09/14
Conflicts of Interest in Research Involving Human Subjects (ID:488)	01/09/14
Children's Hospital of Orange County (ID:1266)	01/09/14

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Alberto Ibarra (ID: 3710113)
- **Email:** alberto.ibarra@pepperdine.edu
- **Institution Affiliation:** Pepperdine University (ID: 1729)
- **Institution Unit:** Graduate School of Education and Psychology

- **Curriculum Group:** Graduate & Professional Schools Human Subjects Training Course
- **Course Learner Group:** Graduate & Professional Schools Human Subjects Training
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for Investigators and staff involved primarily in Social/Behavioral Research with human subjects.

- **Report ID:** 11164097
- **Completion Date:** 02/21/2014
- **Expiration Date:** 02/20/2017
- **Minimum Passing:** 80
- **Reported Score*:** 94

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Belmont Report and CITI Course Introduction (ID:1127)	02/21/14	3/3 (100%)
Students in Research (ID:1321)	02/21/14	7/10 (70%)
History and Ethical Principles - SBE (ID:490)	01/03/14	5/5 (100%)
Defining Research with Human Subjects - SBE (ID:491)	01/09/14	5/5 (100%)
The Federal Regulations - SBE (ID:502)	01/09/14	5/5 (100%)
Assessing Risk - SBE (ID:503)	01/09/14	5/5 (100%)
Informed Consent - SBE (ID:504)	01/09/14	5/5 (100%)
Privacy and Confidentiality - SBE (ID:505)	01/09/14	5/5 (100%)
Research with Prisoners - SBE (ID:506)	01/09/14	4/4 (100%)
Research with Children - SBE (ID:507)	01/09/14	4/4 (100%)
Research in Public Elementary and Secondary Schools - SBE (ID:508)	01/09/14	4/4 (100%)
International Research - SBE (ID:509)	01/09/14	3/3 (100%)
Internet-Based Research - SBE (ID:510)	01/09/14	5/5 (100%)
Research and HIPAA Privacy Protections (ID:14)	01/09/14	4/5 (80%)
Vulnerable Subjects - Research Involving Workers/Employees (ID:483)	01/09/14	4/4 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID:488)	01/09/14	4/5 (80%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Alberto Ibarra (ID: 3710113)
- **Email:** alberto.ibarra@pepperdine.edu
- **Institution Affiliation:** Pepperdine University (ID: 1729)
- **Institution Unit:** Graduate School of Education and Psychology

- **Curriculum Group:** Graduate & Professional Schools Human Subjects Training Course
- **Course Learner Group:** Graduate & Professional Schools Human Subjects Training
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for Investigators and staff involved primarily in Social/Behavioral Research with human subjects.

- **Report ID:** 11164097
- **Report Date:** 06/29/2015
- **Current Score**:** 94

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Introduction (ID:757)	01/03/14	No Quiz
Students in Research (ID:1321)	02/21/14	7/10 (70%)
History and Ethical Principles - SBE (ID:490)	01/03/14	5/5 (100%)
Defining Research with Human Subjects - SBE (ID:491)	01/09/14	5/5 (100%)
Belmont Report and CITI Course Introduction (ID:1127)	02/21/14	3/3 (100%)
The Federal Regulations - SBE (ID:502)	01/09/14	5/5 (100%)
Assessing Risk - SBE (ID:503)	01/09/14	5/5 (100%)
Informed Consent - SBE (ID:504)	01/09/14	5/5 (100%)
Privacy and Confidentiality - SBE (ID:505)	01/09/14	5/5 (100%)
Research with Prisoners - SBE (ID:506)	01/09/14	4/4 (100%)
Research with Children - SBE (ID:507)	01/09/14	4/4 (100%)
Research in Public Elementary and Secondary Schools - SBE (ID:508)	01/09/14	4/4 (100%)
International Research - SBE (ID:509)	01/09/14	3/3 (100%)
Internet-Based Research - SBE (ID:510)	01/09/14	5/5 (100%)
Research and HIPAA Privacy Protections (ID:14)	01/09/14	4/5 (80%)
Vulnerable Subjects - Research Involving Workers/Employees (ID:483)	01/09/14	4/4 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID:488)	01/09/14	4/5 (80%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
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APPENDIX G

Demographic Form

Demographics Form for "PGPD Study"

Please complete the information with the ways in which you chose to self-identify. You may write on the back of this form if you require additional space. Do not include your name or birthdate anywhere on this document. Your responses to the questions will be kept confidential. They will not be stored with or linked to other data provided for this study in any way (e.g., informed consent, journal entries). Participation in this study is voluntary. You are not required to answer every question on this form. There will be no penalty for refusal to complete this form or any other aspect of the PGPD Study. You may withdraw your consent to participate at any time.

