

Theses and Dissertations

2017

Supervision, clinical training, personal growth and the values of novice clinicians

Lauren Armstrong

Follow this and additional works at: <https://digitalcommons.pepperdine.edu/etd>

Recommended Citation

Armstrong, Lauren, "Supervision, clinical training, personal growth and the values of novice clinicians" (2017). *Theses and Dissertations*. 802.

<https://digitalcommons.pepperdine.edu/etd/802>

This Dissertation is brought to you for free and open access by Pepperdine Digital Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Pepperdine Digital Commons. For more information, please contact bailey.berry@pepperdine.edu.

Pepperdine University
Graduate School of Education and Psychology

SUPERVISION, CLINICAL TRAINING, PERSONAL GROWTH AND THE VALUES
OF NOVICE CLINICIANS

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Lauren Armstrong

June, 2017

Joan Rosenberg, Ph.D. – Dissertation Chairperson

This dissertation, written by

Lauren Armstrong

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

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Joan Rosenberg, Ph.D., Chairperson

Robert DeMayo, Ph.D.

Rebecca Rutchick, Ph.D.

© Copyright by Lauren Armstrong (2017)

All Rights Reserved

TABLE OF CONTENTS

| | |
|---|-----|
| LIST OF TABLES | ix |
| ACKNOWLEDGEMENTS | x |
| VITA | xi |
| ABSTRACT | xvi |
| Chapter 1: Overview of the Study | 1 |
| Definitions | 6 |
| Problem Statement | 9 |
| Purpose of the Study | 10 |
| Research Question | 10 |
| Chapter 2: Literature Review | 11 |
| Theoretical Framework: Transformative Learning Theory | 11 |
| Personal Growth | 13 |
| Methods of Personal Development | 20 |
| Clinician Growth and Client Impact | 22 |
| Summary | 57 |
| Chapter 3: Research Methodology | 60 |
| Research Design | 60 |
| Participants and Researchers | 63 |
| Setting | 67 |
| Procedure | 67 |
| Critical Incidents | 68 |

| | |
|--|-----|
| Data Collection and Management..... | 71 |
| Human Subjects/Ethical Considerations..... | 73 |
| Assumptions..... | 74 |
| Scope and Delimitations..... | 74 |
| Chapter 4: Results..... | 76 |
| Coding and Data Analysis..... | 76 |
| Evidence of Trustworthiness..... | 81 |
| Results..... | 81 |
| Summary..... | 97 |
| Chapter 5: Summary, Conclusions and Recommendations..... | 100 |
| Conclusions..... | 101 |
| Limitations..... | 108 |
| Implications..... | 109 |
| Recommendations..... | 111 |
| Final Thoughts..... | 112 |
| REFERENCES..... | 114 |
| APPENDIX A: Institutional Review Board Approval..... | 156 |
| APPENDIX B: Informed Consent..... | 159 |
| APPENDIX C: Confidentiality Agreement..... | 164 |
| APPENDIX D: Participant Recruitment Email Script..... | 167 |
| APPENDIX E: De-identification Protocol..... | 169 |
| APPENDIX F: HIPAA Certifications..... | 171 |

| | |
|------------------------------------|-----|
| APPENDIX G: Demographic Form | 176 |
| APPENDIX H: Coding Process..... | 179 |

LIST OF TABLES

| | |
|--|-----|
| Table 1. Value 1. Awareness | 83 |
| Table 2. Value 2. Knowledge | 87 |
| Table 3. Value 3. Bravery | 90 |
| Table 4. Value 4. Competence..... | 91 |
| Table 5. Value 5. Learning..... | 92 |
| Table 6. Value 6. Humility..... | 93 |
| Table 7. Value 7. Community..... | 94 |
| Table 8. Value 8. Acceptance | 95 |
| Table 9. Value 9. Openness..... | 96 |
| Table 10. Value 10. Curiosity..... | 97 |
| Table H1. Theme 1. Increased Self-Efficacy..... | 179 |
| Table H2. Theme 2. Increased Engagement with Work..... | 183 |
| Table H3. Theme 3. Experiences of Enhanced Resilience..... | 183 |
| Table H4. Theme 4. Experiences that Restore or Maintain Personal Well-Being..... | 188 |
| Table H5. Theme 5. Increased Ability to Help Clients..... | 190 |

ACKNOWLEDGEMENTS

I would like to express my utmost thanks and gratitude to my committee for their continued support and encouragement: Dr. Joan Rosenberg, my committee chair; Dr. Robert deMayo; and Dr. Rebecca Rutchick. I sincerely appreciate the learning opportunities provided by my committee. My completion of this project was aided the support of my dear colleague Alberto Ibarra, who served as a compassionate and consistent source of brilliance, motivation, and laughs throughout this process.

I especially want to express gratitude for my parents, Lawrence and Sandy Armstrong. Your infinitely supportive acts, your incredibly patient ears, and your wise words of encouragement have fueled my endeavors and provided me with endless opportunities to succeed. Thanks to my brother, James Armstrong, who is a symbol of bravery, strength, and perseverance and who keeps me grounded. None of this would have been possible without the three of you.

VITA

EDUCATION:

Pepperdine University, Graduate School of Education and Psychology September 2012-Present

Doctoral Program in Clinical Psychology

Psy.D. Degree expected: 2017

- Dissertation: *Supervision, Clinical Training, and Personal Growth*

**Pepperdine University, Graduate School of Education
and Psychology, Irvine, CA**

December 2011

Master of Arts in Psychology

The University of Arizona, Tucson, AZ

December 2009

Bachelor of Arts in Psychology

CLINICAL EXPERIENCE:

Casa Pacifica Center for Children and Families, Camarillo, CA

August 2015-July 2016

Doctoral Intern

Supervisor: Dr. Joshua Lepore, Psy.D.

Training Director/Testing Supervisor: Dr. Robert Kretz, Psy.D.

- Provided individual and group therapy to culturally diverse transitional age youth in the foster care system with a variety of psychological disorders using a mix of humanistic, psychodynamic, DBT, and trauma-focused interventions
- Provided individual, group, and family therapy to culturally diverse adolescents and children in the foster care, adoptions, and juvenile justice systems within a Level 14 residential treatment facility
- Provided crisis intervention, suicide assessments, safety planning, and conceptualization of unsafe behaviors for adolescents and young adults in crisis
- Provided ongoing case management by collaborating with a multi-disciplinary team across different programs within the facility including psychiatrists, youth development specialists, parents, social workers, probation officers, school officials, administrative staff, recreation therapists, and other crisis or behavioral clinicians
- Led treatment team meetings on a monthly for each individual client in order to provide clinical updates and conceptualizations, collaborate and encourage consistent communication between all members of the treatment team across disciplines, receive feedback about client's individual needs and/or progress, as well as problem solve and plan for next steps in the client's treatment
- Administered psychological assessments to children and adolescents based on individualized referral questions, computed and scored results, wrote integrated assessment reports, and provided feedback to the clients, caregivers, and other members of the treatment team. Assessments batteries and screenings included: WISC-IV, WASI-II, D-KEFS, MACI, M-PACI, MMPI-A, YSR/11-18, CBCL, TOVA, House Tree Person, Sentence Completion, WRAT-4, VMI-6, Robert's-2
- Developed and co-led two new groups within the Transitional Youth Services program: Cooking group and Independent Living Skills group. Each group required development of format, curriculum, standards/rules, and logistics. The groups included both non-minor dependents in the TYS housing program as well as 16 and 17 year olds in the residential program
- Wrote formal intake reports for each client to include the presenting problem, complete background history, cultural considerations, multi axial diagnosis, diagnostic formulation and conceptualization, and treatment plan and goals

- Developed individualized behavioral and safety support plans for each client in order to assist the front-line staff in utilizing interventions that work best with each client as well as information to provide context the behaviors being displayed
- Participated in four hours of weekly supervision: one hour with primary supervisor, one hour with secondary supervisor, and two hours with group supervisor.
- Participated in various team meetings in order to discuss, conceptualize, and collaborate with others about clients. Attended a formal Rounds meeting once a week and completed an in depth presentation on a client in Rounds twice during the year
- Attended weekly 2-hour didactic training on topics such as: psychological assessment and testing, supervision, self-care, termination, private practice, licensing, motivational interviewing, transitional age youth, play therapy, LGBTQI, and crisis intervention
- Maintained thorough progress notes for each client for documentation of all client contact in accordance with Ventura County Behavior Health documentation standards and protocol

Long Beach Child and Adolescent Program, Long Beach, CA September 2014- June 2015

Doctoral Practicum Extern

Supervisor: Dr. Teri Paulsen, Ph.D.

Testing Supervisor: Dr. Ronnette Goodwin, Ph.D.

- Provided individual and family therapy to culturally diverse children and adolescents with a variety of psychological disorders using Cognitive Behavior Therapy and Trauma Focused-CBT
- Provided individual therapy to culturally diverse adult women on welfare in the CalWORKS program
- Administered psychological assessments to children and adolescents based on individualized referral questions, computed and scored results, wrote integrated assessment reports, and provided feedback to the clients and caregivers
- Wrote formal intake reports for each client to include the presenting problem, complete background history, cultural considerations, multi axial diagnosis, diagnostic formulation and conceptualization, and treatment plan and goals
- Provided ongoing case management and consultation which included collaboration with other therapists, psychiatrists, social workers, teachers, and services within the community
- Maintained thorough progress notes for each client for documentation of all client contact in accordance with Department of Mental Health of Los Angeles documentation standards and protocol
- Participated in weekly one hour: group supervision for therapy, group supervision for assessment/testing, and individual supervision
- Participated in weekly one hour case disposition to present and discuss new intakes with supervisors, licensed clinical social workers, and externs
- Attended weekly 90 minute didactic training in Cognitive Behavior Therapy at Harbor UCLA

Pepperdine Community Counseling Clinic, Irvine, CA

September 2014-June 2015

Doctoral Peer Supervisor

Supervisor: Dr. Joan Rosenberg, Ph.D.

- Hand-selected to provide individual peer supervision to a first year doctoral clinical psychology student
- Provided weekly one hour peer supervision utilizing the benchmarks as a guide to format and assess the supervision process
- Provided an individualized approach to supervision utilizing review of video-taped sessions, role plays, reflective discussion, literature review and discussions of personal factors of the supervisee as they related to the work with clients

- Reviewed, edited and provided feedback on supervisee utilizing review of video-taped sessions, role plays, reflective discussion, literature review and di
- Participated in weekly one hour group supervision of supervision with a licensed clinical psychologist to discuss the peer supervisory process

Pepperdine Community Counseling Clinic, Irvine, CA

September 2012-June 2015

Doctoral Practicum Trainee

Supervisor: Dr. Joan Rosenberg, Ph.D.

- Provided individual and couple, Ph.D.c, Irvine, CA with a variety of psychological disorders; recommend techniques to experience feelings on a moment to moment basis in order to be fully aware of themselves and others
- Conducted formal intake interviews in order to develop treatment plans which cater to the needs of each individual client
- Administered psycho-diagnostic assessments to each client to assess for depression, overall mental health, and interpersonal relationship functioning
- Maintained thorough progress notes for each client for proper documentation of all contact with clients
- Wrote formal intake reports for each client to include presenting problem, complete background history, cultural consideration, multi axial diagnosis using the DSM-IV-TR, diagnostic formulation and conceptualization, and treatment plans and goals
- Consulted with other medical and psychological health professionals on an as needed basis with consent from clients in order to provide comprehensive treatment
- Participated in didactic and group supervision on a weekly basis to review each clients with consent frds

Children and Youth Services- Youth Reporting Center, Anaheim, CA August 2013-August 2014

Doctoral Practicum Extern

Supervisor: Dr. Melvin Navarro, Ph.D.

- Provided individual therapy to culturally diverse adolescents (ages 12-19) attending a probation school on a weekly or biweekly basis to address problems with conduct, oppositional behaviors, emotion regulation, substance use, legal and educational needs, and family and interpersonal relationships
- Conducted intake and diagnostic interviews with adolescents and caregivers to assess the needs of each client and develop treatment plans on an individual basis
- Conducted weekly or biweekly group therapy with up to 12 adolescents focusing on anger management and life skills
- Provided ongoing case management and consultation which included collaboration with other therapists, psychiatrists, probation officers, correctional officers, social workers, teachers, and services within the community
- Maintained thorough progress notes, Client Treatment Plans (detailed goals created in collaboration with the client), formal intake/assessment reports, and discharge summaries in accordance with MediCal insurance guidelines and county regulations
- Participated in one hour of both individual and group supervision on a weekly basis

PRYDE Program Pepperdine University, Irvine, CA

February 2011- June 2012

School Counseling Intern

Supervisor: Dr. Robert Hohenstein, Ph.D.

- Provided individual counseling to children and adolescents ages 11-17 at four schools in Covina, CA on a weekly basis
- Assisted clients in emotion regulation, problem solving, boundary setting, study habits, and general life skills

- Collaborated with teachers and parents to promote consistency across environments for the students and to provide comprehensive treatment
- Advocated on behalf of students to receive additional supports as needed from the school or community
- Participated in one hour of didactic supervision on a weekly basis

Community Service Programs, Inc, Youth Shelter, Laguna Beach CA January 2010-August 2012

On Call Youth Specialist

- Provided counseling to adolescents (aged 13-17) living in a crisis residential program
- Duties included dispensing medications, leading groups on life skills, preparing meals, maintaining thorough paperwork and documentation, recording necessary information in daily logs, bed checks at night and providing behavioral interventions throughout the day

Medlink Treatment Center, San Clemente, CA

February-July 2010

Resident Director/Administrator

- Responsible for all resident activity at a dual diagnosis treatment center for adults including: scheduling therapy and psychiatric appointments, transporting clients to medical and other appointments, preparing meals, administering medications, and planning leisure time and therapeutic activities
- Created administrative documents such as logs, schedules, and protocol sheets
- Trained and oversaw other House Managers

Undergraduate Psychology Exploration Program, Tucson, AZ

August-December 2009

Peer Mentor

- Mentored and counseled incoming freshmen psychology students to assist in their transition to college, creating educational plans and goals, and providing support and guidance for personal and interpersonal problems
- Provided one-on-one sessions bi-monthly for each student to discuss problems, challenges, and questions
- Lead discussions in the classroom setting once a week about study habits, career planning, resume writing, and applying to graduate school

Childrencussions in the classroom setting once a week about study habits,

Social Worker Assistant

- Worked closely with caseworkers in supervising visitations for families
- Conducted follow ups with reunited families
- Responded to calls for child removal

ASSESSMENT EXPERIENCE:

BoyESSMENT EXPERIENCE: child removal miliesing visitations for familie

Supervisor: Carolyn Keatinge, Ph.D.

- Conducted a clinical interview and administered a full psychological evaluation to assess the clientting, and intellectual and academic functioning, his emotional functioning, and determine his appropriateness for the Boy's Hope Program
- Wrote an integrated report addressing the referral question, describing strengths and weaknesses, and offering recommendations
- Tests administered: WISC-IV, WRAT-4, Sentence Completion, VMI-6, M-PACI, Roberths a

PSY 713: Advanced Assessment, Pepperdine University

Fall 2013

- Focused on the use of batteries in clinical practice, where interview and observational data are integrated with findings from measures of cognitive and personality functioning to yield appropriate diagnoses and recommendations in professional psychological reports
- Administered a full battery of tests (including clinical interview) on an adult volunteer and wrote an integrated report for class purposes
- Tests covered: WAIS-IV, MMSE, Rorschach, MMPI-2, MCMI-III, TAT, RISB, NEO-PI-R

PSY 711: Personality Assessment, Pepperdine University Spring 2013

- Studied the administration, scoring, interpretation, and reporting of the most commonly used objective and projective personality instruments
- Emphasis placed on learning to administer, score, and interpret the Rorschach Inkblot Test using Exner and projective persona
- Administered a full battery of tests (including clinical interview) on an adult volunteer and wrote an integrated report for class purposes
- Tests covered: MMPI-2, NEO-PI-R, TAT, RISB, Rorschach

PSY 710: Cognitive Assessment, Pepperdine University Fall 2012

- Studied the administration, scoring, interpretation, and reported of the most commonly used clinical instruments for psychological evaluation of cognitive functioning
- Development of rapport, interviewing skills, and structured history-taking also covered
- Administered a full battery of tests (including clinical interview) on an adult volunteer and wrote an integrated report for class purposes
- WAIS-IV, MMSE, WRAT-IV, Trail Making Test, COWAT, RAVLT, Bender-Gestalt-II, VMI-6

PRESENTATIONS:

American Psychological Association Poster

August 2013

Presented

Ibarra, A., Armstrong, L., Dubs, W., Markowitz, S., Faith, A., Walker, A. (2013). *Call for a paradigm shift in clinical training: The personal transformation of novice clinicians.*

RESEARCH EXPERIENCE:

Clinical Supervision Research Lab

October 2012-July 2015

Graduate Student Researcher

Supervisor: Joan Rosenberg, Ph.D

- Focus on the importance of personal development on professional development of the novice clinician
- Thoroughly examine the literature on areas such as supervision, professional development, personal growth, multicultural, psychodynamic, humanistic, APA ethics code, and other related areas
- Wrote journals to document our own personal growth experiences through supervision that will be used as data for future publications and dissertation
- Submitted and presented a student poster with colleagues in 2013
- Continue to participate in this lab as it relates to dissertation and other future projects

Psychology and Law Research Lab

May-July 2009

Undergraduate Research Assistant

- Created a rating system to code laypersons Mand other f
- Used rating system to blind code participant responses

ABSTRACT

The purpose of this qualitative, autoethnographic study was to identify and explore the values that promoted personal growth and that emerged out of the clinical training and supervision experience of novice clinicians within one clinical psychology doctoral program. Participants included three first-year doctoral students in clinical psychology, one of whom was the primary researcher. Participants completed journal entries approximately twice monthly for seven months, resulting in a total of 54 entries that were examined using a content analysis approach. Content analysis, conducted by the primary researcher, involved coding data for themes and patterns that were representative of values, as well as indications that these values oriented the participant toward personal growth. Journal entries were first analyzed and coded based on whether they fit the definitional criteria of a value and then coded secondarily for the value itself. Specifically, cited in descending order, content analysis identified the following values: (a) awareness; (b) knowledge; (c) bravery; (d) competence; (e) learning; (f) humility; (g) community; (h) acceptance; (i) openness; and (j) curiosity. Awareness, as it related to self-regulation and to skill development was the most highly identified value. Future researchers may consider expanding on these results with a larger and more heterogeneous sample of novice clinicians.

Chapter 1: Overview of the Study

Personal attributes of therapists have been associated with the quality of their clinical work with clients (Cartwright, Rhodes, King, & Shires, 2015; Gallegos & Sortedahl, 2015). Because of this influence of personal attributes upon therapists' clinical work, it is important to understand how novice clinicians experience values of personal growth in the context of initial training (Bohecker, Wathen, Wells, Salazar, & Vereen, 2014; Kiweewa, Gilbride, Luke, & Seward, 2013). Understanding how training impacts values of personal growth of novice clinicians may provide insights that are useful in improving training practices and programs for new therapists. This chapter provides an overview of the present study, beginning with a review of background research and definitions of key terms used in this study. The next sections explain the purpose of the study and the research question.

Methods of training have been a focus of clinical psychologists since the inception of mental health services in 1897 (Routh, 2000). The American Psychological Association (APA) has led the field in the development and refinement of ethical codes and standards, as well as training program accreditation standards and guidelines for diversity training and competence in order to improve and regulate the training of clinical psychologists (APA, 2000; 2002b; 2007; 2013). Several questions remain regarding training and how clinicians can achieve a more consistent level of competence. According to Binnie (2011), the field of applied psychology has advanced and has now acknowledged the use of specific competencies as an ideal method of training. The existing variance in clinical competence can be attributed to "therapist' factors" (Blomberg, Lazar, & Sandell, 2001). In another study, Brammer and Shostrom (1977) emphasized the need to study mediating and moderating variables, therapist factors, and highlighted the importance of analyzing therapeutic outcomes.

In several studies, researchers found there is a relationship between therapists' personal factors and clinical work (Cartwright et al., 2015; Darden & Rutter, 2011; Dickson, Moberly, Marshall, & Reilly, 2011; Freund, Blit-Cohen, Cohen, & Dehan, 2013; Gallegos & Sortedahl, 2015). Mental health professionals have shown a longstanding interest in therapist personalities. According to the humanistic model, therapists can only facilitate change when they can relate to the situation that the client is experiencing; they must have undergone the same level of growth to be effective in assisting the patient (Gone, 2014; Hopkins & Proeve, 2013; Jimenez, Navia-Osorio, & Diaz, 2010). Li and Fiorello (2011) and Malik, McKenna, and Plummer (2015) argued that, through facing their own challenges, therapists were able to develop greater levels of strength, wholeness, and well-being.

The personal attributes of therapists are also considered within the following areas of psychology:

- 1) Multicultural counselling – This is a discipline where self-awareness and recognition is strictly emphasized (Merriman, 2015; Moldovan, Cobeanu, & David, 2013; Newman, Nebbergall, & Salmon, 2013; Nedeljkovic, Chaffey, Murray, & Brennan, 2014; Newman, 2012).
- 2) Psychodynamic psychotherapy – In this discipline, therapists are required to use self-relativity to transference and countertransference in order to assist the patient accordingly (Merriman, 2015; Moldovan & David, 2013; Newman, Nebbergall, & Salmon, 2013; Nedeljkovic et al., 2014; Newman, 2012).
- 3) Counseling psychology – In this discipline, therapists' personal factors are said to play an important role in the treatment process of the patient (Merriman, 2015;

Moldovan & David, 2013; Newman et al., 2013; Nedeljkovic et al., 2014; Newman, 2012).

- 4) Cognitive Behavioral theories – Though sparingly, personal factors help in coming up with the context of third wave behavioral theories (Merriman, 2015; Moldovan & David, 2013; Newman et al., 2013; Nedeljkovic et al., 2014; Newman, 2012).
- 5) Application of Aponte’s 1992 Person-of-the-Therapist – Training master’s students how to apply Aponte’s model in real-life situations requires the tutor to possess certain personal attributes (Pakenham & Stafford-Brown, 2012).

While assessing novice clinicians’ success in training, the effect of therapists’ personal attributes on development is considered (Pelaccia, Tardif, Tribby, & Charlin, 2011). However, there has been some form of reluctance (from the supervisors) in assessing personal attributes of the therapist that affect treatment of the patient (O’Byrne, Clark, & Malakuti, 1997; Owen-Pugh & Baines, 2014; Parcover & Swanson, 2013; Plaut, 1982; Stafford-Brown & Pakenham, 2012). Other researchers discovered that some of these overlooked personal attributes have a major effect on the clinician’s career growth. The situation could worsen to a point where some students end up being dismissed from the program, while others begin remediation plans (Shanley & Stevenson, 2006; Smith & Castanelli, 2015; Szecsödy, 2013). According to Townend (2008), acknowledgment of one’s limitations through self-awareness is an ethical imperative. Watkins (2012) also highlighted that optimal professional development is achieved by acknowledging one’s potential to transcend these limitations and adopt the required personality traits.