The PGPD Study is a research project being conducted in partial fulfillment of the requirements of a doctoral dissertation. The purpose of the PGPD Study is to identify, examine and communicate patterns and themes of personal development tied to the learning process that unfolds during training and supervision.

Age _____

Ethnic Background _____

Gender_____

Geographic region where you were raised (e.g., southwest U.S.) _____

Socioecomic Status of family of origin _____

Religion and level of belief/practice_____

Theoretical approach or perspective_____

Types of techniques used in therapy

_____

Basic beliefs about therapy/theoretical approach/ how people heal to include as further description of who you are _____

Beliefs about personal growth _____

Sample Demographic Information: The following is an example of how your information will be presented in the research study.

The second researcher and author, Coder 2, is a 26-year-old, white, single, female clinical psychology doctoral student. She was born and raised in an upper-middle class family in the northern part of the United States. Coder 2 was raised in a Christian family and self-identifies as a non-practicing Christian. Coder 2 generally conceptualizes and treats clients from a humanistic perspective; including acceptance-based cognitive-behavioral techniques. More specifically, she believes that client's gradually experience

healing in therapy as their self-awareness increases, and is contingent upon their willingness to embrace such awareness without denying or distorting the truth of who they are and their experiences in the world. The therapist's role in producing such a shift is that of a metaphorical mirror, in that the therapist experiences the client as they present in therapy and reflects back to them what is observed. This coder believes this process of reflection must take place without judgment of what is observed or experienced. Further, the therapist must be active in their use of empathy in order to both fully recognize all aspects of the client's difficulties, and to validate the client's experience as one that is or could potentially be experienced by all humans. Thus, an additional element of treatment deemed necessary by coder 2 is that the therapist themselves must maintain congruence so as not to collude with the client's denial or distortion, and to model healthy psychological processes. The elements of reflection, nonjudgment, empathy, and congruence are believed to be reliant upon the therapist's commitment to their own personal development. Accurate reflection, for example, can be influenced by the therapist's personal biases and overall life experiences. Thus, ongoing self-awareness and congruence on the part of the therapist precludes the use of accurate reflections in therapy. Further, non judgment and empathy are both effortful processes that may require the therapist to confront their personal biases, thoughts, behaviors, and overall sense of self as it has been shaped by their own unique experiences.

APPENDIX H

Codes Established During Consensual Agreement

The following is the three-arc coding system that was used by the three coders and auditor to structure the review of vignettes. These were the three arcs that were identified at the start of the agreement process and clarified by, and with, all coders and auditors present.

Coding Arcs

1. Arc I: What is the reflection about? This is referred to as the "Pursuit of truth."
2. Arc II: What is the dissonance or change? This is the "Pursuit of greater meaning"
3. Arc III: What is the learning drawn from this experience? This is the "Deeper connection."

Individual Themes

1. Rychlak, 1980: The focus of the third arc is on a self-reflection or awareness that leads to elements of self-identity.
2. Summers, 2012: The concept of "going beyond" will also be recognized as a measure of capacity, limitation or experience, reflecting learning, growth, being more, and measures of competence.
3. Hora, 1987: The emphasis on the pursuit of truth over being right reflects a self-reference of acknowledgement.
4. Torrance, 1994: The higher part of the self and the universe are recognized through awe, inspiration, or moments of spirituality.
5. Clark, 1998: The connection beyond the self is externalized, broad, and/or non-specific to the individual or target of the reflection and/or behavior.

6. Vago & David, 2012: The awareness of the self reflects moments of teaching towards others, with more specificity, or where an emphasis is on the altruistic nature or intent of the reflection.
7. Maslow, 1954: There is a self-growth through an identifiable peak experience.

APPENDIX I

Research Tables

Table 1

Theme 1: Pursuit of Truth, definition of transcendence by Hora (1987)

Category	Key terms	Response
1a	Self-growth, teaching	Committing to self-growth process in order to know [the] self-more truly, and then [I] can begin to teach clients.
2a	Learning	Learning that it is okay and normal to not know everything.
3a	Change, support	Identifying the need to change in order to support our clients.
3b	Learning	Learned that labeling emotions as you experience them makes them feel more manageable.
3c	Learning	I learned to embrace uncomfortable emotions that come up when making mistakes or struggling, in order to learn.
4a	Comfort	Developing comfort with own ability
4b	Confrontation, uncomfortable feelings	Confronting uncomfortable feelings in order to be a better therapist
4c	Past experiences, stagnation	Past experiences can lead to therapeutic stagnation if unaddressed
5a	Negative impact	Recognizing negative impact of history and past on clinical work.
5b	Recognizing past habits	Realizing aspects of my past and habits from the past freed me to make a different choice about how to approach therapy.
6a	Learning, gratitude	Learned how difficult this can be for so many people, and [I] felt a sense of gratitude for having learned what I learned, that allowed me to stay present with my experience.
6b	Failing, learning	Failing is an important part of learning.
8a	Learning, thoughts and feelings, effort	Learning to attune with client's thoughts and feelings is a worthwhile endeavor, and requires more effort on the part of the therapist than simply physically being in the room.
9a	Helplessness	Helplessness is a feeling to endure and as therapists, we can't create movement without acknowledging it.
10a	Success, failure	Success versus failure
10b	Failing, learning	Failure is an important part of learning
10c	Mistakes, development	Making mistakes is part of the process and necessary to development

10d	Learning	Learning is always taking place, and is an ongoing process.
12a	Knowledge, family, boundaries	It's best to not apply psychological knowledge to family, boundaries
14a	Movement, challenge	[I] learned that I'm not challenging this client and I could be, or can, create movement in the client by approaching it differently
17a	Recognition, learning, roles	Recognizing and learning role of counter-transference on own tone and expression
17b	Learning, countertransference, awareness	Learned the importance of being conscious of countertransference reactions in session, and that it involves engaging in self-reflection and increased awareness, and contact with unresolved feelings.
18a	Learning, teaching	Learning from this and teaching it to clients out of personal understanding.
19a	Learning, value	learned that silence is not an indication that I've done something wrong, but rather is a valuable tool to be used in treatment
21a	Learning, confidence, competence	Better understanding and experiential learning of the confidence/competence loop
24a	Recognition, experience, connecting to clients	Recognizing experiencing frustration with inability to connect to client.
24b	Distraction, personal life	Recognizing client [is] distracting, and finding [myself] distracting in personal life outside of sessions.
24c		
25a	Past, present, future	My past has dictated my present, but doesn't have to dictate my future
27a	Adapting	Adapting in therapy
28a	Ownership, behavior	Taking ownership of the frustration as belonging to the writer of this story and not coming from the client's behavior.
28c	Frustration	Understanding that frustration is about [the] self, not [the] client
29a	Productivity, growth	Productivity isn't everything, there are different ways of defining and valuing productivity. It takes time and energy to help clients with their growth
30a	Control	Recognizing loss of control
30b	Experience	Opportunity to experience an experience
33a	Sensory acuity, content, process	Attending to sensory acuities leads to deepening session, shifting from content to process.

34a	Review	Reviewing tape led to understanding of session and emotion
34b	Fear, Disconnection	Recognized fear was disconnection
34c	Dread	Dread
34d	Awareness, review	Watching taped sessions help to gain awareness into processes in session that we may not be aware of
35a	Discomfort	Discomfort not disclosing the issue initially
35b	Recognition	Recognizing mistakes
35c	Vulnerability	Allowing self to be vulnerable, and make voice heard.
36a	Exploration, negative behavior	Exploring the reason for engaging in the negative behavior
36b	Awareness, behaviors	Gaining awareness by exploring difficult behaviors and feelings of myself.
43a	Experience, expression, feelings	Experiencing feelings and expressing them leads to congruence.
43b	Ownership, experience	Feeling true to oneself by taking ownership of own experience.
44a	Speaking your mind, expression, context	Speaking your mind and the truth with others, creates a sense of safety in relationships, in which you feel at ease expressing yourself in whatever context this takes place
47a	Confrontation, understanding, experience	Asking direct questions and making confrontations in clinical work and in daily life to increase understanding of personal and friend's experiences
49a	Decision making	Making better decisions in my dating life
49b	Experiencing feelings, decision making	By experiencing my feelings, I was able to know myself better, and make more informed decisions.
54a	Recognition, emotion, insight, relationships	Allowing yourself to recognize and experience an emotion leads to increased use of knowledge and emotion for good, to benefit one's life, increased insight, increased safety in interpersonal relationships, increased clarity about wants and needs.