Much earlier, the education literature of 1916 addressed the overlap of personal and professional development through John Dewey's *Democracy and Education*. John Dewey believed that the content of the curriculum should not differ from the content of the daily life experiences of the students (Wheeler & Richards, 2007). According to some scholars, students in this field thrive when curiosity, open-mindedness and active reflective thinking is taught to them. In addition, Dewey emphasized the need for teachers to possess the aforementioned traits so that they can best facilitate the teaching process (Burina, Danilova, Grandilevskaya, Rykman, & Trabczynski, 2015). An open mind enables individuals to fully exploit their potential to benefit society (Egan, Haley, & Rees, 2014) where those open-minded individuals demonstrate better problem-solving skills as compared to conservative ones (Egan et al., 2014). A person with an open mind can cover a wide scope and consider various viewpoints before arriving at any decision (Egan et al., 2014). On the other hand, active and reflective thinking enables students to be bold enough to challenge the existing status quo if necessary (Feely & Byrne, 2015).

Similar to outcomes described by Dewey, novice clinicians receive training and supervision through their graduate programs, and personal growth is one intended outcome of this training (Bohecker et al., 2014; Kiweewa et al., 2013). Although researchers have investigated the effectiveness of graduate training programs in developing skills or competencies in novice clinicians, few researchers have examined values of personal growth in relation to training for new therapists (Hill, Kline, Bauman, Brent, Breslin, Calderon, & Knox, 2015). In particular, few researchers have explored first-person accounts describing values of personal growth among novice clinicians within the context of their initial supervision and training in graduate programs (Kiweewa et al., 2013).

A student is said to be growing when he/she can easily adapt to the dynamic environment and portray advanced problem-solving techniques; growth is also indicated by the ability to get more experience to a point where one can boldly challenge intellectual concepts and some kind of behavior accordingly (Hill et al., 2015; McMinn, Vogel, Hall, Abernethy, Birch, Galuza, ...& Putman, 2015). These positive improvements are achieved since there is both personal and professional development occurring at the same time. Some scholars concluded that education catalyzes growth of the novice clinician when the student pursues courses that facilitate both personal and career growth (Nel, Pezzolesi, & Stott, 2012; Omoregbee, Morrison, & Morrison, 2016; Pillay & Johnston, 2011).

Growth occurs when an individual is able to exploit his/her potential without wholly relying on the formal education being offered. This is achieved when there is a suitable environment for individuals to blossom. For example, the kind of teacher-student interaction will have an effect on the growth potential of the student. Teachers must pass information to students in a manner that is appealing and triggers curiosity, rather than being too mechanical in presenting the information to students. Proper learning leads to development of intelligent habits, which guide both the past and the present situations in a manner that fosters and improves human growth (Pillay & Kramers-Olen, 2014; Roberts, Blossom, Evans, Amaro, & Kanine, 2016).

Past literature has debated the improvement of weaknesses (personal or professional) versus development of strengths. Simpson, Rochford, Livingstone, English, and Austin (2014) advocated professional and personal development, which is achieved through cultivation of a hopeful and positive mental attitude. Hope is a virtue that has the ability to calm the human impulse even in adverse conditions (Simpson et al., 2014). Having hope is effective when the individual believes that he/she has the ability to surpass normal expectations; a hopeful approach

may be more effective when training novice clinicians (Simpson et al., 2014), because the development of a value such as hope nurtures the natural potential of the clinicians who end up attaining skills that enable them to achieve both academic and clinical goals (Simpson et al., 2014). When these novice clinicians develop their values, they tend to naturally develop intelligent habits that result in the development of both personal and professional experience (Simpson et al., 2014).

Researchers have found that ongoing personal growth enhances therapists' abilities to engage in therapeutic relationships with clients (Aponte & Kissil, 2014; Bennett-Levy & Lee, 2014). Personal growth increases a therapist's self-awareness and capacity for reflection, which are essential for monitoring and modifying their own responses and behaviors in the clinical setting (Hill et al., 2015; Malikiosi-Loizos, 2013). Personal growth can also enhance resilience, increase self-efficacy, and promote work engagement for therapists; this growth is important for promoting therapists' well-being and abilities to provide quality care to clients (Howard, 2008).

Definitions

The following are definitions for the key terms used throughout this dissertation. Recent literature, as well as the American Psychological Association Dictionary (VandenBos & APA, 2007) of Psychology was referenced to define these terms.

Personal factors. Personal factors are aspects of the person characterized by one's emotions, worldview, schema, meaning and purpose, beliefs, attitudes, assumptions, values, and motivations (Falender & Shafranske, 2012b).

Personal development and personal growth. The concepts of personal development and personal growth have been used interchangeably in the literature and, at times, seem to have overlapping meanings (Donati & Watts, 2005; Irving & Williams, 1999). However, they

represent different aspects of a general growth-like process. Development can be thought of as an effort to improve upon a predetermined path, while growth can be thought of as a less structured process or a result of development activities (Irving & Williams, 1999). Personal development, for the purposes of this study, is defined as the improvement of personal qualities such as self-evaluation, genuineness, positive regard, self-attunement, embracing one's humanity, emotional awareness, intimacy, management of countertransference, and balance of social connectedness (Donati & Watts, 2005; Rosenberg, personal communication, November 15, 2012; Norcross, 2001). Alternatively, personal growth is an outcome of the aforementioned personal development processes (Irving & Williams, 1999). As such, the definition for personal growth used for this study is the result of the development of any personal characteristics or qualities that make up one's self as an individual.

Professional development. The definition for professional development in this study is drawn from one used in competency-based approach to training (Fouad, Hatcher, Hutchings, Collins, Grus, Kawlow, & Crossman, 2009). Professional development is the development of competencies deemed necessary to provide effective treatment to clients. These competencies include knowledge, skills and attitudes learned through graduate coursework, clinical supervision, and other educational and professional activities.

Novice clinicians. The term novice clinician refers to a first-year doctoral student enrolled in a full-time doctoral psychology program and receiving clinical supervision (Taubner, Zimmerman, Kächele, Moller, & Sell, 2013).

Person of the therapist. Carl Rogers identified the concept of the "fully functioning person," in which he identified what kind of person would emerge if the therapeutic process were maximally successful. In order to operationalize an understanding of who the person is in a way

that is congruent with this research, Carl Rogers's definition provides a universally known concept. Thus, when I discuss the concept of the person of the therapist, I am using Rogers's (1961) definition of the fully functioning person. Generally, this definition has included three main processes: (a) accepting and being aware of one's experiences, (b) being capable of responding to one's experience by behaving in the manner that is most genuinely satisfying to the self, and (c) recognizing and accepting that the self is constantly changing (Rogers, 1961).

From the framework of Rogers's person-centered therapy (1961), therapists attempt to guide their clients towards becoming fully functioning persons. Rogers felt that therapists must also work toward becoming fully functioning persons to function optimally in both personal and professional contexts. It should be noted that Rogers generally explained this as an ongoing process as opposed to an end-point that one may strive to achieve. He felt that the ongoing engagement in the processes described above was what best represented his concept of the fully functioning person. The idea that growth occurs as a result of an endlessly evolving process was described much earlier by John Dewey in his education model (1916). Growth is a process of becoming without a fixed end (Saito, 2005). Thus, the person of the therapist is conceptualized as someone actively and thoughtfully engaged in the growth promoting processes described by Rogers.

Resilience. Resilience refers to one's capacity to endure demands and stressors without developing problems related to stress (Howard, 2008).

Self-efficacy. This refers to how capable one feels to complete required actions, tasks, or roles (Howard, 2008).

Values. For purposes of this study, values here are defined by: (a) an increase in self-efficacy, (b) increase in engagement with work, (c) an experience of enhanced resilience, (d) an

experience that restores and/or maintains one's personal well-being, and/or (e) an increase in ability to help clients (Howard, 2008).

Well-being. This term refers generally to a person's overall health and psychological functioning (Howard, 2008).

Work engagement. This refers to the level of involvement and fulfillment one feels in relation to work tasks (Howard, 2008).

Problem Statement

Grafanaki (2010) unequivocally stated, "There is a need to study more closely the training process and the factors that are relevant and meaningful to counselors-in-training (e.g. interpersonal skills development, coping strategies, self-reflection and awareness)" (p. 81). However, few have investigated these experiences from the perspective of the novice clinician (Kiweewa et al., 2013). The literature that exists in this area is largely retrospective in nature (Carlsson, Norberg, Schubert, & Sandell, 2011; Trotter-Mathison, Koch, Sanger, & Skovholt, 2010), from the perspective of senior clinicians (Rønnestad & Skovholt, 2001), and focuses on the quality of the learning process and development of competence (Folkes-Skinner, Elliott, & Wheeler, 2010), in the absence of a focus on values expressed by novice clinicians as they are being trained.

Several researchers have identified this gap and called for additional research on the personal growth of novice clinicians and the impact on their overall development, from the novice clinician's perspective (Auxier, Hughes, & Kline, 2003; Bennett, 1986; Borders, 1989; Coleman, 2006; Ellis, 1991; Gibson, Dollarhide, & Moss, 2010; Grafanaki, 2010; Hanna, Bemak, & Chung, 1999; Hill, Sullivan, Knox, & Schlosser, 2007; Matthews, 2012; Rønnestad & Ladany, 2006; Rønnestad & Skovholt, 2001; Skovholt & Rønnestad, 2003; Taubner, et al., 2013;

Theriault & Gazzola, 2010; Trotter-Mathison, et al., 2010; Truell, 2001). Lack of research on how personal growth occurs within the context of novice clinician training creates a risk that training and supervision programs will be ineffective and fail to adequately develop personal attributes necessary for new therapists' success (Hill et al., 2015).

Purpose of the Study

The purpose of this qualitative study was to identify and explore values of personal growth that directly related to the clinical training of novice clinicians within a clinical psychology doctoral program. Content analysis of journal entries by three purposefully selected first-year clinical psychology doctoral students was conducted to explore values associated with personal growth of participants as novice clinicians. Participants completed approximately two monthly journal entries for seven months that described critical moments of personal growth in relation to their clinical training and supervision experiences. This study aimed to understand the role and impact of values, as one element of personal growth, in the clinical training of novice clinicians. The researcher anticipates that the findings of this study may be helpful in developing supervision and training practices that enhance personal growth of novice clinicians.

Research Question

The following research question was used to address the present study's purpose:
What values emerge in clinical training/supervision that orient a novice clinician toward personal growth?

Chapter 2: Literature Review

The purpose of this qualitative study was to identify and explore values of personal growth that directly related to the clinical training of novice clinicians within a clinical psychology doctoral program. This chapter presents a review of relevant research literature to provide context for this study's aims.

A search of several databases was conducted to obtain relevant research for inclusion in this chapter, and peer-reviewed sources were prioritized. Databases searched were PsycINFO, Psychology and Behavioral Sciences Collection, Academic Search Premier, and Google Scholar. Search terms included *therapist training*, *counselor training*, *novice clinician training*, *therapist supervision*, *personal growth*, *personal development*, *professional development* and combinations of these terms. In order to capture the most current research, articles published in the last five years were prioritized in the search.

The next section provides a discussion of the theoretical framework for the study as well as its relevance to this study's research question. Research relevant to this question will then be discussed and analyzed, including discussion of person of the therapist development, methods of personal development, clinician growth and client impact, humanistic psychology, positive psychology, counseling psychology, current supervision and clinical training, multicultural influences on supervision and training, model for the development of the person-of-the-therapist, and values that emerge through training and supervision. This chapter concludes with discussion of the gap in the existing research literature.

Theoretical Framework: Transformative Learning Theory

The theoretical framework for the present study was transformative learning theory. Mezirow (2009) initially developed transformative learning theory in the 1970s to explain a form

of adult learning that resulted in substantial changes in the individual's perspectives and assumptions. Mezirow (2009) posited that certain types of learning experiences induced adults to revise their fundamental structures of meaning, such as their beliefs, values, and expectations. According to this theory, learning that resulted in such paradigmatic changes to one's frames of reference also resulted in changes to the individual's patterns of feeling, thinking, and acting (Taylor, 2007). Mezirow (2009) theorized that transformative learning experiences influenced personal growth through the expansion of perspectives, habits of thought, and mindsets; such expansion resulted in meaning frameworks that were more open, inclusive, and responsive to change.

According to the theory, self-reflection and discourse with others were key processes involved in shifting one's thinking, beliefs, values, and behavior in transformative ways (Mezirow, 2009; Taylor, 2007). Although specific, disconcerting events may trigger a sudden and dramatic experience of transformative learning by challenging an adult's assumptions or beliefs, the process may also occur cumulatively in response to ongoing experiences of learning that gradually transform the individual's perceptions or habits of thought (Mezirow, 2009). For example, a disorienting dilemma might induce an adult to elaborate upon foundational assumptions or expectations in a sudden manner (Mezirow, 2009). On the other hand, extended processes such as acquiring new knowledge or adopting new roles may result in cognitive, emotional, and/or behavioral changes that reflect fundamental changes in beliefs or values (Mezirow, 2009).

Taylor (2007) noted that although transformative learning could occur spontaneously in response to life events, adult learners also experienced this type of learning in response to formal instruction or training. In a review of literature related to transformative learning in higher

educational settings, Taylor (2007) found that trusting relationships facilitated this type of learning by allowing students to engage in self-reflective discussion and questioning. Taylor (2007) also found that direct learning experiences (i.e., providing clinical services) stimulated transformative learning, especially when combined with reflection upon these experiences. Accordingly, McLeod and McLeod (2014) reported that therapists had experienced transformative learning as the result of formal instruction and training, and also through their work with clients in clinical settings. These experiences caused therapists to reconsider prior assumptions and beliefs, and in some cases resulted in epiphanies that reshaped their internal perspectives and values in relation to their work (McLeod & McLeod, 2014).

Although transformative learning does not account for all personal growth of therapists (McLeod & McLeod, 2014), it is an appropriate theoretical lens for the present study because of this study's use of critical learning incidents. The present study's research question concerned values that related to personal growth experiences among novice clinicians, which emerged through experiences of critical learning incidents. The critical incident represents a major learning event that stimulates growth and development in areas of beliefs, values, and attitudes (Smith-Adcock, Shin, & Pereria, 2015). Transformative learning theory explains the relationship between external experiences (i.e., critical incidents) and internal emotional and cognitive growth.

Personal Growth

The personal development of the “person-of-the-therapist” (a novice clinician) is not currently a formal aspect of clinical training at the doctoral level. Many argue for the value of implementing this education 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, Heppner, & Roehlke, 1986). However, clinical training focuses largely on the development of particular competencies that acknowledge the significance of personal development to training, yet only in the requirement to gain self-awareness (Fouad, et al., 2009). Following below is a comprehensive analysis of current research that addresses the significance of personal development to training, and the ways in which it is or is not being implemented by education programs.

Person of the therapist in training and supervision. Horner and Youngston (2009) noted that the British Psychology Society called for an increased emphasis in the training accreditation criteria for clinical psychology courses to include learning outcomes for personal and professional development. However, in the United States, personal development, as a training focus, is inconsistently addressed. Whether it is addressed at all often depends on the theoretical orientation in which the training is rooted, with humanistic and psychodynamic approaches emphasizing it more than cognitive behavioral approaches (Wilkins, 2006).

Clinical training and supervision literature emphasizes the importance of learning techniques and gauging competence in a novice clinician (Falender & Shafranske, 2012a). There appears to be less concern over a novice clinician's personal development, which seems at odds with the given goals of treatment to guide a client towards becoming a fully actualized individual (Rogers, 1961). Many researchers have, in fact, suggested that the inclusion of personal development within training programs is necessary for professional development (Cain, 2007; Ellis, 1991; Folkes-Skinner, Elliott, & Wheeler, 2010; Grafanaki, 2010; Heppner & Roehlke, 1984; Hill et al., 2007; Ladany, 2007; Luke & Kiweewa, 2010; Mathers, 2012; Orlinsky & Rønnestad, 2005; Rabinowitz, Heppner, & Roehlke, 1986). However, research on personal growth in training has been largely organized around short-term personal development groups

(Ieva, Ohrt, Swank, & Young, 2009; Lennie, 2007; Luke & Kiweewa, 2010), supervision (Batten & Santanello, 2009; Geller, Farber, & Schaffer, 2010; Norcross, 2005; Wiseman & Shefler, 2001), and personal psychotherapy. Though supervision aims, in part, to assist and support novice clinicians in their increased self-awareness of personal issues (Falender & Shafranske, 2004; Rosenfeld, 2008), many current training practices do not formally help students understand how to recognize when personal factors may influence their work. Rather, the training models focus on skill and knowledge acquisition, ethics and professional behavior, stages of growth, and professional and identity development, while there is a glaring absence of emphasis on personal growth and development of the novice clinician (Ibarra, Armstrong, Dubs, Faith, Markowitz, & Walker, 2013).

As the field has begun to adopt a competency-based approach to training and supervision, particular competencies have been identified as imperative to a clinician's development. Many of these competencies point towards a greater emphasis on clinicians' personal growth by utilizing increased self-awareness and reflection (APA, 2002a; Eva & Regehr, 2008; Falender & Shafranske, 2012a; 2012b; Watkins Jr., 2012). Additionally, there is strong support in the literature that therapist efficacy is strongly related to therapist interpersonal factors and their own commitment to personal growth (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Bohart, Elliott, Greenberg, & Watson, 2002; Cain, 2007; Dunkle & Friedlander, 1996; Falender & Shafranske, 2012b; Folkes-Skinner, Elliott, & Wheeler, 2010; Fauth & Williams, 2005; Hill et al., 2007; Ladany, 2007; Najavits & Strupp, 1994; Nissen-Lie & Havik, 2013; Orlinsky & Rønnestad, 2005; von der Lippe, Monsen, Rønnestad, & Eilertsen, 2008).

A competency-based approach in supervision of novice clinicians has been emphasized with an aim to developing objective standards from which to evaluate the clinician's readiness

for practice (Pillay & Kramers-Olen, 2014; Roberts, et al., 2016). Competencies can be defined as a collection of skills, aptitudes, information, conducts, attitudes, personal characteristics, incentives and self-perceptions, which assimilate to form professional proficiency (Hill, Bond, Atkinson, Woods, Gibbs, Howe, & Morris, 2015; McMinn et al., 2015). Therefore, competence is comprised of behaviors, appropriate communication and use of skills, cognitive ability, feelings, ethics, and thinking to advance clinical work (Epstein & Hundert, 2002).

Past research in psychology has been dedicated to examining the competencies essential to a novice clinician's growth; the same competencies were eventually used in setting a standard of clinical training (VanderVeen et al., 2012). In 1986, The NCSPP (National Council of Schools and Programs of Professional Psychology) came up with a list of six main competencies that every clinician must possess: relationships, assessment, intervention, research and evaluation, consultation and education, and management of supervision skills (Egan, Haley, & Rees, 2014). In 2002, a work group of clinical professionals came together to cultivate a culture of competence (Egan, Haley, & Rees, 2014). Their meeting led to the design of a competency cube, which outlined the various essential competencies considered most relevant to practice in this field. The work group of professionals furthered their research in attempt to find out all the key competencies crucial for novice clinician development; for example, the NCSPP included competence in the area of diversity (Egan, Haley, & Rees, 2014).

The Competency Benchmarks Workgroup used the competency cube to develop an extensive training model (Egan, Haley, & Rees, 2014). This model was built on three progressive stages that outlined fifteen foundational key competencies. The stages were further subdivided into subcategories tied to behavioral anchors to observe mastery of the competence. While many

other models have emerged, the competency-based model seems to have won the favor of many clinical professionals based on its efficiency (Egan, Haley, & Rees, 2014).

The key competencies emphasize the need for increased awareness of novice clinicians' progressive experiences and signify characteristics of personal and professional development.

These competences include:

- a) Reflective Practice – It requires novice clinicians to engage in intellectual curiosity and flexibility (Fouad et al., 2009).
- b) Self-Assessment – It requires novice clinicians to evaluate their strengths and weaknesses. They are required to build on their strengths and make some changes to improve their practice (Fouad et al., 2009).
- c) Affective skills – The novice clinicians are required to demonstrate high levels of tolerance and understanding towards conflicting situations (Fouad et al., 2009).

The aforementioned skills are recommended because they train the clinical novice to behave in a manner that is acceptable to fellow clinicians and the clients (Hill, Bond, Atkinson, Woods, Gibbs, Howe & Morris, 2015; McMinn et al., 2015). These skills reflect an emphasis on competency-based training for therapists, as discussed within this section (Fouad et al., 2009; Pillay & Kramers-Olen, 2014; Roberts et al., 2016).

Though the American Psychological Association emphasizes the importance of competence through the completion of gateway achievements (APA Benchmarks: Fouad et al., 2009), the role of self-care and personal factors are seen as contributing to therapeutic efficacy and outcomes. Several authors suggest that these outcomes are not dependent upon theoretical orientation, client diagnosis, therapist experience level, type of training, or professional qualifications, but rather on therapist personal factors (Benish, Imel, & Wampold, 2008; Beutler,

Malik, Alimohamed, Harwood, Talebi, Noble, & Wong, 2004; Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Cain, 2007; Castonguay & Beutler, 2006; Duncan & Moynihan, 1994; Dunkle & Friedlander, 1996; Goldfried, Greenberg, & Marmar, 1990; Hanna, Bemak, & Chung, 1999; Huppert, Bufka, Barlow, Gorman, Shear, & Woods, 2001; Lambert, 1992; Lambert, Shapiro, & Bergin, 1986; Livesley, 2007; Mathers, 2012; Nissen-Lie, Havik, Høglend, Monsen, & Rønnestad, 2013; Norcross, 2011; Sandell, Lazar, Grant, Carlsson, & Broberg, 2007; Sexton & Whiston, 1994; Skovholt & Jennings, 2004; Strupp & Hadley, 1977; Wampold, 2007; Whiston & Sexton, 1993).

Nissen-Lie, Havik, Høglend, Monsen, and Rønnestad (2013) compiled several studies that investigated which personal factors may be relevant. They found that interpersonal skills (Anderson et al., 2009), empathy, responsiveness, the ability to be affirmative (Bohart et al., 2002; Najavits & Strupp, 1994), interpersonal functioning in one's personal life (Dunkle & Friedlander, 1996; Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009), and the ability to maintain boundaries which protect one from reacting aggressively when devalued or rejected by clients (von der Lippe, Monsen, Rønnestad, & Eilertsen, 2008) all play significant roles in therapy effectiveness. Given these findings, there have been several calls for further research to study the personal characteristics of therapists and the ways in which these characteristics can change during clinical training (Nissen-Lie & Havik, 2013; Rogers, 1956, 1961; Rosenzweig, 1936; Strupp, 1958; Taubner et al., 2013). However, Taubner et al. (2013) indicate that such studies remain limited.

Epstein and Hundert (2002) suggest that competence in the field of clinical psychology depends on therapist personal factors such as attentiveness, curiosity, self-awareness, and presence. Others have noted that therapist inter- and intrapersonal factors are largely responsible

for a therapist's ability to empathize, listen attentively, track emotions and nonverbal behavior, form the therapeutic relationship, and to respond to their own feelings that come up during the therapeutic encounter (Falender & Shafranske, 2012b).

The concern over personal development of the novice clinician is discussed by Folkes-Skinner, Elliott and Wheeler (2010), where they note that "training is [therefore a] potentially disturbing personal journey that requires a deconstruction of the self in order to make space for the new therapist-self to emerge" (p. 274). This personal journey is influenced by the experiential learning exercises that include role-play and group supervision. In addition to the role-play and supervision experiences, Folkes-Skinner, Elliott and Wheeler (2010) also suggest that the experience of working with "real clients" drives personal growth. Yet, work with real clients is often one of listening to painful stories, which clinicians often compartmentalize to create an emotional blindness to the self (Warren, Morgan, Morris, & Morris, 2010). Clinicians must also learn to accept and experience feelings of helplessness, weakness, frustration or insecurity that they currently guard against, so as to create a genuine sense of well-being and strength (Kornfield, 1993; Warren et al., 2010).

Clearly, there is a need for self-care and for monitoring the impact of clinical work on clinicians. Burnout and psychological distress are experienced by a significant proportion of psychological therapists (Hannigan, Edwards, & Burnard, 2004). Novice clinicians are at particular risk, and it has been stated that between 25% and 41% of trainee therapists (novice clinicians) report having experienced significant problems with anxiety, depression, low self-esteem, or work adjustment (Brooks, Holttum, & Lavender, 2002; Kuyken, Peters, & Lavender, 1998; Moore & Cooper, 1996; Skovholt & Rønnestad, 2003). As a benchmark for competency

and supported by the field as a whole (American Psychological Association, 2012), the area of self-care likewise relatively underrepresented in the literature.

Youngson and Green (2009) suggested that all clinical psychologists are ethically responsible for addressing their personal development during the entirety of their careers. They note that self-knowledge must lead to development of the self to prevent one from doing harm in one's professional work. Without this kind of commitment, psychologists may find themselves unintentionally projecting unresolved emotional difficulties, confusion and assumptions. This is particularly important, given that psychologists' work involves so much responsibility for the well-being of others, be it for clients, or in the training and supervision of future colleagues. Youngson and Green's (2009) emphasis on personal growth as a means of promoting professional competence for therapists is consistent with the work of multiple researchers discussed within this section.

Methods of Personal Development

Johns (1996) recognizes four models in which personal development can operate: (a) discrete and specific within the course, labeled as personal development through focused activities, undertaken at some depth in groups, structured exercises and individual tasks; (b) through reflection on, implications for, and application to the individual of all other elements of the course, such as skills work, feedback opportunities, theoretical and conceptual study, and assessment experience; (c) through the learning from and application of supervision of direct work with clients; and (d) through the individual student's experience as a client in personal counseling/therapy. A fifth may be through individual exploration: personal counseling, supervision, tutorials, journal keeping, other writing and recording, and reading. Examples of methods of personal development include reflection, meditation, creative writing, reading,

prayer, problem solving, literature and music, sport, specific personal development exercises, e.g., timelines, genograms, therapy, conversations with others, supervision, personal development groups, specific personal development exercises with others, comparing to role model/mentors within work or community, training courses, feedback from others, community groups, religious groups, social action, and political action.

The supervisor's assistance in this process is crucial to the novice clinician's development of self-awareness in their work (Falender & Shafranske, 2004). Traditional training models would require a shift in approach, from rational understanding to an experiential and potentially transformative grasp of therapeutic concepts (Carroll, 2010; Epstein, 1998; Folkes-Skinner et al., 2010; Rogers, 1992; Watkins Jr., 2012). Thus, the novice clinician would experience a level of personal growth that is generally reached in individual therapy, in order to best serve their clients. Researchers have specifically investigated the effects of therapy as a method of enhancing personal development for therapists.

Psychodynamic influences on personal growth and development. Psychodynamic literature has discussed the importance of self-awareness through personal therapy and the reflection of countertransference and transference issues virtually since the advent of psychoanalysis (Duthiers, 2005; Freud, 1912; 1937; Sandell et. al., 2006). Szecsödy (2013) noted that competence in psychoanalysis can only be achieved by applying methods of personal growth to oneself. The notion that personal therapy contributes greatly to personal and professional development, relational capacities, and well-being of a clinician has been argued at length (Orlinsky, 2013; Sandell et al., 2006). Consequently, both novice and experienced clinicians have long been encouraged, and often required, to engage in personal psychotherapy. Falender and Shafranske (2012b) also highlight the need for novice clinicians to manage

countertransference, which includes their ongoing awareness of such personal factors as awareness of their own feelings and biases, maintaining an intact and healthy character structure, establishing control over and understanding their anxiety in the room, developing empathy for the client, and exercising the ability to draw on theory in the room.

Despite an abundance of literature in the psychodynamic framework supporting self-awareness and the personal development of clinicians, little attention has been directed to the training of novice clinicians (Orlinsky & Rønnestad, 2005). Falender and Shafranske (2012b) have noted that novice clinicians are responsible for seeking opportunities for growth in these areas, though such opportunities remain absent in their training and supervisory experiences. In a parallel vein, psychodynamic literature appears to be narrow in scope and centered predominantly on personal therapy, self-reflection, and attending to issues of transference/countertransference (Falender & Shafranske, 2012b; Freud, 1912; Koepf & Vaeth-Szusdziara, 1996; Sandell et al., 2006).

Clinician Growth and Client Impact

Rogers (1961) stated that counselors can support another person's growth and freedom, "only to the level that they have maintained their own" (p. 1). Rogers's observation suggests that the therapist is only able to support the development of the client to the extent that the therapist has managed to develop his or her own person. Other researchers have also suggested that therapists are only capable of facilitating change in their clients to the degree that they themselves have experienced those changes (Benziman, Kannai, & Ahmad, 2012; Warren et al., 2010). Nissen-Lie, Havik, Høglend, Monsen, and Rønnestad (2013) noted that therapist personal factors are highly relevant to therapeutic outcomes. Not only may novice clinicians' personal

growth lead to enhancements in their professional development, it may conceivably also lead to greater changes within the client.

Therapist personal factors have been investigated relative to clinical outcomes, although most research on clinical outcomes focuses on client factors (Roos & Werbart, 2013). Client self-reports of dissatisfaction with therapists have indicated that therapist factors are highly relevant to client dropout. Reports have described therapists as unsympathetic, hostile, unsupportive, invalidating, passive or indifferent. In contrast, therapist factors such as level of experience, training and education, flexibility with respect to treatment manuals, accommodation to client's specific problems, personal experience in psychotherapy, and ability to provide emotional support (e.g., genuineness, openness to negative feelings, high emotional intelligence) were predictive of lower dropout rates (Roos & Werbart, 2013).

Falender (personal communication, October 1, 2014) stated 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." A focus on personal growth is beneficial, including the exploration of concerns over becoming a therapist and factors that may influence therapeutic work (Hill et al., 2007). Furthermore, increased understanding of novice clinicians' personal growth needs and values may contribute to a better understanding of the development of expertise in the field (Bereiter & Scardamalia, 1993; Csikszentmihályi, 1990; Winne, 1995).

The relationship with the client is heavily researched and has influenced the work of psychotherapy for decades, but a therapist's relationship with him or herself is largely underrepresented in research literature. Given the importance of personal growth and development of novice clinicians, and the impact of counselors' overall development and experience on clients, several investigators have called for additional research to address this gap

in the scientific literature (Grafanki, 2010; Rønnestad & Ladany, 2006; Rønnestad & Skovholt, 2001; Skovholt & Rønnestad, 2003; Truell, 2001).

The following sections will examine the role of personal growth in development from the perspectives of different disciplines within psychology. These will include humanistic psychology, counseling psychology, and positive psychology.

Humanistic psychology. In the 1950s and 1960s, an emerging model of psychology was developed to capture and understand the traits of humans that lead to growth and self-actualization, by examining the person as a whole (Buhler, 1971). Abraham Maslow was one of the first theorists to examine and define personal development as a means to achieve healthy human functioning (Maslow, 1968). Maslow identified several traits that make up a healthy human, which include a clear and efficient perception of reality, openness to experience, increased wholeness and unity of the person, increased spontaneity and aliveness, a strong sense of identity and autonomy, increased objectivity, increased creativity, the ability to think concretely and abstractly, well defined character strengths, and the ability to love (Maslow, 1968). He went on to suggest that those who embody these traits are able to achieve self-actualization and hold the necessary attributes to be healers. He defined healers as those who are able to give and accept love, actively seek out truth, have self-worth, and value continuous growth in order to reach their potential (Feist & Feist, 2009).

Maslow, along with Fritz Perls, was amongst the first to place significant importance on the idea that in order to become an effective therapist, one must focus on their own personal development as a person (Teegen, Frassa, & Honiger, 1979). Gestalt therapy emphasizes that the therapist must be fully present in the room with the client, which requires the ability to be self-aware, self-reflective, and able to differentiate one's own processes from that of the client's in

the moment. Carl Rogers posited that in order to develop these skills and traits, the novice clinician must engage in experiential learning. He stated that when the clinician in training develops the capacity to be self-reflective and self-actualized, that they can provide more effective therapy to clients (Rogers, 1969). More recently, in the field of humanistic psychology, others have echoed these ideas. Traits that have been suggested as most important to a therapist's approach are personal involvement, genuineness, understanding, empathy, alliance, receptivity to feedback, and meaning making (Shneider & Krug, 2010; Schneider & Längle, 2012).

The humanistic model of competency and supervision. The humanistic model of training and supervision includes development of competency in knowledge acquisition, professionalism, reflective practice, scientific methods, relationships, cultural diversity, ethical and legal standards, and interdisciplinary systems (Fouad et al., 2009; Rodolfa et al., 2005; Rubin et al., 2007). A cornerstone of humanistic competency is the development of reflective practice on the part of the person of the therapist (Cain, 2002; May, 1983; Yalom, 1980). This practice includes the ability to use self-reflection and self-awareness in order to better help the client (Farber, 2010). Within this model of supervision, Farber emphasizes the importance of the supervisor's ability to help guide the novice clinician in developing themselves as a person. The focus includes engaging the novice clinician's experiential practices that involve using self-awareness in order to understand the client (Farber, 2010). Despite the recent focus on developing a model of supervision within the humanistic framework, there does not exist a current and established model at this time (Farber 2012; Rodolfa et al., 2005; Rubin et al., 2007). Advocates of humanistic psychology emphasized the importance of whole-person growth and development as integral to the therapists' professional abilities (Rogers, 1969; Shneider & Krug, 2010; Schneider & Längle, 2012).

Positive psychology. Martin Seligman, president of the American Psychological Association at the time, developed the field of positive psychology in 1998. Seligman noticed the field of psychology moving away from one of its original objectives, which is to build human strength and to nurture genius. In response, Seligman began to develop a new direction for psychology called positive psychology. Positive psychology, in brief terms, is the scientific study of human strengths and virtues. The prominent aim of positive psychology is to reorient the focus of psychology from solely addressing and mending the worst aspects of life to including a focus on building up positive qualities as well (Csikszentmihályi & Seligman, 2000). A central question that guides this focus is how psychologists can account for the ability of people to live their lives with dignity and purpose despite many difficulties and hardships.

Overview of positive psychology. This new orientation focuses on three broad aspects of human experience: positive subjective states, positive individual traits, and positive institutions. On the subjective level, positive psychology focuses on positive subjective states such as happiness, life satisfaction, love, intimacy, relaxation, as well as optimism, hope and vitality. Positive psychology also includes the study of character strengths and virtues or, for this study, values such as honesty, wisdom, courage, persistence, creativity, and excellence. Finally, positive psychology looks to develop positive institutions on a societal level, addressing civic values, healthy families, and positive work environments. The definition that will be used for the purpose of this paper is offered by Csikszentmihályi and Seligman (2000): “Positive psychology is the scientific study of positive human functioning and flourishing on multiple levels that include the biological, personal, relational, institutional, cultural, and global dimensions of life” (p. 5).

In sum, the stance of positive psychology is that humans are good at doing things well and the recognition and development of these abilities within the field of psychology is an important focus. Positive psychology terms this approach as “the good life”, which is defined as “using one’s signature strengths every day to produce authentic happiness and abundant gratification” (Seligman, 2002). The good life involves connection to others, positive individual traits, and life regulation qualities. These elements foster life enrichment, a meaningful life, and character development. While the focus is to develop individual strengths and values in each person, it is done within the social context, using autonomy, self-control and wisdom-guided behavior to positively connect with others and the broader social institutions encountered along the way.

Positive psychology and character strengths. In order for the good life to be understood and developed, each element must be defined, which can lead to assessment and investigation in order to determine how character is defined, constructed, developed and taught. Peterson (2006) developed positive psychology’s Values in Action (VIA) Classification of Strengths to complement the Diagnostic and Statistical Manual (DSM) of the American Psychological Association, in order to study and specifically highlight what constitutes the strengths of one’s character, ultimately leading to the good life. These character strengths are categorized under six broad categories of “virtues”, which are universal and are required for mastery of moral excellence to promote the advancement of our species. In other words, they are pathways identified in all individuals as the means to gaining inner strengths to achieve one’s full potential. Positive psychology has identified character strengths as blueprints that define and are the vehicles by which virtues are displayed. The VIA Classification was developed through an

extensive review of literature on good character from disciplines ranging from psychiatry, religion, philosophy, youth development, and psychology.

What came from this review for the VIA are seven criteria, which define the essential components of a strength: (a) a character strength must be generalizable across one's behavior, including thoughts, feelings and actions, and must be stable across time; (b) a strength not only helps an individual cope with distress, but propels him or her to be more; (c) a strength is valued morally in its own right, absent of desired outcomes; (d) displays of strength serve to elevate others who witness them; (e) in line with Erikson's (1963) psychosocial stages and the resulting virtues, if resolved, the cultivation of strengths and virtues are supported and cultivated by society at large; (f) a strength is readily identifiable in recognized paragons of virtue; and (g) a strength is uni-dimensional and cannot be decomposed into other strengths in the classification (Peterson, 2006). Furthermore, these criteria were applied to strengths identified through the literature review resulting in six virtues, each with positive traits related to it. The VIA Classification of Character Strengths is as follows: (a) Wisdom and Knowledge, which includes traits of Creativity, Curiosity and Interest in the World, Judgment and Critical Thinking, Love of Learning, and Perspective; (b) Courage, which includes traits of Bravery, Persistence, Authenticity/Honesty, and Vitality; (c) Love, which includes traits of Intimacy, Kindness, and Social Intelligence; (d) Justice, which includes traits of Citizenship, Fairness, and Leadership; (e) Temperance, which includes traits of Forgiveness/Mercy, Humility/Modesty, Prudence, and Self-Regulation; and (f) Transcendence, which includes traits of Appreciation of Beauty and Excellence, Gratitude, Hope, Humor, and Spirituality.

The VIA Classification has helped define important values and optimal functioning. So, in the view of positive psychology, the absence or exaggeration of these strengths or values

could be viewed as indicators of psychological disorders and as a guide to assist clients to achieve their full human potential. Given that this shift in ideation is new to the field, it is not surprising that there has been little discussion of how to identify and cultivate these character strengths in those people who are to help clients achieve them. However, within the field of positive psychology, it has been suggested that efforts be made to assist psychology supervisors, increase their self-efficacy and engagement with their work. Such improvements may also enhance resilience to restore and maintain their well-being, with the implication that this may increase the supervisors' ability to help their clients (Howard, 2008).

There are only a few documented instances of supervisors using character strengths, as defined by positive psychology's VIA Classification literature, to facilitate student's clinical training. It is, however, well-documented that a shift in the focus of clinical training to a more competence-based approach is highly beneficial to trainees' professional development (Falender & Shafranske, 2012a; Fialkov & Haddad, 2012). Making this shift in focus, it seems, can potentially assist in the development of specific skills which have been identified as necessary for professional relationship proficiency, decrease in depression, increase in work-related satisfaction, and increased hope and optimism (Fialkov & Haddad, 2012; Howard, 2008; Linley, Nielsen, Wood, Gillett, & Biswar-Diener, 2010; Sheldon & Lyubomirsky, 2006). Positive psychologists have previously been interested in identifying how a focus on strengths in clinical training and supervision can assist in stress management and restoration of well-being of trainees, ultimately to improve efficacy and competency (Howard, 2008).

Fialkov and Haddad (2012) are the only researchers to date to have discussed the use of positive psychology's well-defined character strengths as a foundation from which to apply a strength-based approach to supervision. Fialkov and Haddad (2012) presented their Appreciative

Clinical Training model, which relies on the capacity for self-reflection and an understanding of and appreciation for individual strengths in order to increase the efficacy of clinical training. In order to demonstrate this approach, they used the VIA Inventory of Strengths (VIA-IS; VIA Survey) to identify trainee character strengths and utilize them in a narrative-based approach to supervision. Additionally, they were the first to identify character strengths of graduate students in a clinical psychology training program. In doing so, they were able to highlight specific character strengths or values which many trainees possess or should possess to increase clinical efficacy, such as kindness, curiosity, social intelligence, and the capacity to love. This study was identified as the only study to date that discussed the use of character strengths as a basis from which to apply a strength-based approach to supervision.

Despite this gap in literature, several values are identified in the APA ethics code as “general principles.” For instance, they include integrity, accountability, wisdom, humanity, justice, knowledge, honesty, respect for others, responsibility, morality, and transcendence (APA, 2010). These general principles highlight the importance of clinicians’ embodying positive qualities, values, or character strengths, suggesting these attributes will help maximize professional success. Each of the general principles are expressed as behaviors which are congruent to the use of beneficence, non-maleficence, fidelity, responsibility, integrity, justice, and respect for people’s rights and dignity. However, these general principles are not emphasized within the current training model. As an example, this researcher was exposed to these principles during only one class session of academic coursework. This suggests, novice clinicians likely are absent a guide or process from which to begin to develop values.

In summary, personal growth according to a positive psychology perspective involves development of one’s strengths and capacities, or values (Fialkov & Haddad, 2012). Such growth

might benefit novice clinicians by building self-efficacy and resilience to work-related stressors (Howard, 2008). Strengths-based training may also enhance essential positive qualities of therapists, such as integrity, beneficence, and responsibility (APA, 2010). The discipline of counseling psychology also includes personal growth and development as integral to therapist competence.

Counseling psychology. Counseling psychology researchers have defined personal development as one's ability to obtain a higher understanding of the self and to be able to utilize this understanding in both social interactions and effective counseling (Carkhuff & Berenson, 1967; Schaef, 1999). Additionally, others have posited that the most important component in effective counseling is one's personality (Carlozzi, Campbell, & Ward, 1982). In fact, a study examining the most effective criteria in determining whether a novice clinician was performing well or poorly found that personal variables were heavily weighted (Wheeler, 2000). The author concluded that the most important characteristic was the personality of the novice counselor. Furthermore, it has been noted that the interpersonal skills of a counselor are viewed by clients as prominent components in positive counseling experiences (Paulsen, Truscott, & Stuart, 1999).

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) states that educators evaluate applicants' capacity for personal and professional development in addition to their academic ability (CACREP, 2001; Smaby, Maddux, Richmond, Lepkowski, & Packman, 2005). Counseling psychology researchers concur and have stated that skills development and knowledge of counseling techniques fall short of developing an effective counselor; they suggest that counselor self-awareness is critical for novice clinicians to be able to determine when and how to use the skills they have learned (Smaby et al., 2005).

In order to address vagueness within the ethics code as they relate to the values that counselors should possess, the field of counseling psychology worked to propose “an aspirational statement articulating training values” (Mintz & Bieschke, 2009, p. 635). The values statement that was developed is consistent with the APA Ethics Code, Principle E, which requires psychologists and novice clinicians to examine their personal values and to learn to work effectively with different clients (APA, Ethics code, Principle E, 2002a; Bieschke & Mintz, 2012). Counseling psychology’s values statement broadens this requirement to the expectation that novice clinicians will learn and be willing to “examine and attempt to resolve any attitudes, beliefs, opinions, feelings, or personal history that might impair their abilities to provide effective services to individuals different from themselves” (Bieschke & Mintz, 2012, p. 197).

The values statement intends to provide guidelines for novice clinicians to maintain their values, as well as develop into competent counseling providers to diverse clients. Based on the initial values statement, Winterowd, Adams, Miville, and Mintz (2009) suggested implementation strategies for counseling programs to infuse these expectations and the development of these values into their curriculum, practicum, research, and evaluation. The idea is that if these values are made explicit to novice clinicians, modeled by supervisors and professors, discussed in the classroom, and used as evaluative measures, novice clinicians will develop both professionally and personally, and become more competent providers. The next section discusses the current supervision and clinical training practices for novice clinicians.

Current supervision and clinical training. This section provides an overview of current standards and approaches for supervision of novice therapists. This includes a discussion of the history of clinical training, which provides a context for discussion of current training practices and standards. This section also includes discussion of ethical regulations associated with

therapeutic practice, which inform training standards for new therapists. Finally, this section includes a discussion of current training approaches for new therapists.

History of clinical training. For many decades, identifying the most suitable way of training and monitoring psychologists has remained a challenge (VanderVeen, Reddy, Veilleux, January, & DiLillo, 2012). Clinical psychology has become a common discipline across the world (Swierc & Routh, 2003). Undeniably, most of the contemporary activities of psychologists involve clinical work, while some include individual and group therapy, and clinical evaluation of the mental and behavioral characteristics of health care problems. In addition, psychologists also work in partnership with other health professionals or are consulted in various clinical procedures. The services of clinical psychologists are also used in educational procedures such as teaching or research in institutions of higher education. Regardless of the widespread activities of psychologists, the emergence of these roles can only be traced back to 1896.

It is important to note that there have been numerous changes in the approach taken to train novice clinicians in doctoral programs. The first clinical psychology training programs emerged in 1946. These programs were introduced after the Veteran's Administration requested an outline of the training process of psychologists (Pillay & Kramers-Olen, 2014; Roberts, Blossom, Evans, Amaro, & Kanine, 2016). This request resulted in efforts to identify the most appropriate method for training psychologists, which required clarification of the factors that were essential for professional growth.