Table 2

Theme 2: The pursuit of self-identity as defined by Rychlak (1980)

Category	Key terms	Response
1a	Self-awareness	Gaining self-awareness
1b	Listening to thoughts, behavior	Learned to not listen to negative thoughts about [individual], or let those thoughts guide my behavior, but that I could be my own guide.
3a	Learning	Recognizing it is a learning process
4a	Reflection, emotional distress	Reflecting on the emotional distress
4b	Recognition, emotional growth	Recognizing need for emotional growth
4c	Past patterns	Addressing the past patterns
4d	Identification, feelings	Identifying own feelings and emotions
4e	Learning, trust	Personal learning to trust myself
7a	Experience, professional, fear	Fear is worth experiencing to get what I want out of my professional goals
10a	Learning	Learning can be tiring and exciting
10b	Learning	Shift towards learning
11a	Shame, ability, feelings	Internalization of shame through past experiences impact daily ability to feel my feelings
12a	Responsibility, emotion	Sensation of responsibility and power, internalizing emotions and knowledge, family role, and responsibility.
13a	Reflection, boundaries, love	Reflecting on importance of self-care, setting boundaries at home, with family and loved ones, recognizing passion and dreams we pursue and the importance of loved ones in that growth.
14a	Learning	Learning that my response to client was influenced by my family history, and that I can respond differently now.
15a	Learning, validation	Learned the importance of self-validation for being successful in life and as a therapist.
17a	Experience, disappointment	Experiencing disappointment after reviewing session in supervision
18a	Learning	Learned that we can apply what we learn to ourselves; it helps to understand stuff we are doing in session at a personal level
19a	Learning	Learning about the self, recognizing doubt, and acknowledging silence

21a	Recognition, confidence, competence	Recognizing a need to view the self differently, importance of increasing confidence to feel competent
21b	Awareness, competence, confidence	New awareness of competence and confidence
22a	Understanding, values	Increased understanding about what it takes to behave congruent to values
22b	Emotional experience	Recognizing increased exposure to emotional experience, finding it difficult not to comment on racist jokes, standing up for the self, for one's belief, whole-heartedly, congruent life.
25a	Process, experience	Greater understanding of own processes and tendencies based on past experience
30a	Learning	We have to apply everything we are learning to ourselves first, to fully understand how to help others.
37a	Growth, confidence	Realizing that being brave leads to growth and feeling confident
39a	Change, acculturation	Recognizing something was wrong, making a change, experiencing acculturation
39b	Learning, culture	Learning to mesh one's own cultural background with the therapist culture to develop one's approach in therapy
41a	Bravery, vulnerability	It takes bravery to be vulnerable, and being vulnerable gives you strength as a therapist, bravery or brave acts make us congruent with what we ask of our clients
46a	Knowledge, self-awareness	Application of knowledge to personal life has led to increased self-awareness, better decision making, and greater awareness and understanding of others. More adaptive to hanging moods and feelings with clients (professionally) and with personal relationships
48a	Voice, confidence	Using my voice helped me to feel more confident
50a	Growth	Growth in the program has led to becoming braver, wiser, and more attuned to the self and others. These changes can happen relatively quickly under the right circumstances. Helping others furthers own growth and development
51a	Skill, bravery	Identifying new skills and relationships as a benefit of being brave
51b	Bravery, growth, feelings	Being brave has facilitated my growth in several areas, facing difficult feelings, using my voice, becoming happier, deeper relationships

51c	Skills, relationships	Approaching new things or things that I'm hesitant about with bravery has resulted in developing new skills and creating new relationships, meaning being brave in both my personal and professional lives has been beneficial in a variety of ways (happier, more well-rounded, increased support, bolder in trying new things, learning new skills, new relationships).
52a	Flexibility	Flexibility in planning activities and social life leads to less concern about planning
54a	Change, emotion, relationships	Changed to actively feel anger, emotion, feeling that led to insight into myself, especially in romantic relationships, and navigating out of toxic relationships.