Before 1946, there was no official accreditation process of clinical training, which resulted in an 'undefined' professional development process (VanderVeen et al., 2012). Nevertheless, for the past three decades, clinicians have expended efforts to improve clinical training by exploring more systematic ways of defining the process. With regard to the medical

field training model, it is evident that clinical psychology has leaned towards improvement of capabilities during training (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). Psychology training patterns in many European and Latin American countries, as well as other countries over the world, are not typical to those in the U.S. and U.K.; in these countries, psychology graduates from institutions of higher education get a diploma or licentiate degree, which is usually lawfully adequate for them to start practicing psychology. However, many of these graduates complement their knowledge through informal training in some of the fields of psychology, such as psychotherapy. In the U.S. and U.K., master's and doctoral degrees often lead the graduates into an academic career rather than a career where they can practice psychology.

Ethics, laws, and guidelines. The discipline of clinical psychology clearly articulated what they believe should be the conduct of an ethically practicing psychologist. It is mandatory for all clinical psychologists to be well-acquainted with and to abide by the ethical codes that regulate the profession. Some of the ethical codes of conduct that pertain to clinical psychology as a profession include, but are not limited to record keeping, confidentiality, and integrity. The guidelines for this professional practice are outlined within the APA ethics code (APA, 2001a) and also in a few reports distributed by APA. In these documents, they describe personal factors of a therapist as one component for establishing a viable clinical practice.

Self-awareness is emphasized in the ethics code for both professional psychologists and instructors, and personal factors are also key for a beginning clinician (ACA, 2005; APA, 2002a). It is an expectation that psychologists will make use of self-reflection to remain vigilant on any personal challenge, which could keep them away from working competently (APA Ethics Code, Standard 2.06). Moreover, as stated under section 1396.1 of California's Laws and Regulations for Psychological Practice, sound interpersonal abilities and analysts' identities

affect their expert viability. The same law indicates suggests that a psychologist should not intentionally attempt any activity that may harm a patient or client as a result of personal problem (California Department of Consumer Affairs, 2012, p. 115).

Certain values that psychologists must always strive to hold anytime they undertake clinical work are well emphasized by the APA ethics code's general principles. These values seem to set a higher standard by moving past mindfulness to urging psychologists to accomplish more by empowering the development of their moral character to benefit their clients. In particular, the values guiding them include integrity, responsibility, beneficence and non-maleficence, justice, fidelity and appreciation of individuals' rights and dignity. In order to execute these values, psychologists are encouraged to develop conflict resolution skills. This will enable them to prevent harm, be able to manage mental health, and accept responsibility for their actions. Additionally, interpersonal skills for developing trust, reasonable judgment, and consideration of personal boundaries in making professional commitments will create both awareness and respect for culture, individuals, and role differences in a society. Despite the fact that these qualities are optimistic in nature, some have proposed that psychologists ought to be considered responsible for them (Hill, Bond, Atkinson, Woods, Gibbs, Howe & Morris, 2015; McMinn et al., 2015).

APA publications have stressed throughout their guidelines that in professional practice, self-awareness is key for personal growth. For instance, *The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change* state that psychologists must recognize themselves as cultural beings whose attitudes and beliefs add up to their perception and interaction with others (APA, 2002b). The same document notes that an individual always categorizes others on the basis of stereotypes or negative beliefs. The

document recommends the use of self-awareness of individual attitudes and values, together with intentional effort and practice in anticipation to changing stereotypical beliefs. Moreover, activities for building trust and increasing tolerance of others, such as increase of contact with others, empathy, taking perspective and intentionally avoiding stereotyping others, can improve this perspective of seeing others as individuals. Therefore, psychologists should seek higher levels of personal and professional self-awareness. This can be done by seeking growth promoting activities so as to improve multicultural self-awareness in the professional practice.

As The Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (APA, 2000), Guidelines for Psychological Practice with Girls and Women (APA, 2007), and Guidelines for Psychological Practice with Older Adults (2013) all indicate, self-awareness alone might be insufficient. In the same guidelines, psychologists are urged to take part in progressive self-investigation and interest in exercises that encourage development in a form that comes from increased sensitivity to diversity. For example, such exercises may incorporate sensitivity to gender and differences in training for work with young ladies and women.

It is evident in the research that a therapist is equipped to only facilitate change for a client to the extent of his or her own particular reflective process (Hill et al., 2015; McMinn et al., 2015). Doing so permits the clinician to continually assess the adequacy and potential effect of individual components on their healing work. Notwithstanding, it doesn't oblige programs to incorporate training and education objectives that address the significance of self-awareness, or rules for how to take part in such continuous self-reflection (APA, 2013). Despite the importance of self review, stated under section 1397.61 of the Department of Consumer Affairs (2012), psychologists are not qualified to look for educational credit for exercises intended to promote self-improvement.

A foundational ethical guideline oversees personal elements that can possibly affect one's work in clinical psychology (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). This is especially stressed within multicultural and psychodynamic training. The guideline also suggests that personal awareness and ongoing investigation through self-evaluation and appraisal are essential for compelling practice (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). However, the importance of self-awareness and personal growth to clinical psychology research is suggested more extensively by the writings of ethical codes and principles, practice guidelines, state laws and regulations, rather than genuine training practice.

The competency benchmark model has been used as a foundation for further research, thus making it widely acceptable for evaluating clinical training. The model has been used to identify other key competencies for training and evaluating clinicians' readiness for clinical practice (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). Other proposed models differ in structure and content, and their proponents have different opinions regarding competencies to be developed, but they maintain consistency with respect to the actual defined competency areas (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). However, the essential competencies established for a clinician's professional development are not comprehensive, and are, in most cases, in the early development phases. As an example, self-awareness is a competency that has been identified as an essential necessity for personal development, but the extent to which it should be emphasized has not been discussed. In addition, there is lack of formal training methods to train on self reflection or personal growth. A formal method is necessary for novice clinicians to demonstrate such competencies before practicing.

Theoretically, the competency-based approach to supervision has been developed properly. However, there is lack of a formal or required application of the model today. The

main aim of constructing the model was to ensure that novice clinicians received evidence-based training and that their progress is monitored by observing their integration of particular competencies (Pillay & Kramers-Olen, 2014; Roberts et al., 2016).

The use of a competency-based approach in supervision takes into consideration existing individual differences among novice clinicians. This method is efficient because it enables supervisors to meet the novice clinicians either halfway or wherever they have reached in terms of training and development (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). However, there exists a gap in novice clinicians' training, since there is no platform for the clinicians to give a perspective of their experiences relative to their growth. That said, an investigation of the novice clinician's experiences becomes important. Responsive training will aid in identifying novice clinicians' strengths and weaknesses.

Past literature has put much emphasis on the importance of self-awareness to develop effective clinical practices (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). One study implied that clinicians ought to have continuous self-reflection in order to achieve overall professional competence (Binnie, 2011). Another study suggested that novice clinicians' career development depends on their involvement in self-reflection and evaluation, thus recommending that this behavior should be adopted by trainees immediately after training commences (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). When clinical psychologists are faced with ethical dilemmas, they are expected to utilize their own judgment based on their professional knowledge and experience to deal with them. However, if their professional knowledge and experience are insufficient to make good judgments, they are encouraged to seek support and advice from colleagues, supervisors or other professionals. However, help seeking may be encumbered if interpersonal relationships in supervision are poor. Thus, the ability to deal with ethical

dilemmas among clinical psychologists can be impinged on by unsupportive supervision and lack of access to personal therapy to deal with personal issues.

Training approach. The main objective of training novice clinicians is to equip them with necessary skills, impart knowledge, cultivate an ethical culture, and develop self-reflective behaviors such that their attitudes are congruent with practices of therapists (Binnie, 2011). In experiential learning, it is expected that a novice clinician meets a real-world client and attends to his/her needs with supervision from the trainer. The supervisor is obligated to ensure that the client's welfare is properly supported and the novice clinician simultaneously receives practical and beneficial clinical experiences (Pillay & Kramers-Olen, 2014; Roberts et al., 2016).

According to Saito (2005), becoming a psychologist requires more than just academic success; it is a continuous process of becoming, seeking to transcend fixed competencies. In a case of unmet needs for personal development, the end result is usually ineffective training for novice clinicians (Pillay & Kramers-Olen, 2014; Roberts et al., 2016).

Thus, the efficacy of clinical training and supervision influences the quality of the therapeutic services offered by the psychologists. The services offered by psychologists will be adversely affected if the applied clinical training and supervision are substandard.

Clinical psychology is a profession that requires clinicians to use the 'self' more than any other profession (Binnie, 2011). It is essential to teach novice clinicians how to use the 'self' when embarking upon psychiatric jobs. Future therapists learn important concepts needed for efficient therapeutic practicing through supervision (Pillay & Kramers-Olen, 2014; Roberts et al., 2016), yet inadequate supervision limits their ability to gain needed frameworks for understanding clinical processes. Given that the initial training stages are very crucial for

forming the habitual behaviors of therapists (Pillay & Kramers-Olen, 2014; Roberts et al., 2016), there is a possibility that necessary learning will be compromised.

Currently, all training programs are expected to include procedures for addressing novice clinicians' competence problems (American Psychological Association, 2013). Today, the acceptable standard is to encourage personal self-assessment and enact remediation plans when necessary with little or no attention given to development of preventative measures (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). According to Binnie (2011) one sign of incompetence to practical work is limited insight caused by insufficient self-awareness. Thus, it becomes necessary for training programs to include activities that develop a culture that values self-assessment; these activities are expected to explore personal factors that produce feelings of discomfort (Pillay & Kramers-Olen, 2014; Roberts et al., 2016).

Due to the aforementioned challenges, there is a need to explore methods that move away from individualistic and socially isolated self-assessments (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). These alternative methods may provide better solutions to prevent professional incompetence by diagnosing the fluid nature of issues while considering culture and context in their assessment (Binnie, 2011). According to Binnie (2011) a systems approach could be used as an alternative method since it involves taking into consideration the influence of academic and professional organizations, life stressors, individual personalities, and coping styles. They also suggested identifying psychological symptoms common in psychologists for the purpose of implementing preventative measures, if students experienced too much strain.

Binnie (2011) also suggested that the community rather than the individual should ensure that professional competence is maintained because psychologists are interdependent and share a common goal. In a community with strong-willed individuals who are not only determined, but

also willing to support and nurture connections, novice clinicians may be able to undergo both professional and personal transformation to promote positive development. There could be peer validation and motivation, which could lead to better emotional health and wellbeing (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). This approach supports novice clinicians' use of a psychological community to foster personal growth, and it subsequently facilitates their continual development and maintenance of professional capabilities.

The engagement of novice clinicians in personal growth may prevent later issues related to professional competence. The use of the psychological community for accurate self-awareness and support can be encouraged by training programs that have the power to shift current concepts regarding how personal difficulties are identified and addressed (Binnie, 2011). Novice clinicians can be advised to fully utilize peer and relational mentoring, which have the capability of building empathy, self-efficacy and emotional intelligence. They also enhance professional competences and create work-recreation balance (Pillay & Kramers-Olen, 2014; Roberts et al., 2016).

In summary, a competency-based approach in supervision of novice clinicians has been emphasized, which aims to develop objective standards by which to evaluate the clinician's readiness for practice (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). Competency-based training and supervision included benchmarks for successful practice, such as reflective practice, self-assessment, and affective skills (Fouad et al., 2009). The APA ethics guidelines also included professional requirements for therapists that reflected technical competencies and personal attributes such as self-awareness (APA, 2013). Novice clinician training programs were aimed at developing the skills, knowledge, ethics, attitudes, and behavior necessary for successful practice as a therapist (Binnie, 2011). Despite the premium placed on these

competency benchmarks, specific elements tied to a novice clinician's personal growth have yet to be enacted.

Multicultural influences on supervision and training. Current training of multicultural competence in novice clinicians emphasizes knowledge and skills acquisition and cultural awareness (Sue & Sue, 2003; Hanna, Bemak, & Chung, 1999). Researchers have especially emphasized that the understanding of one's own culture, biases and worldview inform their approach as clinicians (Falender & Shafranske, 2007; Pope-Davis & Coleman, 1997; Sue & Sue, 2003). As a result, multicultural literature places great importance on self-awareness in the development of multicultural competence, along with knowledge and skills training (Pope-Davis & Coleman, 1997; Sue & Sue, 2003).

Through teaching and developing cultural self-awareness as an added skill, one may begin to experience greater overall self-awareness, leading to increased personal well-being, growth, and development (Falender & Shafranske, 2007). It is in this sense that a precedent has been set for the significance of personal growth on the overall effectiveness of a clinician to provide appropriate care for clients. Additionally, it can be viewed as a foundation from which the field of psychology began to shift its focus to the personal development of novice clinicians in training. In terms of training, the multicultural field is the only one in clinical psychology that requires novice clinicians to reflect on the personal aspects of themselves in order to increase their competence. It appears that this level of self-awareness and self-reflection has not been facilitated outside the realms of multicultural or diversity training within clinical psychology programs.

While self-awareness is an important aspect of development, it has been suggested by researchers that it is not enough on its own, but self-reflection, coping skills, and interpersonal

skills are worth examining more deeply and require intentional and meaningful exploration (Crethar, Torres-Rivera, & Nash, 2008; Duran, Firehammer, & Gonzalez, 2008; Rønnestad & Ladany, 2006). Without the opportunity to engage in experiential learning, novice clinicians may lack the depth in understanding of themselves or others and may not be aware of blind spots or biases that often emerge within the therapeutic context (Hanna, Bemak, & Chung, 1999). Researchers have suggested that multicultural training may have too narrow a view of the importance of personal factors in novice clinicians. It has been posited that a clinician's wisdom, resulting from self-reflection and introspection, may account for a significant amount of variance in multicultural competence (Phan, Rivera, Volker, & Maddux, 2009). These findings suggest that an emphasis on overall personal development in training would lead to increased competence (Hanna, Bemak, & Chung, 1999). The idea that personal characteristics of clinicians influence therapeutic outcomes more so than the approach to treatment or the knowledge and skills of the clinician has been well-established (Goldfried, Greenberg, & Marmar, 1990; Lambert, 1992; Whiston & Sexton, 1993). While there is movement towards personal growth via multicultural competency training, the focus remains narrow and there is a gap in the emphasis of the overall personal growth of the person-of-the-therapist.

Model for development of the Person-of-the-Therapist (POTT). The person-of-the-therapist is addressed in great detail by Harry Aponte, who has developed a model for supervision and training (2009). His Person-of-the-Therapist (POTT) model was developed and provided to professional clinicians as a continuing education opportunity; more recently, it was integrated into master's level clinical psychology training (Aponte et al., 2009). Due to its efficacy, the American Association for Marriage and Family Therapy is looking at marriage and

family therapy programs to integrate the focus on the person of the therapist as an area of competency.

The POTT model's goal is to engage the clinician in a process of self-discovery and self-mastery in order to better undertake clinical challenges as they arise with clients. Through this model, the clinician will: (a) know their personal psychological, cultural and spiritual challenges, both past and present; (b) be able to observe, have access to, and use good judgment about personal feelings, memories, and actions in the therapeutic setting; and (c) be able to actively and intentionally manage their emotional, cultural, and spiritual factors in order to identify with and differentiate from clients (Aponte et al., 2009).

In order to achieve the aforementioned goals, the novice clinician must understand and agree to engage in a journey of personal growth for the purpose of becoming a more competent clinician. Aponte proposes that this growth process is integrated into the graduate coursework in three parts: (a) students become acquainted with the concept of the person-of-the-therapist; (b) students partake in experiential work to learn and understand their "signature themes" (i.e., emotional, cultural, spiritual factors that may have an impact on their clinical work); and (c) students apply their knowledge of signature themes to their clinical work through professional activities such as discussions and role plays.

The POTT model was evaluated in a master's level program and the researchers hypothesized that the use of the model would result in an increase of clinicians' understanding of their impact on relationships, their personal and interpersonal vulnerabilities, and their ability to use their new awareness and knowledge to provide more efficacious care to clients (Nino, Kizzil, & Claudio, 2015). The researchers found that novice clinicians trained in this model reported numerous positive outcomes, including increased awareness of strengths and limitations, the

ability to conceptualize clients from worldviews other than their own, more confidence and sense of competence in the room with clients, and a heightened ability to manage their own reactions and feelings in sessions. Furthermore, novice clinicians reported that they developed more acceptance for their own personal pain, which allowed them to be more authentic as people and as clinicians. This model appears to be the first major step towards integrating the personal development of novice clinicians into clinical training programs within the field of clinical psychology. Researchers found that training under the POTT model improved trainees' capacities to provide services by prompting personal growth (Nino et al., 2015). Another area of personal growth that enhances therapeutic practice relates to therapists' values.

Values that emerge through training and supervision. Studying and examining the personal characteristics or qualities necessary to be an effective clinician began with Carl Rogers, and has continued to be a focus in clinical and counseling psychology, as well as other helping professions. In one analysis, Young (2001) discovered five common qualities of 'good helpers'; these include having a positive view of others, a stable self-concept, self-care habits, proficiency in creative and intellectual pursuits, and courage. In addition, Egan (2007) argued that professionals in the helping field must be wise and possess common sense. Norcross (2002) conducted a broad review of qualities of the person of an effective clinician, and found that common factors related to the person of the clinician such as therapeutic alliance, empathy, positive regard, congruence, openness to processing client reactions, and providing effective feedback account for twice as much positive outcomes in therapy as theory (Crews, et al., 2005; Gibbons, Cochran, Spurgeon, & Diambra, 2013; Norcross, 2002; Stein & Lambert, 1995; Stevens, Dinoff, & Donnenworth, 1998). Specifically, it has been argued that interpersonal characteristics such as self-efficacy, self-monitoring, and dogmatism are closely related to

empathic skills in counselors (Barrow, 1990; Haferkamp, 1989; Haverkamp, 1994; Ottens, Shank, & Long, 1995; Tongue, 1989).

There are several aspects that make up the individual and unique characteristics and personal qualities of each person (Gibbons et al., 2013). The terms disposition, attitudes, values, virtues and personality have been used to examine the person of the therapist. These, along with skills, abilities, aptitude, cognitive style, and motivation, are all distinct variables in one's overall disposition and are interesting in their own right; however, for the purposes of this research, the focus will not be on all of these particular areas. Instead, the distinction between values and dispositions will be explored, with the ultimate emphasis being on values.

The term disposition refers to the tendency of one to act in a particular manner across time and situations. Within one's disposition are variables that are generally stable over time and are also carried with the individual into different situations; some can be easy and some can be more difficult to change, and include values, attitudes, personality traits, skills, abilities, and aptitude, as well as cognitive style, virtues, and motivation (Scholl, 2008). Values are typically defined as stable preferences that reflect socialization in a person (Bilsky & Schwartz, 1994). Values can be useful in describing individual behavior and represent desired end states or outcomes (Mischel, 1990; Scholl, 2008). The definition used here to describe values includes five components and has been developed from an examination of many definitions of values (Howard, 2008). Values as defined here are: (a) an increase in self-efficacy, (b) increase in engagement with work, (c) an experience of enhanced resilience, (d) an experience that restores and/or maintains one's personal well-being, and/or (e) an increase in ability to help clients (Howard, 2008). Within the field of positive psychology, it has been suggested that assisting clinicians, specifically psychology supervisees, to increase their self-efficacy, increase

engagement with their work, and enhance resilience may be helpful to restore and maintain their well-being, with the implication that this may increase the supervisees' abilities to help their clients (Howard, 2008).

Dispositions, according to counselor training, are “the external manifestation of underlying values that guide decisions about clients, interventions, and practice” (Holst, 2010; Sockett, 2009; Dollarhide, 2013). These can be innate personality characteristics such as open-mindedness, patience, and empathy, or learned qualities such as holding diverse perspectives or the appreciation of cultures (Sockett, 2009; Thompson, 2009). Specifically, behavioral dispositions that are related to effective counseling are empowerment, advocacy, and collaboration (Brubaker, Puig, Reese, & Young, 2010; Thompson, 2009), and are guided by the values of appreciation for diversity, empathy, and compassion.

Within counseling, some suggest that values are the core of counseling (Boysen, 2010; Ratts, 2009). While skills are critical, values are equally important. If a counselor is skilled in asking questions and implementing interventions, but does not have empathy or an appreciation for diversity, they wouldn't actually be conducting therapy. Becoming a counselor requires the individual to internalize professional perspectives and values (Auxier, et al., 2003; Nugent & Jones, 2009). Thus, counselor-training programs are encouraged to emphasize values exploration, teach professional values, and measure the degree to which the student internalizes these values. Current training places focus more on assessing students' skills and knowledge acquisition, but not necessarily on assessing their internalization of values (Dollarhide, 2013). While supervision must focus on skills and knowledge acquisition, researchers agree that a focus on the development of the person of the trainee is imperative to developing effective clinicians (Gibbons et al., 2013).

Importance of personal growth related to values for therapists. For purposes of this study, the values of primary interest include self-efficacy, resilience, and work engagement. According to Howard (2008), personal growth related to these values enhances the therapist's well-being and therapeutic skills.

Self-efficacy. Therapists with high levels of self-efficacy feel capable of responding to the demands and tasks associated with their jobs (Hill et al., 2015). Researchers found that increases in self-efficacy among novice therapists were associated with increased comfort with the role of therapist, perceived increases in therapeutic skills, and improved ability to manage their own difficult emotions during therapy sessions (Hill et al., 2015). Counseling psychology doctoral students expressed that modeling and feedback from their supervisors helped them to feel more self-efficacious in their work with clients in a training program (Hill et al., 2015). Novice clinicians said their supervisors spurred their personal growth by prompting them to think about and discuss their personal reactions to clients' psychological issues (Hill et al., 2015). This aspect of supervision aided personal development, which ultimately enhanced the novice therapists' self-efficacy (Hill et al., 2015). These findings were supported by Marmarosh et al. (2013), who found that the quality of the supervisory relationship was associated with perceived self-efficacy among novice clinicians. Self-efficacy also increased in novice clinicians as the result of training that prompted personal development in the area of stress management (Stafford-Brown & Pakenham, 2012).

Work engagement. Work engagement refers to feelings of vigor, absorption, and dedication in relation to one's job (Blomme, Kodden, & Beasley-Suffolk, 2015). In a review of the work engagement literature, Schaufeli (2012) found that personal growth was one of several factors that promoted work engagement. Personal resources such as self-esteem, optimism, and

stress resilience have also been linked to higher levels of work engagement (Blomme et al., 2015). Training programs that promoted worker self-efficacy were related to increased work engagement (Schaufeli, 2012), and researchers found that leaders were instrumental in promoting work engagement by providing access to social support, effective coaching, and job feedback (Blomme et al., 2015). In studies that involved workers from a variety of professions, work engagement was associated with higher levels of job satisfaction and lower levels of burnout (Schaufeli, 2012). A research literature specifically concerned with work engagement among therapists was not discovered; however, as Howard (2008) indicated, work engagement in the general worker population was found to be protective against work-related stress and burnout. Promotion of work engagement through supervision may therefore promote therapists' resilience (Howard, 2008).