Table 3

Theme 3: An individual's capacity or limitation as described by Summers (2012)

Category	Key terms	Response
1a	Understanding	Moving towards understanding what one is capable of
1b	Bravery, embrace	Have to embrace bravery, which means embracing hardship, recognizing truth, having awareness of self, and of what it takes to succeed
3a	Growth	Moving towards growth
3b	Control, learning	Letting go of control and allowing myself to make mistakes while learning
5a	Growth	Moving towards overcoming the negative impact and moving towards growth
6a	Learning	Learning takes time
6b	Gratitude, learning	Feeling gratitude for knowledge, learning leading to emotional strength
6c	Learning	Learning won't happen if you don't try new things
7a	Reframe, anxiety	Reframing anxiety into excitement
7b	Fear, excitement	Understanding fear in a different way, as excitement in this case, and something worth facing.
7c	Fear, reframe	Reframing fear as excitement
7d	Willingness	Willingness to try again
8a	Skills	Identifying necessary basic skills
10a	Learning	Integrating new learning as knowledge
10b	Learning	Learning won't happen if you don't try new things
12a	Learning	Learning how to maintain professional and ethical boundaries with family members
15a	Learning	Learning to confront the client with truth, learning to trust the self in the room, understanding full range of emotions
16a	Learning, empathy	Learned what true empathy is and how it can be expressed, how empathy results in increased awareness of emotional strength
18a	Awareness, change	Awareness of patterns makes it possible to change them
18b	Learning	Learning to identify patterns, understand patterns, recognize them, and reverse them
19a	Awareness	Awareness of discomfort with silence and ability to work through that discomfort.

20a	Validation, listening	Listening, validating, and sitting with client's uncomfortable feelings is how to approach treatment and silences
20b	Comfort, experience, feelings	I have to be comfortable myself with unpleasant feelings, in order to sit with the client's experience instead of trying to fix it
20c	Recognition, validation, growth	Recognizing comfort with experiencing helplessness, recognizing need to listen and validate, use discomfort for purposes of growth in the room
20d	Learning	Learned to become comfortable with silence and difficult feelings that come up in silence
22a	Congruence, change	That living a congruent life can be difficult as perspective changes, but it [is] ultimately well worth it.
23a	Teach, improvement	Ability to teach clients what we are able to improve on ourselves, difficulty teaching clients what we are afraid to do
23b	Learning	Experiential learning of therapeutic concepts is important to our success in using them
24a	Empathy, feelings	When feelings aren't addressed or "owned" in session, they can be experienced as lingering discomfort within the therapist, which helps to increase empathy for client's experience
25a	Frustration, anger, reflection	Experiencing frustration and anger and reflecting on need to diffuse unpleasant feelings
26a	Acceptance, change	Acceptance leads to change or makes change possible
26b	Acceptance, change	Acceptance can lead to change
27a	Adapt	Our ability to adapt is what makes the chaos of life manageable, and is almost evidence that we are supposed to live in this ever changing chaos
27b	Adapt	Recognizing that adapting is crucial in effective therapy
29a	Growth	Recognizing growth
29b	Productivity	Feeling productivity
29c	Growth	Directing energy into fewer things can create focus, calm, and more growth
30a	Growth	Need to engage in personal growth in order to help clients
31a	Change	Adjusting to changes based on treatment planning

31b	Adapt, flexibility	Remaining adaptive, prepared but flexible, keeps us in the dance" or able to work effectively as clinicians
31c	Adapt, flexibility	Importance of adapting and being flexible while holding the treatment plan in mind
31d	Adapt, flexibility	Adapting and preparing with flexibility
32a	Growth	Recognizing content versus process to facilitate growth
33a	Acuity	Attending to acuity led to depth in conversation
37a	Bravery, comfort	Using bravery, one can enter situations in which they are not yet comfortable or "ready" per say
39a	Change, competence	Making a personal change for the purposes of increasing therapeutic competency is a gradual process which shifts the whole experience
41a	Vulnerability	Recognizing vulnerability as a therapist, willingness to make myself vulnerable
41b	Growth, competence, strength	Using bravery as a way to face challenges in the growth process, as well as to increase strength and competence
42a	Feelings, experience	Realizing one is able to handle feelings, allowing the self to experience and express an experience
42b	Learning	Learning you can handle your feelings
42c	Learning	Learning to manage your feelings more effectively
43a	Growth, vulnerability	Gaining personal and professional growth by facing vulnerability
43b	Vulnerability, teaching	Vulnerability helps build strength and resiliency, increase honesty with others, and development of deeper bonds with others. Personal practice accepting and embracing vulnerability leads to greater ability to teach this to clients
45a	Shift, knowledge	Attitude shift impacting clinical work and change in attention, notes, reading, and application of knowledge in personal and professional lives
46a	Attunement	Attuning to others verbal and nonverbal
46b	Understanding	Greater understanding based on intuition
48a	Contribution	Recognizing speaking up leads to contribution
48b	Voice, recognition	Pursuing finding own voice and recognizing challenging myself leads to increased rewards
48c	Voice, truth, vulnerability, depth	Using 'voice' means speaking up about the truth of your experience, adding to your