Resilience. Resilience refers to the therapist's ability to withstand the demands and stressors of the job without developing psychological problems (Howard, 2008). Multiple researchers noted that resilience was important for therapists because exposure to clients' trauma and distress placed them at risk of compassion fatigue or vicarious traumatization (Kamicker, 2014; Pack, 2013; Ray, Wong, White, & Heaslip, 2013). Kaminker (2014) emphasized that resilience training was an important aspect of personal growth for therapists because of these work-related emotional risks. Pack (2013) reported that therapists' awareness of their own emotional responses to client trauma and ongoing clinical supervision promoted resilience within therapists. In semi-structured interviews, therapists expressed that they felt most emotionally vulnerable to clients' trauma within their first five years of practice (Pack, 2014). Novice clinicians reported that exploring their own emotional and physiological responses to client trauma in combination with clinical supervision increased their resilience to this form of work

stress (Pack, 2014). Personal growth through spiritual development and cultivation of friendships with fellow therapists also promoted resilience among therapists (Pack, 2014). Training in stress management also promoted personal growth that enabled novice clinicians to manage work-related stress more effectively (Stafford-Brown & Pakenham, 2012).

As Howard (2008) explained, personal growth in relation to self-efficacy, resilience, and work engagement led to increased well-being and capacity to help clients for therapists. Researchers found that psychological well-being was associated with general wellness in online counseling psychology students (Merryman, Martin, & Martin, 2015). The researchers suggested that personal growth in the area of self-care was important for novice therapists, because management of psychological health had implications for the individual's overall wellness (Merryman et al., 2015). Researchers also found that high levels of distress and conflict in therapists' personal lives were associated with clients' perceptions of poorer quality therapeutic alliances (Nissen-Lie, Havik, Hoglend, Monsen, & Ronnestad, 2013). These findings suggested that personal growth in the area of self-care was related to enhanced well-being for the therapist as well as better ability to establish a helpful relationship with clients (Merryman et al., 2015; Nissen-Lie et al., 2013).

History of values (dispositions) training in counseling psychology. Helping professions began using the term 'dispositions' more widely when the National Council for Accreditation of Teacher Education (NCATE, 2007) included the concept as a tool for teacher educators to evaluate teachers in training (Gibbons et al., 2013). NCATE (n.d.) defined dispositions as "professional attitudes, values, and beliefs demonstrated through both verbal and non-verbal behaviors as educators interact with students, families, colleagues, and communities". School psychology and social work programs also integrated dispositions in their accreditation

standards, resulting in statements such as “respect for human diversity, communication skills, effective interpersonal relations, ethical responsibility, adaptability, initiative, and dependability” (National Association of School Psychologists, 2009) and “service, social justice, the dignity and worth of the person, the importance of human relationships, integrity, competence, human rights, and scientific inquiry” (Council on Social Work Education, 2008). Based on these principles appearing in multiple helping professions’ educational policies and accreditations standards, it seems that a focus on developing and preserving professional skills and personal characteristics is gaining importance.

Gatekeeping is a part of professional standards for counselor and psychologist educators (American Counseling Association, 2005; CACREP, 2009; American Psychological Association, 2002a), and refers to the ongoing monitoring and evaluation of trainees’ competence to enter the field. Researchers suggest that disposition development is closely tied to gatekeeping in counselor education (Gibbons et al., 2013). The field of teacher education has been on the forefront of proposing that dispositions impact student learning and development (NCATE, n.d.). Researchers in the field of counseling psychology have also acknowledged a need for supervisors to include personal characteristics or the person of the trainee when gatekeeping (Gaubatz & Vera, 2002). Remley and Herlihy (2005), also stated that some students may have well-developed intellectual abilities but are deficient in the development of important personal characteristics. In a field where the role of the person of the clinician in the room with clients is impactful to such a degree, a focus on personal characteristics and values seems not only justified, but also imperative.

In order to meet the ethical standard to protect the welfare of clients, psychology training programs must properly monitor and assess their trainees throughout their development within

the program (APA, 2002a). Counseling psychology has similar mandates and added greater specificity with the adoption of the 2009 Standards by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009). With these additional standards, CACREP requires training programs in counseling psychology to continuously conduct “a developmental, systematic assessment of each student’s progress throughout the program, including consideration of the student’s academic performance, professional development, and personal development” (Section IV, Standard B). Thus, effective training within counseling psychology includes the evaluation of aspects of the person of the counselor in training as outcome measures (Thompson, 2004). In fact, personal qualities such as integrity, discernment, acceptance of emotion, self-awareness, and interdependence with the community not only complement knowledge and skills, but also enhance overall professional competence for those in helping professions (Meara, Schmidt, & Day, 1996). Furthermore, a counseling training program identified and implemented five dispositions into all aspects of their training model. The five dispositions are commitment, openness, respect for self and others, integrity, and self-awareness (Gibbons et al., 2013).

In order to address this aspect of training, Spurgeon, Gibbons, and Cochran (2012) implemented an assessment of the development of dispositions in a counseling training program. Dispositions, in this study, refer to “core values, attitudes, behaviors, and beliefs needed to become an effective and competent professional” (Spurgeon, Gibbons, & Cochran, 2012). The researchers argue that training programs could benefit from implementing dispositions as a framework to screen student admissions, guide trainee development, and evaluate trainees (Spurgeon, Gibbons, & Cochran, 2012).

Currently, CACREP does not explicitly require dispositions to be part of counselor training but, as mentioned above, dispositional traits are included in the 2009 Standards adopted by CACREP. These include self-awareness, ability to relate to diverse persons, sensitivity to others, and the promotion of optimal human development and mental health (CACREP, 2009). A requirement of CACREP for admissions into counseling programs involves an applicant's ability to engage in self-examination and be open to personal and professional development (Section V1. 5). The emphasis on this mindset of openness as a screening tool for applicants further highlights the importance of growth and development in counseling psychology. In a study examining the impact of personal therapy on psychology trainees, researchers discovered that personal growth within the participants expanded their ability to engage in self-discovery and increase their self-awareness, which ultimately impacted their professional practice (Kastberg, Jordan, Kiweewa, & Clingerman, 2014).

The ethical and accreditation standards within the field of counseling call for values-related qualities, but these are often described in cognitive and behavioral terms (Dollarhide, 2013). In this way, important elements can be easily overlooked, ultimately to the detriment of the professional and personal growth of trainees. Methods that have been applied to measure learning of values, attitudes, and learned dispositions such as compassion, empathy, and open-mindedness are called affective measures of learning. Affective measures of learning have been used in other professions such as the training of psychiatric nurses and theological education (Dollarhide, 2013). One such affective measure has been used in examining multicultural dispositions and applied to multicultural counseling (Dollarhide, 2013). Research into the application of affective measures in relation to multicultural training suggests that cognitive training does not result in the development or internalization of professional multicultural values

and attitudes (Carter, 2003; Krathwohl, Bloom, & Masia, 1964; Villalba & Redmond, 2008; Watt et al., 2009). The internalization of values, according to Krathwohl et al. (1964), is “the acceptance of attitudes, codes, and principles that inform value judgments used to evaluate conduct”. In this respect, growth is assessed by the degree to which external prompts (i.e., professors, lectures) develop into internal prompts, as well as the degree to which the student becomes invested in the internalization process as well as becomes aware of being more emotionally involved in the process. Therefore, this basically states that as internalization occurs, there are motivational and emotional factors and contexts present. Internalization progresses through five stages: (a) receiving a value, (b) responding to the learning, (c) valuing, (d) organization, and (e) characterization by a value or value complex. By exploring the progression of internalization, counselor educators can understand how to identify a student’s level of value integration, implement affective skills training into the coursework, and assess for the amount of internalization throughout the program.

One counseling program implemented an approach to training that included a focus on trainees’ dispositions. Specifically, it reoriented the training program to shift its paradigm to use dispositions to guide the students, the program structure, delivery of information and knowledge in the curriculum, and evaluation of students. A group of researchers examined this approach through the lens of the students. They were particularly interested in the students’ reactions to the integration of dispositions into a counseling training program in terms of students’ level of understanding, recognition, and appreciation of the dispositions’ role in their own development and in the program itself (Gibbons et al., 2013). The results showed that when dispositions are thoughtfully and intentionally integrated into the training program, students experience both

personal and professional growth and express appreciation for new learning experiences (Gibbons et al. 2013).

Within the field of clinical psychology, in 1987, Blocher posited that the degree to which training programs promote growth is an important factor in the professional development of trainees. Thus, he realized that personal growth was a critical piece to developing professional practices in psychology trainees. Others have argued that psychologists should have the ability to nurture their strengths and manage their own well-being and that this should be an integral part of their training from the beginning (Jordaan, Spangenberg, Watson, & Fouche, 2007). One approach to supervision, called Interpersonal Process Recall, can build on a skills-focused approach by using the existing personality traits of the trainees and integrating them with fundamental counseling skills (Crews et al., 2005).

Another way to facilitate this type of training in clinical psychology is through the use of positive psychology framework. This framework has been shown to empower trainees who can identify their personal strengths and use them as building blocks from which to grow. Trainees that had been trained in this framework reported that identifying and applying their signature strengths resulted in overall better functioning, life satisfaction, deeper self-understanding, and feeling more connected with and understanding to others (Guse, 2010).

Scaife and Walsh (2001) argue that the development of the self is worth paying attention to in supervision. They are clear that the primary goal of supervision is not personal growth of the trainee, but are intent on arguing that it is influential in the trainee's development as a clinician. Supervision can serve a foundational ground in which trainees can develop skills that will help prevent burnout and ultimately poor performance. How supervision can address this issue has been researched extensively, and concepts such as sense of coherence, resilience, job

control, work engagement and flow have been identified as important aspects to consider (May, Gibson, & Harter, 2004). In fact, a sense of coherence has been found to be crucial to well-being in professionals (Antonovsky, 1987). Perceptions of work experiences, evaluating personal ability to cope with work demands, and goals and values related to work appear to be important topics to address in supervision. The focus on these areas can help enhance self-efficacy in trainees, as well as offer an environment conducive to enhancing resilience and leading to flow (Bakker, 2005; Howard, 2008). Identifying and building on strengths of trainees beyond their typical functioning is the template of a positive psychology approach and can be the guiding force behind the supervision process.

Combining literature from both clinical and counseling psychology on personal characteristics, values, or dispositions of trainees has formed the basis for this current study. The literature reveals a need to focus on, define, and explore the values that emerge during clinical training, especially as they relate to the overall personal growth and development of novice clinicians. There seems to be a wealth of research on values and dispositions within the counseling psychology field, yet, less is found within clinical psychology. Additionally, despite the values outlined within the APA Ethics Code, there is not an emphasis on the ethical training that guides novice clinicians to embody these values. A progression toward the explicit implementation of values-based learning within clinical psychology will be of benefit to clinicians from both a personal and professional standpoint. The focus of this study was to examine what values are ignited, built upon, or formed through the supervisory process in the first year of a clinical psychology doctoral program that orient a novice clinician toward personal growth.

Summary

Since its start in the late 1800s, the field of clinical psychology has been active in its efforts to fine tune clinical training and supervision (Hill, Bond, Atkinson, Woods, Gibbs, Howe & Morris, 2015; McMinn et al., 2015). The recent establishment of the competency benchmarks marks a notable milestone relative to these advancements (Hill et al., 2015; McMinn et al., 2015). It is likely that this field will continue to enhance its training efforts to improve the competency of psychologists getting into the workforce, but much work remains.

Supervision literature spans 50 years within psychology research and the focus has largely been on ethics and professionalism, acquisition of skill and knowledge, stages of growth, and professional identity development. There is a significant gap in the literature on examining the values related to the personal growth of novice clinicians and its impact on their professional development. The research conducted on personal development can be summarized as: (a) focusing on the perspective of seasoned, licensed clinicians (Rønnestad & Skovholt, 2001); (b) retrospective in nature (Carlsson, Norberg, Sandell, & Schubert, 2011; Trotter-Mathison, Koch, Sanger, & Skovholt, 2010); (c) narrow in focus, i.e. predominately multicultural in nature (e.g., APA, 2007; Lutz & Irizarry, 2009; Tryssenaar & Perkins, 2001); and (d) focused on competency and the learning process (Folkes-Skinner, Elliott, & Wheeler, 2010).

Over the last fifteen years, there has been a call for more research on the values of personal growth and development of novice clinicians. Key researchers in this area have noted the importance of examining how the training process impacts novice clinicians' values of development and growth (Grafanaki, 2010; Rønnestad & Skovholt, 2001; Skovholt & Rønnestad, 2003; Truell, 2001).

It was noticeable that psychologists, coupled with other mental health practitioners, have looked back at their training and work a number of times and pinpointed a need for the development of values and personal factors to enhance success in the field (Hill et al., 2015; McMinn et al., 2015). However, such practices are few (Hill et al., 2015; McMinn et al., 2015). Self-reflection and personal awareness have been elevated in importance as part of the move to competency-based clinical training and supervision. The focus on values during training on the overall personal growth of the novice clinician remains largely absent, despite the fact that the psychodynamic, humanistic, cognitive-behavioral and multicultural perspectives all believe that the person-of-the-therapist is a field of significance for training and effective clinical practice (Hill et al., 2015; McMinn et al., 2015). There have been a few more explicit efforts to address values in training in the parallel fields of counseling psychology and marriage therapy (Pillay & Kramers-Olen, 2014; Roberts, Blossom, Evans, Amaro, & Kanine, 2016). The clinical psychology field has, however, all but left out attention to values related to personal factors while training and supervising novice clinicians (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). There is also very little discussion and few efforts to address the personal growth of values related to the ‘person-of-the-therapist’ during training and supervision.

There is a need to understand experiences in the lives of novice clinicians that arise during clinical training in a bid to highlight the areas of supervision and training that promote the development of values of personal growth and development of these clinicians. Without this understanding, there arises a gap between stated values of personal growth in training and values of personal growth actually occurring during supervision. It is important to close these gaps in personal growth during training and supervision (Pillay & Kramers-Olen, 2014; Roberts et al., 2016). No such studies were found to have been completed with doctoral students, despite the

fact that there have been a small number of educators reviewing the values of novice clinicians at the master's level in both counseling, and marriage and family therapy programs (Pillay & Kramers-Olen, 2014; Roberts et al., 2016).

Chapter 3: Research Methodology

This chapter details the research methodology used in this study, including the rationale for the study design, a description of the archival data, data collection, descriptions of the participants and auditor, approach to research, researcher biases, and methodological limitations and contributions.

This researcher was inspired to seek understanding of the values of personal and professional growth and development as it related to the personal experiences of clinical training. This researcher, along with other members of her first year supervision group, experienced an organic and inspiring level of personal growth throughout supervision, which prompted an investigation into what qualities of supervision allowed for such growth to take place.

The purpose of this study was to identify and explore the values that emerge out of the clinical training and supervision experience that promote the personal growth of novice clinicians. This researcher believes that increased awareness and understanding of these factors could influence how novice clinicians are trained in order to improve competency and client care.

Research Design

Autoethnography as a method. Ellis, Adams, and Bochner (2010) define autoethnography as “an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural experience” (pg. 1) Used as a research method, autoethnography allows researchers to examine data that is not easily observable or documented in a traditional manner. It is described as an introspective method that provides the researcher with the means to gain insight into aspects of the human experience, such

as self-reflection, that may not otherwise be available for examination (Stanley, 2015; Wambura, Ngunjiri, Hernandez, & Chang, 2010).

By utilizing the researcher as a participant, this method allows for a deeper analysis of human experience, including areas of personal awareness and self-reflection to understand experiences and emotions that emerge within the self as related to a particular topic (Crawford, 1996). Autoethnography can serve as a unique method to understand complex and unique processes within individuals (Berry & Patti, 2015). Further, Stanley (2015) suggests that the use of this method provides researchers with an opportunity to directly examine actual lived experiences of those currently engaged in clinical psychology training.

The participants of this study included the researcher and two of her colleagues. Using one's own observations as data in a study has merit, despite its uncommon nature. Past literature has been identified using similar methods. For example, Jung analyzed his own dreams in his research and Wundt used his own introspection as data. Furthermore, many personality theories within the field of psychology were developed through the use of the theorists' own personal experiences as data (Selby, 2003). Thus, the precedent exists for using the researcher as a participant.

Qualitative approach. Due to the exploratory nature of the research question, the preexisting data set was analyzed through inductive, qualitative content analysis (Elo & Kyngäs, 2008). This approach was used to examine the data without imposing preexisting theories upon it. A qualitative approach was utilized in order to capture the complexities of the topic at hand, as well as to allow the researcher to examine other relevant values that emerge that may inform future inquiries into the development of novice clinicians (Morrow, 2007).

Qualitative methods are useful in exploring topics about which little is known, which was appropriate for the present study because of the lack of research about novice therapists' values of personal growth in relation to clinical training (Merriam & Tisdell, 2015). Further, qualitative methods are useful in exploring the perspectives of individuals in relation to their experiences (Merriam & Tisdell, 2015). Thus, a qualitative approach was selected because the researcher wished to explore the values related to personal growth experiences of participants, that were in fact, based upon their own first-person perspectives of clinical training (Merriam & Tisdell, 2015). Although quantitative methods are useful in determining statistical relationships between countable phenomena, the researcher was not interested in investigating such relationships within this study; therefore, a quantitative design was not appropriate (Maxwell, 2012).

The content analysis approach limits the findings in the sense that it lays the foundation on which to build a theory (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005); thus, content analysis was utilized so study results could inform theory related to the clinical supervision and training of novice clinicians. The researcher used open coding in order to examine the values that emerged from the data in an effort to add to and inform the limited existing literature on this topic (Hsieh & Shannon, 2005; Mayring, 2000).

Research question. This study investigated the following research question: “What values emerge in clinical training/supervision that orient a novice clinician toward personal growth?” The researcher coded the data for values, as well as indications that these values oriented the participant towards personal growth. Based on the definition for values in this study, the instructions were to code any phrases or sentences that imply: (a) an increase in self-efficacy, (b) increase in engagement with work, (c) an experience of enhanced resilience, (d) an experience that restores and/or maintains one’s personal well-being, and/or (e) an increase in

ability to help clients. The researcher first coded the criteria to establish that a unit of meaning was a value, and then coded the value itself.

Participants and Researchers

Participant demographics. The participant sample consisted of three first year doctoral students under the clinical supervision of a licensed psychologist (white, female) with 28 years' experience training and supervising novice clinicians (see Appendix G for form). Although the researcher initially invited five fellow students to participate, three ultimately declined this invitation, resulting in a sample of three doctoral students including the researcher. The researcher was personally acquainted with the other two participants in the study. The three doctoral students, 1 man (multiracial) and 2 women (white) with a mean age of 28 (SD: 2.71) completed their first academic year at a major Southern California private university accredited by the American Psychological Association. They began their academic year having already completed master's degrees in psychology and their first year practicum placements were located at two community counseling centers. All three participants had no prior clinical experience. At the time of data collection, none of the students had committed to a specific theoretical orientation, and all three participated in a year-long clinical training and supervision experience under this same supervisor. Each novice clinician received a total of 140 hours of supervision. All three are coders for this study.

At the time of data collection, supervision was provided, which consisted of a minimum of one 7-hour educational training experience within the first two weeks of the first semester of the first year of the doctoral program. Content of the training included 15 basic premises involving the role and approach to conducting psychotherapy; 6 basic listening skills drawn from the work of Allen Ivey (Ivey, Normington, Miller, Morrill, & Haase, 1968); 9 elements that

enhance attunement to the client (J. Rosenberg, personal communication, November 14, 2012); explicating the movement between content and process; grounding in interpersonal neurobiology including concepts of neuroception, neuroceptive challenges, safety, window of tolerance, bodily experience of feelings, affect tolerance of 8 unpleasant feelings, and a psychotherapy model of congruence and connection (J. Rosenberg, personal communication, November 14, 2012).

Students also participated as a group of six in two hours of case conference with one student presenting during that two-hour period, and one hour of dyadic training per week throughout the academic year with the aforementioned supervisor.

Below are descriptions of the intended coders and auditor. Although the second and third coders were ultimately not involved in the analysis that yielded this study's findings, for the sake of thoroughness, this section includes their descriptions.

Coder 1. The primary researcher and author of this study, the sole coder, was 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. The coder was raised in a Christian family, and self identifies as spiritual and non-religious. The coder 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, therapists must be willing to reflect upon their own process and be willing and open to continuously grow.

Coder 2. The second coder, Coder 2, was a 28-year-old, white, married, female clinical psychology doctoral student. She was born and raised in an upper-middle class family in the

mid-western part of the United States. Coder 2 was raised in a Catholic 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 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. Furthermore, 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, non-judgment, 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. Furthermore, non-judgment and empathy are both processes that need effort to be expended, 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.

Coder 3. Coder 3 was a 31-year-old 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 3 was raised in a Catholic family, and considers himself spiritual with affiliations to Buddhism and the Catholic Church. Coder 3 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 has 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.

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 a 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 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 the 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.

Setting

Because participants in the study wrote journal entries about their experiences, they did so where it was most convenient. Settings for the study, then, included the participants' respective offices, homes, and other spaces in which they decided to write about their experiences.

Procedure

Sampling procedures. Convenience sampling was used for this study based on its relevance to this type of qualitative research. This sampling procedure was used to examine all 54 journal entries in the data set. Convenience sampling allowed the researcher to recruit members of targeted population in order to address the research question, but was based on ease or practicality of obtaining such participants. In order to account for varied and diverse experiences amongst participants who differ in age, gender, culture, and clinical experience, a maximum variation approach was used (Miles & Huberman, 1994). This approach allowed for results to emerge that were representative of values that can be observed across a diverse range of doctoral level psychology students.

The sample of students was selected from one clinical psychology program at one university. Selection criteria were as follows: (a) participants were first-year doctoral students in a clinical psychology program and (b) participants were under the supervision of one licensed supervisor. Participants were not excluded due to gender, age, clinical experience, or culture. These criteria allowed the researchers to identify themes in the data unrelated to age, gender, culture, clinical experience, education level, or supervisory style.

The archived data set of 54 journal entries represented three points of view and were considered to be sufficient for the purposes of this study, with the aims that the findings and results be used in subsequent research studies examining similar questions. This study served to provide an initial understanding of the values that emerge in the training of novice clinicians. The results and subsequent research provided a framework for developing new training approaches, with a specific focus on the personal development of the novice clinician in supervision (Miles & Huberman, 1994). The procedures and materials used in this study were approved by the university's Institutional Review Board (IRB) prior to conducting the study (see Appendix A).