		experience and those of others of being in the world. It requires facing potential or perceived embarrassment and vulnerability. Speaking up leads to greater depth in connections with others, increased understanding of others, and increased self-confidence. Increased self-agency
49a	Attunement	Finding space to be more in tune with own process in the moment to moment
49b	Awareness	Greater awareness of emotions as they erupt moment-to-moment leads to, or allows for making better decisions in various areas of life, quicker than if one was not aware of these things. Sometimes allows one to avoid negative experiences altogether (creates increased safety).
52a	Learning, flexibility	Learning to accept change and appreciate calm moments has helped me be more flexible
53a	Support	Seeking out support of colleague to feel "afloat."
54a	Experience, knowledge, insight, clarity, needs	Allowing yourself to recognize and experience an emotion leads to increased use of knowledge and emotion for good, to benefit one's life, increased insight, increased safety in interpersonal relationships, increased clarity about wants and needs.

Table 4

Theme 4: Moments involving others altruism as defined by Vago & David (2012)

Category	Key terms	Response
1a	Growth, teaching	Shifting towards finding a way to teach others, our clients, how to achieve similar growth
2a	Growth, development	Recognizing growth, development, constant move towards learning more
3a	Change, support	Identifying the need to change in order to support our clients.
5a	Patterns	Past patterns can come up unexpectedly, but I addressed them and was able to adjust my approach with clients
6a	Emotions, feelings	Recognizing others inability to access emotions or feelings
6b	Experience, knowledge	Experiencing a desire to share the knowledge with others
6c	Learning	Learning can be tiring and exciting
8a	Needs	Attending to client needs.
8b	Insight	Providing insight
9a	Experience	Moving client towards emotionally distressful experience, by sitting in the experience with them.
9b	Helplessness	Enduring own helpless feelings to help client move towards growth
9c	Tolerance	Realizing that I need to be able to tolerate client's pain with them
11a	Processing emotion	To help a patient process emotion, they have to feel it, go through it, connect to it.
12a	Learning	Learning how to maintain professional and ethical boundaries with family members
13a	Change, relationships	As you change, the people around you notice and are affected by it too. It's important to be conscious about what we're learning relative to how it impacts others, our world, our relationships
13b	Presence, support	Be present with your loved ones, and grateful for their support
14a	Learning, experience, emotion	Learning about reaction in parallel process to own experience, identifying sadness, recognizing inability to experience full range of emotion (sadness) with the client

16a	Learning, empathy, distress	Learning role of empathy, reflecting on true empathy, sitting in discomfort with a client as they experience emotional distress
16b	Tolerance, emotions	Tolerating difficult emotions with client helps client learn to tolerate them
17a	Motivation, awareness	Feeling motivation to increase awareness of counter-transference
17b	Awareness, counter-transference	Importance of being aware of, and working through, counter-transference
18a	Awareness, change	Awareness of patterns makes it possible to change them
23a	Experience, confidence	experiencing a concept on a personal level increases ability and confidence to share with client
29a	Growth	Recognizing growth
32a	Content, process, generalization	Differentiating content versus process with clients is valuable for work with that person, and generalizes to work with all clients
32b	Growth, confidence	Experiencing a growth experience in a session with one client, can increase feelings of confidence in my ability to do the same with other clients
33a	Instinct, trust	Realization to follow one's instincts and trust attunement with client as it often has therapeutic relevance
33b	Safety	Developing safe space
34a	Fear, disconnect, challenge	Fearing as a clinician a disconnect relates to fearing an emotional disconnect that doesn't allow you to help the client, which happens when you don't challenge the client to dig beneath the surface
35a	Experience, value	Always speak up about your experience because there is value in doing so, for yourself and for other
35b	Learning	Realizing that speaking up can lead to learning for both myself and my peers
38a	Shift, learning	Recognizing shift in education towards learning to help clients, help others, and because we want to
38b	Learning, purpose	Learning for intrinsic and altruistic purposes creates true purpose
38c	Learning	"True education" involves learning for intrinsic value and to benefit others, not ourselves