Critical Incidents

The types of journal entries used for this study can be thought of as critical incidents which have previously been defined in clinical psychology research. Critical incidents are defined as a significant event or situation that could be described in a retrospective manner in order to interpret an experience (Flanagan, 1954). Critical incidents provide a template to analyze complex processes or values (Fraser & Hunt, 2011).

The Critical Incident Technique developed by Heppner and Roehlke (1984) was used in a study examining major events or turning points within the supervision process by Ellis in 2006.

Ellis looked to examine any important event in supervision that “resulted in changes in the effectiveness as a counselor” (Ellis, 2006, p. 124). The Critical Incident Technique is similar to that of the data in this study because it was used to analyze and understand meanings and values that participants placed on significant events related to their development as counselors.

In psychology research, critical incidents have been used as a measure to capture competence, emotional awareness, personal issues, learning events and other experiences related to counselor development (Smith-Adcock, Shin, & Pereria, 2015; Howard, Inman, & Altman, 2006; Furr & Carroll, 2003; Ellis, 1991). Furthermore, it has been found that critical incidents capture the experiential learning process as well as resulting therapeutic impacts on clients and counselors (Smith-Adcock, Shin, & Pereira, 2015; Kivlighan, Multon, & Brossart, 1996).

In terms of supervision research, it has been found that novice clinicians or counselors tend to describe themes of competence, autonomy, purpose and directions issues in their critical incidents, while supervisors tend to describe themes of relationship issues (Ellis, 2006; Fine & Fenell, 1985). It seems that the difference between the two may have to do with the difference in development between a novice clinician and a seasoned, licensed professional.

The use of critical incidents in supervision have been found to be effective and safe for novice clinicians to examine, describe, reflect, and process challenging experiences and feelings that occur throughout their development (Sommer et al., 2009; Nelson, Oliver, & Capps, 2006; Borders, 1989; Stoltenberg, 1981). Furthermore, critical incidents have been used to examine ethical issues that emerge during supervision, as well as measures of shifts in attitudes, values or beliefs of the novice clinician that impact their professional competence and development (Delsignore et al, 2010; Arredondo et al., 1996; Goodyear, Crego, & Johnston 1992; Kitchener, 1984).

Critical incidents and the current study. Critical incidents have been used within the fields of psychology and counseling as a way to analyze qualitative data (Angelides, 2001; Cormier, 1988; Delsignore et al., 2010; Furr & Carroll, 2003; Leong & Kim, 1991; Mwaba & Pedersen, 1990; Skovholt & McCarthy, 1988).

The journal entries used in this study are representative of a modification of the Critical Incidents Questionnaire (CIQ) developed by Heppner and Roehlke (1984). The participants in this study wrote journals, which can be viewed as ‘critical moments’, that were described as visceral reactions, cognitive shifts, or significant events resulting in increased self-reflection, insight, effectiveness as a clinician, self-awareness, growth, and self-efficacy. An experience of challenge or inspiration for the novice clinician to “be more” was also a defined quality of these critical moments.

Within this study, it was found that, more often than not, critical moments came about when supervision experiences and personal life experiences collided. These moments emerged through an experience where learning in supervision through the discussion of a topic or client data elicited a personal revelation on the part of the novice clinician. This often occurred in an unsolicited manner in which, through a discussion, the novice clinician gained insight or awareness that was personal in nature and related to their growth as both a person and a professional. The learning and insight emerged through various forms of supervision, a one-day training, individual supervision, peer supervision, or group supervision. The learning then could be reflected upon and applied to one’s personal life and well-being, as well as their competency as a clinician.

For the purposes of this study, personal growth and professional development emerge in three ways: (a) supervision in the absence of a personal experience related to the material

discussed; (b) supervision followed by a personal experience related to the material; or (c) supervision followed by a personal experience related to the material and an engagement in self-reflection of the process.

This description of critical moments was used to guide the participants' (novice clinicians) journaling activity. The novice clinicians began journaling on average twice every month for seven months to reflect upon events or experiences where they were challenged or inspired to "be more."

Data Collection and Management

The archival data set used in this study is best described as phenomenological in nature, as it represents the lived experiences of the participants via their self-report (Moustakas, 1994). Three first year doctoral students in clinical psychology at a private university in Southern California noticed significant personal changes emanating from clinical supervision. They engaged in regular informal discussions of their experiences as they related to professional development. Based on these initial observations, they began documenting critical moments that led to personal and professional development from their supervision and practicum training experience. Data collection took place primarily during the students' first year spring semester.

The current research study was proposed after all journal entries were completed; thus, the journals reflect the naturalistic, lived experiences of each student and were not influenced by their inclusion in the current study. However, it is noted that the researchers' interests in completing the aforementioned journals may represent biases in the ways in which they view growth and development in the field. Thus, the current study is influenced by such biases.

The data set used for the purposes of this study comprises the totality of journal entries. All three novice clinicians were approached to provide their consent for using their individual

entries for the purposes of this research study (average data set per student is 18 entries). Provided in the informed consent (see Appendix B) document is information regarding the nature and duration of their participation, how data will be kept confidential, and how it will be handled, potential risks and benefits of participation, and where questions or concerns may be directed.

The following process was completed in order to collect and de-identify all data entries. Journal entries were collected from all consenting participants using a password-protected flash drive. The researchers requested, via the informed consent, that each participant submit the flash drive to the dissertation chair's professional mailbox in a sealed manila envelope. The dissertation chair collected all flash drives and released them to a third party to undergo a de-identification process. The third party was a master's student at Pepperdine University Graduate School of Education and Psychology, unfamiliar with the researchers and participants, who signed a confidentiality agreement outlining proper handling of the data (see Appendices C and D). The researchers provided the third party with a protocol for de-identifying all data (see Appendix E). Upon completion of the de-identification process, all third parties were asked to resubmit the flash drives to the dissertation chair's mailbox.

The dissertation chair collected all flash drives and printed four copies of each entry, creating four data sets. Initially, all data sets were stored in a locked drawer in the dissertation chair's professional office at Pepperdine University Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, California, 90045. The researchers accessed the data from this location for purposes of establishing inter-rater reliability (see Coding and Data Analysis).

In August 2015, each researcher collected three sets of data to individually code for their own and the other two research questions. However, for the purpose of this particular study, coding was ultimately limited to just the primary researcher because of issues of internal consistency in the coding process. Although permission to use NVivo Qualitative Data Analysis software was obtained from this researcher's dissertation committee, it was not utilized in the final coding process because the researcher felt it was unnecessary and potentially detrimental to her coding efforts. There are no NVivo data files to account for. This researcher restarted coding as a single coder in the absence of any communication with her committee about the non-use of the software program nor the restart of coding on her own. The reader should remain aware that this dissertation was completed using a single coder, the author of this dissertation.

Researchers stored data in locked drawers located in their individual home offices. Upon completion of coding, journal entries were provided to the researcher for which it was coded. Data was transferred in person to the appropriate researcher. Additionally, participant-signed informed consent documents were kept in a separate locked drawer in the office of Dr. Joan Rosenberg (address above). Data will be maintained for a duration of five years, and will then be destroyed.

Human Subjects/Ethical Considerations

Confidentiality and maintenance of ethical standards for the treatment of research participants was maintained in several ways. As previously stated, all data entries were de-identified utilizing an external reviewer. For a full description of this process, the reader should review the section entitled "Data Collection" on page 106 of this document. In addition to the research data preparation, provisions were made so that those handling the de-identified data did so in a confidential and ethical manner. Prior to accessing research database content,

researchers/coders completed an IRB certification course and Health Insurance Portability & Accountability Act of 1996 (HIPAA) course to ensure adherence to ethical standards of participant research and handling confidential health information (see Appendix F).

Assumptions

It is assumed that participants described their perspectives and experiences honestly and accurately, and that they did not withhold or misrepresent information about critical moments of personal development as novice clinicians. Because participants wrote about values of personal growth in relation to supervision and training, it is possible that self-presentation concerns affected how they presented information about these experiences. The researcher was specifically interested in first-person accounts of values of personal growth for novice clinicians, however, which required making the assumption of honesty in participants' journal entries.

Another assumption is that participants possessed sufficient levels of self-awareness to identify critical moments of personal growth as they occurred. It is possible that participants might retrospectively recognize critical moments of personal growth later in life, after accumulating additional experience and maturity. The researcher was specifically interested in exploring novice clinicians' perspectives on values of growth and development during training. This specific interest required making the assumption that participants were sufficiently self-aware to recognize critical moments of personal growth and describe them fully.

Scope and Delimitations

In this study, the researcher focused on values of personal growth of novice clinicians, as this topic has received less attention from researchers in comparison with professional development practices and outcomes. In a review of the literature, the researcher discovered that although personal attributes were important for the success of therapists, researchers had not

thoroughly explored how development of values occurs in beginning clinicians. For this reason, the researcher chose to focus on values of personal growth rather than professional development of therapists. The study was further delimited through inclusion of first-year clinical psychology doctoral students and exclusion of more experienced clinicians. Limiting inclusion to first-year students ensured that all participants were encountering personal growth opportunities and challenges with the same limited amount of clinical experience. All participants were newly providing clinical services to clients, and this shared level of experience in participants allowed the researcher to explore values of personal growth experiences in the earliest stages of clinician training and supervision.

The researcher further delimited this study by focusing on transformative learning theory as a framework to the exclusion of other theories. The researcher considered using experiential learning theory as a theoretical framework, in which learning is explained as a process that occurs as the result of tensions between different types of direct experience and conceptual processing (Kolb & Kolb, 2012). Specifically, learners derive new knowledge from engaging in concrete experience balanced with abstract conceptualization, and also participate in active experimentation balanced with reflective observation (Kolb & Kolb, 2012). Although this theory has some applicability to values of personal growth of novice clinicians during training and supervision, transformative learning theory was preferred because it includes examination of changes in values in response to key learning events (Mezirow, 2009). Development of values in the context of training and personal development is an essential consideration within this study; therefore, the researcher felt that transformative learning theory was a more fitting theoretical framework than experiential learning theory.

Chapter 4: Results

The purpose of this qualitative study was to identify and explore values of personal growth that directly related to the clinical training of novice clinicians within a clinical psychology doctoral program. The research question was “what values emerge in clinical training/supervision that orient a novice clinician toward personal growth?” The following chapter details the results of the study, including a review of coding and data analysis procedures as well as evidence of trustworthiness. The chapter concludes with a description of study findings and summary.

Coding and Data Analysis

The researcher of this study, who was also a participant, was a clinical psychology doctoral student who coded the collected data. A licensed clinical psychologist and supervisor acted as the auditor for the study and supervised the researcher throughout the entirety of the data collection, coding and data analysis. Initially, two other clinical psychology doctoral students acted as coders for this study, and coded all 54 journal entries as well in order to provide alternate perspectives, to minimize individual bias, and to create interrater reliability (Hill, Thompson, & Williams, 1997).

The researchers and two other clinical psychology doctoral students began coding journal entries. Data analysis for this study was done through an open coding process in which values emerged from the journal entries (Creswell, 2009; Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). The initial phase of coding began with a careful reading of each journal entry line by line to uncover the main processes and themes. A second read through each story was completed to highlight or underline meaningful phrases or sentences based on the primary researcher’s

research question. The coder noted all journal entries with line numbers using initial impressions and documented relevant categories that emerged (see Appendix H).

Data was initially coded for values, as well as indications that these values oriented the participant towards personal growth. Values in journal entries were coded for any phrases or sentences that imply: (a) an increase in self-efficacy, (b) increase in engagement with work, (c) an experience of enhanced resilience, (d) an experience that restores and/or maintains one's personal well-being, and/or (e) an increase in ability to help clients. Journal entries that did not fit into any of the values were determined to be discrepant and therefore not used. Two journal entries, one incomplete and one referring only to negative experiences, were not included in the results.

Interrater reliability was established prior to the beginning of the coding process. Five journal entries were randomly selected using a random number generator. The auditor and the coder independently coded all five entries and compared their codes for similarities and discrepancies. This process was done several times with new sets of five journal entries in order to establish a minimum of 80% agreement between the coders (Miles & Huberman, 1994). Once all coding was completed, the coder and the auditor examined an Excel document containing a list of their codes to ensure agreement for all codes.

This researcher began to compile all codes from each coder into one Excel spreadsheet. Then this researcher looked for overlap between each set of codes by color coding similarly coded items on the Excel sheet. Once values patterns and overlaps began to emerge from this process the researcher grouped the codes into categories preemptively. After speaking with the auditor, this researcher stepped back from grouping the codes and instead returned to the color coded Excel document to track the frequency of all the values that were coded. This researcher

found that a total of 168 individual values had been coded and ascertained how many times and where in the stories each value was coded. The auditor reviewed the new spreadsheet of coded tallies and the researcher then began the next step of determining whether or not each coded value was, in fact, a value based on the definition used for this study.

This researcher found 11 coded values and reviewed these with the auditor. This researcher and auditor referred back to the data, and after doing so, seven out of the 11 in question were determined to be values. The remaining four were determined not to be values either because they were specific to personal issues or there were inconsistencies in the coding (i.e., narration, uncertainty, silence, and non-judgment). Then, this researcher put all 164 coded values that were determined to be values into another Excel sheet in the form of groups (i.e., all codes related to knowledge were in a group, all related to learning were in a group, etc.). The researcher then referred to the data in order to ascertain subcategories within larger categories of codes.

The second phase of data analysis was the categorization process, in which the identified values were compared and contrasted to others both within journal entries and across them. The values were then clumped into an overall category list under which all other codes fell. The resulting lists served as a means to confirm the values, as well as identify any values that may have been missed or do not capture important themes that have emerged from the journal entries. A third and final reading was completed in order to limit values that may have been previously missed, as this is a common limitation in the process of content analysis (Hsieh & Shannon, 2005). Lastly, using the process of abstraction, fewer main values were formed with several subcategories in order to organize and condense the findings into communicable parts. In order

to illustrate the categories, a diagram was created to visually represent the main categories, subcategories and individual quotes to represent them.

An early audit in this process revealed the need to refine the distinctions between codes, which led to a more refined research question: “What values emerge in clinical training/supervision that orient a novice clinician toward personal growth?” In many cases one could only make inferences about the supervisor values and as a result there was a need to come up with a more specific question. The coders re-examined the journal entries to delineate the codes and categories that had emerged through initial analysis. Once again, this phase of recoding began by compiling all codes from each coder into one Excel spreadsheet. Codes consisted of a short or long phrase that symbolically assigned a summative, salient, essence-capturing, and/or evocative attribute for a portion of data (Saldana, 2009). This researcher looked for overlap between each set of codes by color coding similarly coded items on the Excel sheet. Once patterns and overlaps began to emerge from this process the researcher grouped the codes into categories preemptively. After speaking with the auditor, this researcher stepped back from grouping the codes and instead returned to the color coded Excel document to track the frequency of all the values that were coded. Journal entries that did not fit into any of the values were determined to be discrepant and therefore not used; only two journal entries, one incomplete and one that referred only to negative experiences, were not included in the results.

However, following multiple reviews, there was an absence of internal consistency in the coding that was unable to be resolved. The researcher sought and was granted permission from her committee to use the NVivo Qualitative Data Analysis software program to address this issue. However, this researcher abandoned the use of the software program and restarted coding as a single coder in the absence of any communication with her committee about the non use of

the software program nor the restart of coding on her own. The reader should remain aware that this dissertation was completed using a single coder, the author of this dissertation, and the circumstances under which the coding occurred.

The coding then began again with this researcher as a single coder, who used the following criteria of a definition of value to establish the values for further coding: (a) an increase in self-efficacy; (b) increase in engagement with work; (c) an experience of enhanced resilience; (d) an experience that restores and/or maintains one's personal well-being, and (e) an increase in ability to help clients. This process yielded 137 statements, each of which was coded under one of the criterion of a value.

Although qualitative researchers have their own thoughts on the appropriate number of themes (Creswell, 2007; Lichtman, 2006; Wolcott, 1994), or values as this study presents, the major themes or concepts should be held to a minimum to keep the analysis coherent; there is no standardized or magic number to achieve (Saldana, 2009). For this study, values were determined and defined by how each contributes to personal and professional growth toward client care. Ten codes were determined from the data.

Further analysis of the statements revealed that many of these statements could be further categorized as demonstrating two values: knowledge and awareness. The researcher then returned to the statements and journal entries to determine whether these or other values were conveyed in the data. After that analysis and another audit, this researcher found that 140 individual statements conveying values had been coded, and determined through analysis that the following values emerged: (a) knowledge; (b) awareness; (c) community; (d) humility; (e) competence; (f) acceptance; (g) openness; and (h) learning. This researcher and auditor referred back to the data, and this researcher then examined the statements beyond the definitional criteria

of a value to categorize the statements. Through this process, two more values, bravery and curiosity, emerged.

Evidence of Trustworthiness

In establishing trustworthiness, data sources, collection and study results should be of credibility, transferability, dependability and confirmability (Bowen, 2005). The use of limited yet triangulated research methods helped maximize credibility and adequacy of study findings and minimize any complexities that may occur in the study (Bowen, 2005; Guba, 1981). A continuous review of data sources, procedures, and findings by the researcher and advising faculty throughout the study time period was intended to confirm study results. The coding process was completed by the primary researcher of this study. Though this study faced methodological challenges, in establishing dependability, the researcher has provided relevant methodological information for replication of the study (Givens, 2008). As the study was conducted at one private university in Southern California, and the specific doctoral program of clinical psychology, study findings are viewed as a starting point for subsequent research endeavors.

Results

The research question that was addressed in this study was “What values emerge in clinical training/supervision that orient a novice clinician toward personal growth?” Fifty-four journal entries were collected from three participating graduate student clinicians. Journal entries were first analyzed and coded based on whether they fit the definitional criteria of a value and then coded secondarily for the value itself. Entries were then compared and contrasted under each value for similarities and differences. Journal entries that did not fit into any of the themes were determined to be discrepant and therefore not used; only two journal entries were not

included in the results. Results of study are presented below, along with respective journal entries and a brief summary of findings within each value.

Value 1. Awareness. Within journal entries, critical moments that referred to awareness were noted. Within the 54 journal entries, 57 critical moments of awareness were identified. Awareness was defined as coming to a realization related to one's self over the client or clinical impact and/or being aware of an impact. Critical moments identified as awareness fell into two categories: self-regulation and/or self-development and skill development. Thirty-four reflections demonstrated awareness of self-regulation and/or self-development; twenty-three reflections were a demonstration of awareness toward skill development. Table 1 displays journal entries that were a demonstration of clinician awareness within each category.

Reflections that demonstrated awareness toward self-regulation and/or self-development were of moments that participating novice clinicians acknowledged their abilities and/or change of their abilities toward growth as a therapist as well as a person. For example, journal entry 14a was a demonstration of novice clinicians' realization of their self-development; doubt was holding this particular novice clinician from developing their self as a therapist. Journal entry 33 demonstrated the recognition and realization of one's skills and ability toward identifying what needed to occur between client and therapist.

Value 2. Knowledge. Among journal entries were reflections of knowledge that contributed to client care. Knowledge was defined as the result of the learning or result of the awareness; reporting of things learned; or an understanding of a process or concept. Twenty-nine critical moments were identified within journal entries as valuing knowledge. Table 2 displays journal entries that were a demonstration of clinician knowledge toward one's ability to care for

Table 1

Value 1. Awareness

| Awareness | |
|---|---|
| <p>1a. I gained an awareness of my true self, and that awareness allowed me to finally discover who I am; (deciding to stop listening to voices inside head) meant the start of my confidence and my career.</p> <p>1b. ...no images of me as a psychologist. That's when I decided it was time to stop ...most exciting part was not that I opened the doors to my career for the first listening to the voices inside my head. time, but that I opened my eyes to my life for the first time</p> <p>1d. ...awareness of truth and that truth is all we need to become the best version of ourselves. Now the challenge is to teach that to my clients</p> <p>2. I have just begun to grow</p> <p>5a. [kicking parents out of the room] freed me up</p> <p>7c. ...that my anxiety would no longer be a psychological disorder...but excitement</p> <p>13b. [an interest in psychology is] a passion for life, an awareness of the impact you want to have on the world that permeates every aspect of your life. Not just school, not just work. And because of that it changes you.</p> | <p>3b. Allowing me to try and be a therapist in the room</p> <p>4. I realized that my fear of confronting clients came from a fear that if I made them feel at all uncomfortable, I was doing something wrong and risking losing them as a client</p> <p>5b. How awful that the "expert" they've come to see is uncomfortable with facing the conflict</p> <p>6a. I feel a sense of urgency now to teach [riding the wave] to others</p> <p>6b. Sat back in awe as I listened to my family talk about their state in a rigid, emotionless, matter-of-fact way...and felt so awful that they must not know how to access their feelings either</p> <p>7a. Walked into my next session with little or no fear and every session after that</p> <p>7b. I realized it was very unlikely that my next attempt at therapy would be as bad as the first</p> <p>9a. The therapist must endure their own helpless feelings to sit with this client</p> <p>9b. ...as I watched tapes of clients who I was told in supervision were extremely disconnect[ed] from their experiences, I felt myself identifying with them</p> |

(continued)

Table1 (continued)

Value 1. Awareness

| Awareness | |
|--|--|
| 13c. Sometimes your growth stretches other people... | 13a. [look at and comment on process] brings me comfort knowing that whenever I'm "stuck" in a room, 99% of the time commenting on the process will help me along |
| 14a. I doubted my perception of things. But when you doubt your own reality, you have no standard to live by...no foundation | 16. It was pointed out to me that I relayed pity to my client for their situation rather than expressing empathy...it never occurred to me that was an odd response |
| 14b. I realized after a long time that I could tie [doubting my own perception of reality] back to how I was raised. | 17a. I disregarded their shame and other feelings in response to being raped, and I didn't help them but rather induced additional shame by communicating through my tone that I was angry with them...the disappointment that ensued when I became aware of this a week later while transcribing the tape, was overwhelming |
| 15. I had to learn to trust myself without receiving validation from others before I could perform therapy | 17b. Become more aware of countertransference IN THE ROOM, and get it in check. 20. I found that tape after tape, I was talking a lot and not effectively. |
| 18. I realized how accurately our childhood patterns follow us into adulthood | 21. ...to create a new self-story that I was competent...and that created this competence/confidence loop that allowed me to become more confident, and then more competent |
| 23a. Learning to trust myself for the first time was not easy, but it was a journey well worth it. | 23c. Having a supervisor who was able to act genuinely while modeling this |
| 23b. I recall some of the most difficult times in my personal life were times I didn't feel that I was being heard, and/or when I felt I was being told my thoughts/feeling were not valid...we just need the find the "right" people to give it to us | |
| 26a. Letting go is the only way to win the war | |
| 26b. I felt a sense of defeat. I stopped fighting to be a therapist cause clearly I was failing. It was only then that I freed myself up to start doing therapy | |

(continued)

Table 1 (continued)

Value 1. Awareness

| Awareness | |
|--|--|
| <p>28. When my frustration towards a client would occur I came to realize that often time it was because I felt the sessions were not progressing....[becoming frustrated] is often of my own violation, my own doing.37a. I stepped into the room and I can't imagine what would have happened if I kept delaying the process. I found myself in that room, quite similar to the way we aim to help others find themselves</p> <p>42. 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</p> <p>44a. I have felt more at ease stating my opinions with friends and colleagues, as well as sharing more in classroom and supervision settings</p> <p>44b. By [speaking my mind in interpersonal relationships], I was able to create a sense of safety between myself and others that had not previously been there.</p> <p>46a. I have found myself being much more in tune with myself and my surroundings</p> <p>46b. I have found myself better able to adjust to changing moods and feelings...with clients</p> | <p>connectedness with their thoughts and emotions in supervision, gave me the confidence to also stay connected to myself, and the passion to believe I should be helping my clients do this as well 29. Through that growth [of doing less projects] I could better assist my clients in the room because I wouldn't have the distraction or time constraints.</p> <p>31.even in that preparation we have to remember to be flexible</p> <p>32. was through this growth ...that I began to apply and grow across the board to other clients</p> <p>33. [a paper sitting off to the side of a patient] was enough to cue me to know that there was something going on - and on a subconscious level it was enough to prompt me to ask</p> <p>37c. ...after those first few weeks of training before seeing clients I couldn't possibly imagine a week going by without seeing some of my clients. They're now under my care, I have to be responsible.</p> <p>39. It was impossible for me to "interrupt" someone or filter in key words or phrases</p> |

(continued)

Table 1 (continued)

Value 1. Awareness

| | Awareness |
|---|---|
| 47. ...I am much more likely to ask questions and I have found that I have many more questions about things than I had even realized...I am able to acquire much more detail about even my closest friends' experiences... | where necessary...I sat in silence. I waited, waited. Like most other conflicts I've come across, it was simply a matter of insight, recognizing that I was doing something wrong that was not benefitting my clients, so I made the change 43b. [sharing concerns and feelings instead of shutting down and keeping to myself] |
| 48. I am still finding my voice, but as I keep challenging myself, I have found only reward from this process and no drawbacks | had allowed me to...model this behavior in the room with my clients. |
| 49a. I have been able to catch onto warning signals in my body much quicker than before | |
| 49b. ...when I learned that feelings are body sensations that last a short while, they come in like a wave and then they pass. All I had to do was ride the wave...I kept at it, with encouragement from my supervisor and colleagues, and I have now found myself to be much more in tune with my own process and moment to moment experience which in turn allowed me to make better decisions especially in my dating life | |
| 50b. ...want to contribute to others' lives and share with them a way to become more. This drive and desire to share and help others is what has inspired our work under our supervisor | |

(continued)

Table 1 (continued)

Value 1. Awareness

| Awareness (continued) |
|---|
| 52....hearing my supervisor talk about change shifted my view...this shift in my mindset has facilitated my ability to be less rigid...more open to improvisations and spontaneity |
| 53. When I would start to feel down I would remind myself of [that as you become more confident, you become more competent and the other way around] think about where I was a month ago, and seek out a listening ear in one of my colleagues 54a. [having access to my feeling of anger gave me much more insight into myself]...helped me navigate out of toxic relationship successfully. |
| 54b. ...my supervisor challenged me on naming a particular feeling...they said something along the lines of “I wonder if this is a feeling you often avoid.” As soon as I actively started feeling anger when it was present, I was able to understand it more and use it to my advantage54c. ...my supervisor challenged me on naming a particular feeling...they said something along the lines of “I wonder if this is a feeling you often avoid.”...having access to my feelings of anger gave me much more insight into myself |

clients. Concepts learned or awareness of the knowledge gained were reflected in several journal entries, such as journal entry 18a. This particular reflection of knowledge gained not only was acknowledging the specific idea, i.e., theories, but of perceived application toward one's personal life as the result of knowledge learned. Journal entry 32 demonstrates the transition of learning to the result of knowledge learned.

Table 2

Values 2. Knowledge

| Knowledge |
|---|
| 2. Knowing why the psychological diagnosis is happening that makes it go away |
| 4. So I kicked my parents out of the therapy room and decided to get to work |
| 5a. It's very clear to me that [problem solving], that it's the default approach to addressing conflict in life for so many people |
| 5c. This [kicking my parents out of the room] freed me up to slow down, listen, respond with empathy and open-ended questions, and allow the client to discover their own "solutions" |
| 8b. Having this ability [acknowledging client's affective states] to bring to light something that the client is not for whatever reason is an invaluable tool |
| 9. I am glad to be able to identify with [feeling disconnected] because I understand the disinterest and fog that comes with being disconnected from your self |
| 10. [doctorate program] is where I hit the wall...try new things and mess them up, because it's the only way you start down the road to integrating them as new knowledge |
| 11. How I can use [knowledge] to help clients and gauge where they are at in their psychological growth |
| 12. I've learned to keep much of what I think I know about family to myself in effort to leave doors closed |
| 15. I had to learn to trust myself without receiving validation from others before I could perform therapy, especially before I could confront any clients |

(continued)

Table 2 (continued)

Values 2. Knowledge

Knowledge

explanations for some things

16. Being empathetic is to acknowledge the difficult situation...the client then recognizes their own ability to deal with unpleasant affect because they see that you have faith in their emotional strength

17. Sometimes neglecting aspects of yourself, no matter how much you think you have them “under control” can result in hurting your client....What I did (countertransference) was not ok

18a. ...take theories we’ve learned...make patterns...more clear so we can understand and reverse [patterns] when they continue to happen, in order to reverse them...I can understand it on a personal level

18b. ...to take some of the theories we’ve learned, and apply it to our own lives to provide explanations for some things

18c. ...this lesson [of understanding and recognizing bad patterns when they continue to happen] I’ve been able to take into therapy and use with my clients, because I can understand it on a very personal level

19. I knew there was no evidence for the client thinking I was incompetent...because it was just silence

20b. ...know that I cannot and should not try and “fix” my clients feelings but rather should listen, validate, and sit together with them.

23. This [connection to thoughts and feelings] allowed me to maintain the positive change within myself and then teach it to others

26a. I am grateful for my client’s relentless fight because the person showed me that sometimes letting go is the only way to win the war.

26b. It was then I knew if the person couldn’t win the battle, the person had to accept defeat

29a. Through that [exponential] growth I could better assist my clients.

(continued)

Table 2 (continued)

Values 2. Knowledge

Knowledge

32. ...the stare was a blank one for few moments, and I suspected I did a terrible job of explaining [the difference between content and process]. ... After the differentiation between the two we began cueing to conversations we could easily identify as content or process, making the experience significantly easier with other clients
33. It is by creating that safe space that we allow ourselves the opportunity to dig deeper into our clients challenges and in doing so, we can present opportunities to overcome these challenges
34. I learned that my fear wasn't that I would yawn in front of a client. My fear was that I would disconnect from them, therefore being unable to help them
38. We learn, because it will help our clients
39. You acculturate to the therapist culture. It's no longer about "interrupting" a client as they're talking, or making statements or responding to questions. Now it's about becoming involved in a conversation, rather than a monologue. I felt acculturated into my own career.
42. My supervisor described psychological disorder in such a way that I have been able to decompress much quicker than before when I feel psychological disorder. This involved riding the wave and allowing myself to experience and express my experiences.
45. I paid even closer attention, took more copious notes, spent more time outside reading and also attempted to apply all knowledge directly to experience I have had either in my personal or professional life
48. Recently, I have come to a deeper understanding of shyness and that it is linked to the misuse of my voice. I have discovered that when I do speak up and contribute I am able to create and to add to a conversation in a way I hadn't before and this has given me a sense of agency and confidence.
-

Value 3. Bravery. Within self-reflections, participating novice clinicians described critical moments of bravery. Bravery was defined as being brave or acting on something that makes one feel vulnerable; taking a risk. Ten critical moments were identified among journal

entries. Table 3 displays journal entries that demonstrated bravery during participating novice clinicians' supervision program. Some novice clinicians noted perceptions of themselves or the situation they were experiencing that would lead to bravery. Journal entry 41c demonstrates a novice clinician's new perception of themselves in order to grow professionally. Other critical moments that were demonstrated as bravery came from information provided by others or lessons learned about themselves or others. As reflected in journal entry 36, one novice clinician recognized bravery within herself based on the interaction and learning from her supervisor.

Table 3

Value 3. Bravery

| Bravery |
|--|
| 36. It took me a full week before I gathered the courage to discuss it with my supervisor, because I recognized it was something I should address sooner than later...with my own need for bravery |
| 37b. This was the first application of bravery came into place. It was time to step out of my comfort zone and be brave [to step into a room with my first client], and so I was |
| 41a. The shift in attitude [toward being brave] is what allowed me to go into the room on the first day with a client and to try new techniques with a client |
| 41b. This bravery on my part is what makes me congruent with what I am ultimately asking of my clients |
| 41c. Being brave is now a motto that I live my life by. |
| 43a. What I have come to realize is in the moments of vulnerability I have a choice to either be brave or to cower, I choose bravery |
| 43b. I have found strength and resiliency from moving toward the vulnerability instead of away from it. |
| 50a. In just a short time I feel I like I am becoming braver, wiser and more attuned to myself and others |
| 51a. I remind myself frequently to "be brave" in regards to sharing a mistake in supervision, attempting a new technique with a client, or in my personal life... |
| 51b. I am experiencing first-hand the benefit from doing things that require bravery (for me personally) |

Value 4. Competence. Among journal entries were reflections of a perceived competence. Competence was defined as clinical impact or work with clients and/or the specific application of knowledge to a client or with a client. Nine critical moments were identified

within journal entries as competence. Table 4 displays nine journal entries that were demonstrations of clinician’s valuing competence. Journal entry 31b demonstrates valued competence as a moment of growth in helping clients.

Table 4

Value 4. Competence

| Competence |
|---|
| 8. Now I have accomplished being physically present |
| 9. Sitting with them in their experience of hopelessness |
| 17. Sometimes neglecting aspects of yourself, no matter how much you think you have them “under control,” can result in hurting your client. |
| 23. ...showed me that we were not teaching our clients things that we ourselves were afraid to do, but rather we were teaching things that we knew worked to improve well-being |
| 27. We adapt to every patient we see, we adapt our treatment plans, we adapt our diagnosis, and we adapt our procedures. There is no other way to do it |
| 31a. Simultaneously we have to adjust for [new information] within the context of our treatment planning |
| 31b.even in that preparation we have to remember to be flexible [with clients] |
| 33. By attending to those sensory acuities, we allow ourselves the opportunity to dig deeper into the content of a conversation and allow it to shift towards process |
| 39. You engage with the client in conversation because it’s what we do |

Value 5. Learning. The value of learning was defined as the process of gathering knowledge and/or transition of gathering new knowledge. Among journal entries, nine critical moments were identified as moments of valuing clinician learning. Participating novice clinicians’ reflections included demonstrations of learning a concept or the process of understanding a concept toward their development as a therapist. Table 5 displays journal entries that were a demonstration of clinician learning.

Table 5

Value 5. Learning

| Learning |
|---|
| 5b. Didn't know it [I was jaded] until I played the tapes for my supervisor and knew something was off and when the phrase "problem solving" came up, I have had "uh-oh" moment |
| 8a. I finally learned how to sit in a room with a client |
| 7. I had built up this fear and psychological disorder of 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 feel again |
| 12. This puts you as a trainee in an interesting position...you don't really know what you're talking about just yet but you want to help |
| 20a. I learned I had to become comfortable with my own experience of helplessness in order to sit with silent moments |
| 21. The person taught the concept of updating your self-story to one that is positive, by recognizing all the evidence to the contrary |
| 23. I feel [because we experienced it first hand and could testify to its success] was the validation I needed as an emerging therapist.... |
| 29b. By having the "break" [the semester break] in the chaos...I didn't have to work on 10 projects at one time to feel productive, if I focused my energy on a few limited projects I could grow exponentially. |
| 39. Now its about becoming involved in a conversation, rather than a monologue...within two weeks I was able to have dialogues, not monologues... |

Value 6. Humility. Within journal entries, eight critical moments were identified as humility. Humility was defined as an unassuming approach or openness to learning. Participating novice clinicians described moments of vulnerability and honesty toward becoming a therapist. Table 6 displays journal entries that were a demonstration of clinicians valuing humility.

Value 7. Community. Among journal entries were reflections of experiences of community that involved others' support (peers, supervisors, and/or significant others); each of which helped promote the novice clinicians' personal or professional growth. Community was defined as

Table 6

Value 6. Humility

| Humility |
|---|
| 2. ...how could I have expected myself to see what my peer saw in my work when I do not have the height to see yet |
| 3. I can't learn if I don't make mistakes, and I can't make mistakes if I physically unravel every time an opportunity to try something new presents itself |
| 19. I especially had trouble in therapy with silences, because I always filled the silence with the idea that I was incompetent as a therapist and that the client was perceiving me in that way...taught me a lot about my tendencies to doubt myself and helped me combat these thoughts |
| 22. I find it difficult to discuss because on one hand I want to defend them, but on another I cannot find a way to do it successfully with respect to making racist jokes...is a challenge to my ability to live a congruent life. But no one said it would be easy! |
| 23. Experiences of being truly connected to my thoughts and feelings was very new for me...I had to look to others to find a different standards for how to experience your thoughts and emotion, to determine if I was going about it in the best way |
| 35. I was filled with this tremendous amount of guilt knowing that I could answer so many of the questions that could have helped this clinician help their client, yet simultaneously learning things about my friend that I might have never learned otherwise...it wasn't until I absolutely had to make the choice to share it [with my supervisor]...that was only one in a litany of mistakes that I made. But here I stand with a second chance to teach my peers a lesson |
| 41. I am still unsure about many aspects of becoming a therapist but the difference is that I willing and actively making myself vulnerable... |
| 45. During the last class of the day, a professor...challenged us to make this change in attitude: to view our education...as a means to provide the best care for our clients. I realized I am no longer learning just for myself, I am learning for any client I may see this year or any year after. This attitude has greatly impacted the way I approached the program |

seeking out others for support. Six critical moments were identified as the value of community. Table 7 displays journal entries that were a demonstration of community. Journal entry 2 is a demonstration of growth acknowledging the support of a peer. Another novice clinician experienced growth, both personally and professionally, through the support provided by those closest to them, as pointed out in journal entry 13c.

Table 7

Value 7. Community

| Community |
|--|
| 2. ...[talked to a classmate who pointed out participant's peer is still growing) How could I have expected myself to see what my peer saw in my work when I do not have the height to see yet |
| 6. ...[significant other] accepted my sorrow and the intensity of my pain in that moment |
| 13c. ...then you go home and you talk to your partner, friends, and/or family about [changes made that day in graduate school], because it's profound as far as you can see. |
| 50. ... six of us have all felt a monumental shift in our growth and development (on a personal level)... |
| 51. From these relationships I have been more bold in trying new things, which is making me a more well-rounded person and also a happier one |
| 53. When I would start to feel down I would remind myself [when you become more confident, you become more competent and the other way around], think about where I was a month ago and seek out a listening ear in one of my colleagues |

Value 8. Acceptance. Five journal entries from participating novice clinicians included self-reflections of critical moments that demonstrated acceptance towards one's growth.

Acceptance was defined as coming to terms with a hard truth or a need to change. Table 8 displays journal entries that were a demonstration of clinician acceptance. Journal entry 10 exhibits a critical incident or moment of change; specifically acknowledging and accepting that "not doing things well" is the exact change that needs to occur to move forward. Similarly,

Journal entry 3a points to accepting change within one's self; acknowledging and accepting the state one was in and where one needed to be in moving toward their role as a therapist.

Table 8

Value 8. Acceptance

| Acceptance |
|---|
| 3a. I stopped trying to be a 'good therapist' and I just settled for 'student' instead |
| 4. So I gave [my past] some attention and slowly learned to trust my abilities and my feelings |
| 10. The not doing things well is exactly what needs to happen because it's a step in the right direct[ion] |
| 21. ... "reality testing" I believe it's called. I realized that this was my answer to understanding myself as a competent therapist... I had to take all this information and internalize it to create a new self-story that I was competent |
| 30. I had to experience the change before I could instill change |

Value 9. Openness. Journal entries also included reflections of a perceived openness towards one's growth as a therapist. Openness was defined as a general open approach to gathering new info or changing as a result of new learning. Five critical moments were identified within journal entries as a demonstration of valuing openness. Table 9 displays journal entries that reflected novice clinicians' openness.

Value 10. Curiosity. Only two journal entries reflected curiosity as a value contributing to their growth as a therapist. Curiosity was defined as being interested or questioning knowledge and/or learning. Table 10 displays journal entries that demonstrated clinician curiosity about their client care ability. Both moments of curiosity were perceived as a moment of growth in becoming a therapist.

Table 9

Value 9. Openness

| Openness |
|--|
| 10. [making mistakes as part of the process of growing] sometimes you get things right and it's encouraging and then you get "knocked down" when you don't do something as well |
| 30. There was a moment I thought I had a clutch portion of my life under control, fully understood, developed and accomplished...allow myself the opportunity to experience what I had to experience |
| 36. I drank in excess for four days in a row immediately after the semester ended...it was all about loss...but it was also the start of a new year |
| 43. I decided to change this [avoiding vulnerability] about myself and I began to speak my mind in my interpersonal relationships |
| 44. As I began to learn more about [vulnerability] and challenge my clients to move toward vulnerability, I began to look more critically into my mechanisms of avoidance...I experience the feeling and express it in the moment which provides me a sense of congruency and power I never thought possible |

Summary

Qualitative content analysis of 54 reflective journals from the three participants of the study revealed ten themes. Two of these themes had highly substantial presence in the results and thus will be referred to as "major themes," while the remaining eight themes had significantly less presence and therefore will be considered to be "minor themes." The two major themes that emerged from the analysis were awareness with 57 occurrences and knowledge with 29 occurrences. Awareness, which was defined as coming to a realization related to one's self over the client or clinical impact and/or being aware of an impact, was further subcategorized into two sub-themes: awareness of self-regulation or self-development with 34 occurrences and awareness toward skill development, which had twenty-three occurrences. Given that each of these sub themes had enough occurrences to be considered a major theme—over twice that of any minor theme—awareness can be said to be the most pronounced result on the whole. The other major

Table 10

Value 10. Curiosity

| Curiosity |
|--|
| 44c. By reframing the delivery of curiosity in my mind...I am more at ease asking [clients] direct questions or making confrontations |
| 47. One thing that I have learned through supervision is a concept that has propelled me through life: curiosity...I would call myself a quietly curious person. However this has changed ever since I have looked at it in a new way...being curious, in a kind way, is almost always received well and responded to enthusiastically |

theme, knowledge, was defined as the result of the learning or result of the awareness; reporting of things learned; or an understanding of a process or concept, and had no notable subthemes. Although less pronounced than awareness, the occurrence of knowledge was still nearly thrice that of the most widely occurring minor theme.

The eight minor themes were, in order of prevalence, bravery, competence, learning, humility, community, acceptance, openness, and curiosity. Bravery was defined as acting on something that makes one feel vulnerable or taking a risk and occurred in 10 of the journal entries. Competence was defined as clinical impact or work with clients and/or the specific application of knowledge to a client or with a client and occurred in nine of the reflective journals. Also appearing nine times was learning, which was defined as process of gathering knowledge and/or transition of gathering new knowledge. Thus, learning has a clear relationship to the second major theme of knowledge. The next theme, humility, was defined as an unassuming approach to learning and appeared eight times. Community was defined as seeking out others for support and occurred in six of the reflective journals. Acceptance was defined as coming to terms with a hard truth or a need to change, and occurred in five journals. The value of openness occurred as a theme in five journals and was defined as a general open approach to

gathering new info or changing as a result of new learning. Finally, curiosity defined as being interested or questioning knowledge and/or learning and occurred in only two instances. Thus, despite its clear relationship to the major value of knowledge, it was barely present in the findings at all. Overall, although there was a greater percentage spread amongst the minor themes—the least having only 20% as many occurrences as the least—this spread was significantly less in numerical terms (a difference of 8 between bravery and curiosity) than that between the major themes (a difference of 28 between awareness and knowledge).

Chapter 5: Summary, Conclusions and Recommendations

The purpose of this study was to answer the research question: “what values emerge in clinical training/supervision that orient a novice clinician toward personal growth?” Using 54 reflective journal entries detailing “critical moments,” a qualitative, autoethnographic study was undertaken to investigate the clinical training/supervision experiences of three novice clinicians in the first year of one clinical psychology doctoral program.

Researchers have expressed concern about the personal development of the novice clinician especially relative to personal factors; “training is a potentially disturbing personal journey that requires a deconstruction of the self in order to make space for the new therapist-self to emerge” (Folkes-Skinner et al., 2010, p. 274). The need for such research has been affirmed by a significant number of scholars (Auxier, Hughes, & Kline, 2003; Bennett, 1986; Borders, 1989; Coleman, 2006; Ellis, 1991; Gibson, Dollarhide, & Moss, 2010; Grafanaki, 2010; Hanna, Bemak, & Chung, 1999; Hill, Sullivan, Knox, & Schlosser, 2007; Matthews, 2012; Rønnestad & Ladany, 2006; Rønnestad & Skovholt, 2001; Skovholt & Rønnestad, 2003; Taubner, Zimmermann, Kachele, Moller, & Sell, 2013; Theriault & Gazzola, 2010; Trotter-Mathison, Koch, Sanger, & Skovholt, 2010; Truell, 2001). Therefore, this study endeavored to understand the values that emerge throughout the course of clinical training / supervision and how each of these values may contribute to the personal growth and development of novice clinicians.

This chapter discusses and expands on the study findings by contextualizing them through existing research literature. Conclusions are noted, followed by implications of this study; finally, recommendations for future studies are described.

Conclusions

Ten values were uncovered in the study. In order of occurrence from highest to lowest, were awareness, knowledge, bravery, competence, learning, humility, community, acceptance, openness, and curiosity. Given that the first two values occurred at least three to five times as often as the other eight, the first two values will be termed “major values,” while the other eight correspondingly become “minor values.”

Awareness and knowledge are both intended outcomes of the supervisory process (Greenfield, Anderson, Cox, & Tanner, 2008; Luke & Kiweewa, 2010), and so their prevalence is to be expected. It is also unsurprising that bravery should rank highly, as fear of failure, an experience that often prevents clinicians from helping others, can be overcome through bravery or courage (English, & Sutton, 2000). While competence might have been expected to have been identified with greater frequency, it is aligned with the two major values as being an expected and desired result of supervision (Epstein & Hundert, 2002).