43a	Change, deeper bonds	Establishing deeper bonds with people in my life by changing and modeling behavior in clinical work
43b	Vulnerability, honesty, strength, teaching	Vulnerability helps build strength and resiliency, increase honesty with others, and development of deeper bonds with others. Personal practice accepting and embracing vulnerability leads to greater ability to teach this to clients
45a	Learning	Learning not only for the self, but learning for the client
45b	Learning	Learning in program is to benefit clients, not ourselves
45c	Learning	Learning for the benefit of clients increased my dedication to my education
50a	Contribution, sharing	Desire to contribute to others lives and share and help others
50b	Growth, development	Growing and developing to help others, by furthering and growing and developing
50c	Experience, growth, development	Desire to share experiences with others, and help others experience the same growth and development
50d	Growth, attunement, development	Growth in the program has led to becoming braver, wiser, and more attuned to self and others. These changes can happen relatively quickly under the right circumstances. Helping others furthers own growth and development

Table 5

Theme 5: Externalized reflections towards others as understood by Clark (1998)

Category	Key terms	Response
2a	Growth	Accepted growth as a process and journey
6a	Learning	Learning is always taking place, and is an ongoing process
8a	Presence, connection	Understanding the importance of presence, and being emotionally connected through fundamental skills
10a	Learning	Learning takes time
17a	Feelings	Disregarding the feelings of others
23a	Growth	Growth from experiencing genuine and congruent modeling through supervision and training
24a	Feelings, avoidance	Client's avoidance of feeling in session means the feeling is being held by clinician
32a	Content	Recognizing blank stares as content
36a	Change, shift	In order to understand shifts or changes with us, we need to consider contextual changes (ex: time and timing).
44a	Safety	Creating safety between the self and others
44b	Emotions, safety, connection	By choosing to speak up and face difficult emotions, in doing so, I can create safety in relationships leading to deeper connection to others
46a	Adjustment, relationships	Adjusting mood and feelings in clinical work and in interpersonal relationships
47a	Curiosity, understanding, experience	Curiosity, when coupled with kindness, is likely to be received well and responded to with enthusiasm, and allows for greater understanding of the experiences of others
47b	Comfort, understanding	Feeling comfortable to ask questions and be curious allows me to understand my clients and friends better
47c	Recognition	Recognizing impact of asking questions on clients
48a	Truth, experience, vulnerability, depth, confidence	Using 'voice' means speaking up about the truth of your experience, adding to your experience and those of others of being in the world. It requires facing potential or perceived embarrassment and vulnerability. Speaking up leads to greater depth in connection with others, increased understanding of others, and

		increased self-confidence. Increased self-agency
53a	Support, confidence, competence	When struggling, it's effective to reach out to others for support and/or remind myself of the confidence/competence loop (that things will get better again).

Table 6

Theme 6: Moments of growth through peak experiences (Maslow, 1954)

Category	Key terms	Response
7a	Reflection, distress	Recognizing and reflecting on benefit of experiencing distress and overcoming the challenge
11a	Reframe, feelings, emotions	Reframing psychological disorder as shame, recognizing shame and emotions, internalizing feelings, ownership of emotions
37a	Feelings	Feeling liberated stepping into the room
37b	Experience, bravery	Experiencing moment of bravery.

Table 7

Theme 7: Moments of awe and spirituality as defined by Torrance (1994)

Category	Key terms	Response
6a	Awe	Sitting in awe listening to family
6b	Gratitude, learning, strength	Feeling gratitude for knowledge and learning leading to emotional strength
26a	Acceptance, gratitude	Accepting bad feelings, moving forward, gratitude.
38a	Learning, purpose	Learning for intrinsic and altruistic purposes creates true purposes
43a	Bravery	Choosing to be brave
52a	Learning	Shifting mindset to learn and embrace new things
52b	Change	Embracing change allows one to enjoy and appreciate moments of serenity and calm, decreases rigidity, and increases spontaneity
54a	Awareness, experience, insight	Being aware of feelings opens you up to living your full experience and gaining insight