One possible explanation for the relatively weak presence of learning, community, humility, openness, and curiosity as values is that novice clinicians are more open to structured learning than unstructured learning. This would explain the high prevalence of awareness and knowledge, which are values explicitly fostered by the structured nature of education process, and also why the values that would relate to more unstructured learning through community, openness, and curiosity are less represented.

The first major value identified, awareness, is pronounced in the literature. Various factors can contribute to the growth of awareness, and other studies have sought to identify some of these factors as a foundation for personal development on the part of clinical trainees (Luke & Kiweewa, 2010). Developing self-awareness as a value is often a goal of clinical instruction

programs with significant resources directed toward producing it in novice clinicians (Lennie, 2007). The presence of awareness as a value in the findings is in keeping with the person-of-the-therapist model, in which awareness is a crucial aspect of the therapist's growth and thus both personal and professional development (Aponte et al., 2009). Indeed, the need for self-awareness and awareness in general extends beyond clinical psychology; its importance has also been noted for medical clinicians (Severinsson, 2001).

The development of awareness as a value also plays a somewhat meta role with regard to values, in that awareness itself—especially as self-awareness—can include the awareness of values (Collins & Pieterse, 2007). In this sense, developing the value of awareness becomes a necessary condition for personal growth (Collins & Pieterse, 2007); through valuing awareness, the novice clinician becomes more aware of his or her other values and how they shape his or her perceptions and actions. Thus, awareness may be thought of as a foundational value upon which other values that promote personal growth may be built.

The value of knowledge was the second major theme identified in this study. In a very basic sense, knowledge as a high value is not surprising given the point of clinical education is ultimately to acquire knowledge. Thus, one might anticipate that novice clinicians would hold knowledge similarly as a high value. The importance of acquiring certain skills and attitudes is emphasized in clinical education (Greenfield et al., 2008). The importance of knowledge was likewise noted by Spruill et al. (2004), who explained that a clinician may be technically proficient at psychological interventions but remain ineffective if he or she lacks knowledge, abilities, skills, and values that will allow him or her to become independent for practice. Personal growth and knowledge are inseparably intertwined by their very nature, and personal growth cannot occur in the absence of knowledge (Tesoriero, 2006).

Therefore, valuing knowledge can be seen as a catalyst for the process of personal growth; even if the other requirements for personal growth are met, it will not come about without the necessary knowledge to create a change (D'Amato, & Krasny, 2011). Valuing knowledge also makes a novice clinician more likely to experience transformative learning, as knowledge is a necessary part of the transformative learning process (Mezirow, 2009). Thus, in many ways, valuing knowledge resembles that of awareness; novice clinicians holding or developing knowledge as a value is expected and desired from the supervisory process.

Bravery was the most pronounced value of the minor themes. While the applications of bravery to the process of personal growth may be intuitively obvious—that bravery allows a person to confront difficult situations and unpleasant realities—the literature exhibits a dearth of research specific to bravery, save perhaps to note it as a characteristic of moral exemplars (Walker, 2002) or that it is important for supervisors to be brave in providing feedback to novice clinicians (Tsui, O'Donoghue, & Ng, 2014).

However, the closely related concept of courage has been studied more widely by scholars. In medicine, for example, Lachman (2007) identified courage as a value in need of further development, suggesting that moral courage may be the only ethical response to situations that create moral distress, such as those in which a practitioner understands what should be done but feels unable to achieve this. This notion is easily extended to psychology and developing clinicians; bravery is a value and virtue that may allow novices to take necessary action in spite of personal risk or perceived vulnerability, an important quality in one whose work is essentially helping others. In an additional study, courage was considered both important for counselors and synergistic with therapeutic processing (Hewitt, 2014). Bravery is also essential in overcoming the fear of failure, which can be a powerful limiting factor to

successfully helping others (English, & Sutton, 2000). Thus, valuing bravery more highly could lead to the development of courage as actual quality novice clinicians embody.

Competence was the next value found in the study. Competence as a value was identified by journal entries that reflected awareness of impact, whether with a client or the personal realization of one's impact on others and appreciation of the importance of competency in one's practice. Promoting competence is one of the primary objectives of education in a broader sense (Brotman, Liberi, & Wasylyshyn, 1998); the development of competence as a value may encourage personal growth by encouraging novice clinicians to place a greater importance on developing their own skills (Epstein & Hundert, 2002). Given its importance in education, one might have expected the value of competence to rank more highly in the results.

Learning was the fifth value identified from participant responses and is deeply related to knowledge, as learning represents the acquisition of knowledge. Learning from clinical educators through opportunities in professional development workshops and mentoring is important (Higgs & McAllister, 2007). Multicultural competence training for novice clinicians highlights knowledge and skills acquisition, or learning, as important values needed by a clinician to become effective (Hanna, Bemak, & Chung, 1999; Sue & Sue, 2003).

The essential difference between knowledge and learning lies in the fact that knowledge represents the application of what the trainee already knows, while learning refers to placing value on the knowledge acquisition process itself. In this study, knowledge was more highly valued than learning; perhaps novice clinicians are reluctant to change themselves and prefer structured activities where they can apply what they already know as opposed to those activities or experiences that require considerably more effort to learn new things.

Humility was the next value identified. Brymer and Oades (2009) found that humility promotes an openness to transformational experiences such as personal growth. The unassuming nature of humility as a value is important as it can allow the transformational learning suggested by Mezirow (2009) to occur by removing some of the barriers represented by existing preconceptions and assumptions. Thus, humility as a value opens the novice clinician to the learning process, lowering barriers and promoting personal growth (Snow, 1995). However, valuing humility too highly could ultimately come into conflict with valuing knowledge; knowledge is, by nature, a form of preconception, and valuing humility too highly could lead to an erosion of confidence in the knowledge obtained through the supervisory process (Standish, Smeyers, & Smith, 2006). The presence of humility as a value is important, as it reflects an openness to learning and growth. Given the relatively few times it was identified as a value, perhaps its ranking in this study speaks to ambivalence about change and the efforts required to enact or achieve change.

Community was the seventh value identified. The use of the psychological community for accurate self-awareness and support can be encouraged by training programs that have the power to shift current concepts regarding how personal difficulties are identified and addressed (Binnie, 2011). Community is a factor often used to promote personal growth through interaction with others and the resulting exchange of ideas, especially in counseling students (Lennie, 2007). In many cases, values develop in relation to the prevailing opinion of community, and personal and communal values can be interdependent (Sagiv & Schwartz, 2000). However, community had a relatively weak presence as a value relative to the other values in the study. One potential implication is that a lack of value on community could lead to a lesser focus on multicultural competence and less intercultural contact (Díaz-Lázaro & Cohen, 2001). Lack of community as a

value may also serve to reflect the methods of the program, as certain approaches such as service learning would more actively foster this value (Burnett, Long, and Horne, 2005).

Acceptance was the eighth identified value and has long been considered an essential component of the personal growth process (Zhang & Chen, 2016). Acceptance was defined as coming to terms with a hard truth or a need to change. While some acceptance can promote growth, too much acceptance may lock a person into the way things presently are (Oldham, 1975), and acceptance does not necessarily correlate to increased effectiveness. Acceptance may also have weaker effects on promoting personal growth than other factors (Prati, & Pietrantonio, 2009). Acceptance is also tied to making mistakes and coming to terms with them (Zhang & Chen, 2016); thus, one possible reason for the middling presence of acceptance as a value could be that there were a limited number of mistakes that the novice clinicians came to accept.

Openness was the next-to-last noted value. While humility is concerned with taking an unassuming approach to learning, openness more explicitly represents a willingness to change in response to new ideas or experiences; it was defined as a general open approach to gathering new info or changing as a result of new learning. Though, openness: (a) has been found as a predictor of constructive personal growth (Zoellner, Rabe, Karl, & Maercker, 2008); and (b) is linked to transformative learning (Mezirow, 2009) and the development of wisdom (Le, 2011), its presence as a value in this study was quite weak. One possible explanation is that novice clinicians might not want to change themselves even as they seek to help others. It is also possible that participant's learning experiences were not transformative in nature, or that students have simply become accustomed to structured learning experiences such as class work and supervision; thus more openness was not generalized to the supervisory experience.

The last identified value was curiosity, which barely appeared. Curiosity has been noted to be an under-researched value in general (Kashdan & Silvia, 2009). However, curiosity relates highly to both knowledge and learning. It has been noted to be a positive emotional motivator for goal attainment and challenging oneself, especially with regard to learning (Kashdan, Rose, & Fincham, 2004). Curiosity is also highly associated with accepting and embracing new circumstances and experiences (Karwowski, 2012). Therefore, valuing curiosity intuitively leads to valuing learning. In addition, however, curiosity as a value may lead to greater exploration of oneself and values, linking it to awareness, and on the whole leading to personal growth (Kashdan et al., 2004).

In the sense of its connection to new experiences and circumstances, curiosity is related to openness, and both of these themes were weakly represented in the results. Curiosity is also related to knowledge, and so the low presence of curiosity is surprising in light of awareness and knowledge dominating as major themes. The low presence of curiosity as a value might suggest that the participants did not value wanting to learn about new things—and a lack of curiosity can indicate an intolerance for uncertainty (Kaczmarek, Bączkowski, Enko, Baran, & Theuns, 2014). It could also be indicative of information processing styles, which have been found to predict the degree of importance given to curiosity and cognitive closure (Mikulincer, 1997). Another possible reason for the weak presence of curiosity lies in the hypothesis that novice clinicians may be more open to structured learning experiences such as those in the supervisory process than to unstructured and more self-motivated learning experiences.

Limitations

There are several limitations to this study. The use of a small, homogeneous sample size under the direction of a single supervisor, as well as purposive sampling, potentially limits the generalizability of study findings. The sample may not have been an accurate representation of novice clinicians within a clinical psychology program at a private university. Additionally, purposely selecting participants under a single supervisor may not accurately depict critical moments among novice clinicians; not all supervisors instruct and supervise their students in the same manner and therefore their students may not experience critical moments similarly. A sample of novice clinicians under various supervisors may have provided a broader range of critical moments more generalizable to the greater population of novice clinicians. Further, a self-selection bias, resulting from study participants having voluntarily engaged in and submitted their journal entries for this type of research, may indicate bias in the data emanating from participant interest in the research topic area.

As data collection involved self-reflection, it is widely known that individuals possess limited capacity to self-assess accurately; the self-reporting nature of the data used in this study should be interpreted with caution (Dunning, Heath, & Suls, 2004). Although study participants were aware of their journaling, their entries may have not been an accurate self-assessment if distractions were occurring simultaneously; distractions such as assignment deadlines and phones, televisions, or even others in the room may not have allowed study participants to fully journal their self-reflection. Furthermore, the social desirability response bias is likely to have played a role in the writing of the journal entries. Thus, the data may under-represent undesirable characteristics and processes, and over-represent those thoughts to be perceived as desirable (Zerbe & Paulhus, 1987).

The researcher may have failed to represent the results accurately by failing to develop a thorough understanding of its context and consequently identifying fewer categories than may actually be represented by the data (Hsieh & Shannon, 2005). Additionally, the researcher's past experiences, biases, culture, and background may result in a filtered method of coding that differs from the manner in which a different person would interpret the same data. Furthermore, the researcher's decision to forego both the use of qualitative data analysis software and to conduct the content analysis without the approval or explicit direction of her dissertation committee may have resulted in an analysis that was more biased and less accurate than had these resources been employed.

Participant journal entries were analyzed and categorized under the most appropriate value within the context of the journal entry; however, words or phrases may be perceived as within a different context than actually intended by the participant. Lastly, it is believed that additional sources of data would have strengthened reliability.

Implications

These results suggest certain implications for the participants, for professional practice. The two major values, awareness and knowledge, may be foundational values. Improvements in the supervision process have been called for by many researchers (Grafanki, 2010; Rønnestad & Ladany, 2006; Rønnestad & Skovholt, 2001, Skovholt & Rønnestad, 2003; Truell, 2001). The results of this study provide a preliminary suggestion about the values that may arise in clinical training. Given its position as both antecedent of growth and result of transformative learning (Mezirow, 2009), the value of openness could perhaps benefit from being more prevalent in novice clinicians.

Greater openness would potentially increase transformative learning—or more transformative learning might serve to create more openness. On the other hand, these results suggest that the nature of the participants' supervisory experience was particularly effective at fostering awareness and knowledge, important foundational values. Aspects of the supervisory process in the current study—such as the critical reflection process itself, which likely contributed to the prevalence of awareness—could be applied to other programs that are experiencing difficulty developing these values in novice clinicians. Aspects that seem to have been particularly influential for the development of awareness and knowledge and values include putting novice clinicians in a setting where they are both highly aware of what they know and must confront the limits of their present ability.

These results contribute to the body of knowledge on the supervisory process, which lacks research from the perspective of novice clinicians (Kiweewa et al., 2013) and needs more research with respect to the development of values (Trotter-Mathison et al., 2010). Understanding how novice clinicians' values develop may help to improve their self-efficacy, which in turn may improve their confidence and abilities to manage their own emotional responses to clients (Hill et al., 2015). These changes may help new therapists develop emotional strength or resilience, which can subsequently reduce the experience of work-related stress and decrease burnout (Pack, 2014; Schaufeli, 2012; Stafford-Brown & Pakenham, 2012).

Enhancing personal growth processes during initial training may also improve novice clinicians' abilities to provide therapeutic services to clients (Nissen-Lie, Havik, Hoglend, Monsen, & Ronnestad, 2013), which would be of direct psychological benefit to clients seeking treatment from novice clinicians. Since all the values uncovered in this study promote personal growth, understanding them may allow for such enhancement to be more effectively fostered.

Recommendations

The current study adds to existing literature on the clinical training process, specifically increased understanding of what values emerge during clinical training and how these values can promote personal growth. However, additional research could extend findings from the current study. Conducting a similar study using a larger sample size could provide additional and different insight into the values that emerge in the training of novice clinicians. Additionally, using a heterogeneous sample of novice clinicians could provide insight into the different ways that values emerge across different groups, such as males and females or of different ethnicities. Studying a diverse sample can benefit training programs toward professional development of novice clinicians by learning what population groups perceive as areas needing greater professional development.

Another interesting avenue for future research would be to focus on the values that were weakly represented (e.g., curiosity) in this study. Placing a low importance on curiosity could represent a dangerous intolerance of uncertainty (Kaczmarek et al., 2014), or be explained by more benign factors such as different styles of information processing (Mikulincer, 1997), and the scope of this study is not large enough to determine which created the low incidence of curiosity as a value. Thus, to understand this, future qualitative studies might explore the perceptions of other novice clinicians about curiosity and why they feel it is or is not present as a value emerging from their experience with training and supervision. On the other hand, a quantitative approach could be used to probe the prevalence of curiosity on a much larger scale, to determine whether or not the results of this study suggest a low value placed on curiosity by novice clinicians as a whole. Similar approaches might be applied to the weakly represented themes of community and openness. Alternately, such studies might instead seek to determine if

there are any values that develop during clinical supervision that inhibit rather than encourage personal growth.

Lastly, the setting of the current study was of one clinical psychology doctoral program within a private university. Conducting the same study within clinical psychology programs at public universities may yield different findings. Similarly, extending the study sites to clinical psychology programs at multiple public universities could benefit training programs that enroll many transfers or older students. More research into the growth-promoting values that emerge over the course of the training and supervision process can only benefit both novice clinicians and their future clients. Future research could also include supervisor observations of growth, clinical outcomes, or measures of novice clinician change over time.

Final Thoughts

Participating novice clinicians were asked to journal about critical moments during their clinical supervision and training program. Thematic analysis of reflective journal entries suggested two major values, awareness and knowledge, as the values that may most orient novice clinicians toward personal growth. Minor values that emerged were bravery, competence, learning, humility, community, acceptance, openness, and curiosity. Participating novice clinicians pointed to acceptance, curiosity, community, and bravery as values contributing to one's approach to learning and personal growth from their experience in supervision. Humility and openness are values that were less endorsed by novice clinicians as they engaged in clinical practice and subsequently missed in one's role as therapist. All of these values served to promote personal growth, however.

These findings are important because personal growth contributes meaningfully to the development of the effective therapist (Hill et al., 2015). Thus, understanding the values that lead

to personal growth suggests a path by which it might be reached. Moreover, though, these results illuminate how certain values that develop naturally in the clinical supervision process promote personal growth. While understanding this is valuable in itself, it also provides a potential venue through which to make the improvements that researchers (e.g. Grafanki, 2010) have called for with respect to the clinical supervision process. Clinical psychology training programs can benefit from a heightened focus on activities that promote self-reflection self-awareness – each are elements of the training process that lead toward transformative learning. (Mezirow, 2009).

Those changes are the same ones that clinicians can instill in their clients (Brotman et al., 1998). As the study shows, and was part of a journal entry by a participating novice clinician, one has to “experience change in order to instill the change in others.” Thus, the understanding of how values emerge in the context of clinical training and supervision provides not only insight for professional improvement on the part of clinical training programs, but it is also a valuable tool for self-analysis on the part of novice clinicians.

REFERENCES

- American Counseling Association. (2005). *ACA code of ethics*. Retrieved from <http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx>
- American Psychological Association (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist*, 55(12), 1440-1451.
- American Psychological Association (2002a). *American Psychological Association ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code2002.html>
- American Psychological Association (2002b). Criteria for practice guideline development and evaluation. *American Psychologist*, 57, 1044-1051.
- American Psychological Association (2007). Guidelines for psychological practice with girls and women. *American Psychologist*, 62(9), 949-979.
- American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/principles.pdf>
- American Psychological Association. (2012). *Revised competency benchmarks in professional psychology*. Retrieved from <http://www.apa.org/ed/graduate/benchmarks-evaluation-system.aspx>
- American Psychological Association (2013). *Guidelines and principles for accreditation of programs in professional psychology*. Washington, DC: American Psychological Association.
- Anderson, T., Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology*, 65(7), 755-768. doi:10.1002/jclp.20583

- Angelides, P. (2001). The development of an efficient technique for collecting and analyzing qualitative data: The analysis of critical incidents. *International Journal of Qualitative Studies in Education*, 14(3), 429-442.
- Antonovsky, A. (1987). The salutogenic perspective: Toward a new vision of health and illness. *Advances*, 4(1), 47-55.
- Aponte, H. J. (1992). Training the person of the therapist in structural family therapy. *Journal of Marital and Family Therapy*, 18(3), 269-281.
- Aponte, H. J., & Kissil, K. (2014). "If I can grapple with this I can truly be of use in the therapy room": Using the therapist's own emotional struggles to facilitate effective therapy. *Journal of Marital and Family Therapy*, 40(2), 152-164. doi:10.1111/jmft.12011
- Aponte, H. J., Powell, F. D., Brooks, S., Watson, M. F., Litzke, C., Lawless, J., & Johnson, E. (2009). Training the person of the therapist in an academic setting. *Journal of Marital and Family Therapy*, 35(4), 381-394. doi:10.1111/j.1752-0606.2009.00123.x
- Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). *Operationalization of the Multicultural Counseling Competencies*. AMCD: Alexandria, VA.
- Auxier, C. R., Hughes, F. R., & Kline, W. B. (2003). Identity development in counselors-in-training. *Counselor Education and Supervision*, 43(1), 25-39.
- Bakker, A. B. (2005). Flow among music teachers and their students: The crossover of peak experiences. *Journal of Vocational Behavior*, 66(1), 26-44.
- Barrow, A. R. (1990). The comparative effectiveness of discrimination and communication training on empathy level of high and low self-monitoring counselor participants. *Dissertation Abstracts International*, 51(8-A).

- Batten, S. V., & Santanello, A. P. (2009). A contextual behavioral approach to the role of emotion in psychotherapy supervision. *Training and Education in Professional Psychology, 3*(3), 148. doi:10.1037/1931-3918.a0014801
- Bennett, M. J. (1986). A developmental approach to training for intercultural sensitivity. *International Journal of Intercultural Relations, 10*(2), 179-196.
- Bennett-Levy, J., & Lee, N. K. (2014). Self-practice and self-reflection in cognitive behaviour therapy training: What factors influence trainees' engagement and experience of benefit? *Behavioural and Cognitive Psychotherapy, 42*(1), 48-64.
doi:10.1017/S1352465812000781
- Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical psychology review, 28*(5), 746-758.
- Benziman, G., Kannai, R., & Ahmad, A. (2012). The wounded healer as cultural archetype. *CLCWeb: Comparative Literature and Culture, 14*(1), 11.
- Bereiter, C. & Scardamalia, M. (1993). Computer support for knowledge-building communities. *Journal of The Learning Sciences, 3*(3), 265-283. doi:10.1207/s15327809jls0303_3
- Berry, K., & Patti, C. J. (2015). Lost in narration: Applying autoethnography. *Journal of Applied Communication Research, 43*(2), 263-268. doi:10.1080/00909882.2015.1019548
- Beutler, L. E., Malik, M., & Alimohamed, S. Harwood. T. M., Talebi, H., Noble, S. & Wong, E. (2004). Therapist variables. *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 227-306). New York, NY: John Wiley and Sons.
- Bieschke, K. J., & Mintz, L. B. (2012). Counseling psychology model training values statement

- addressing diversity: History, current use, and future directions. *Training and Education in Professional Psychology*, 6(4), 196.
- Bilsky, W., & Schwartz, S. H. (1994). Values and personality. *European journal of personality*, 8(3), 163-181.
- Binnie, J. (2011). Cognitive behavioural therapy supervision: Supervisee and supervisor development. *Issues in Mental Health Nursing*, 32(3), 158-162.
doi:10.3109/01612840.2010.536612
- Blatt, S. J., Zuroff, D. C., Quinlan, D. M., & Pilkonis, P. A. (1996). Interpersonal factors in brief treatment of depression: Further analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 64(1), 162. doi:10.1037/0022-006X.64.6.127
- Blocher, D. H. (1987). *The professional counselor*. New York, NY: Macmillan.
- Blomberg, J., Lazar, A., & Sandell, R. (2001). Long-term outcome of long-term psychoanalytically oriented therapies: First findings of the Stockholm Outcome of Psychotherapy and Psychoanalysis Study. *Psychotherapy Research*, 11, 361-382.
- Blomme, R. J., Kodden, B., & Beasley-Suffolk, A. (2015). Leadership theories and the concept of work engagement: Creating a conceptual framework for management implications and research. *Journal of Management and Organization*, 21(2), 125-144.
doi:10.1017/jmo.2014.71
- Bohart, A. C., Elliot, R., Greenberg, L. S., & Watson, J. C. (2002). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to clients* (pp. 89-108). New York, NY: Oxford University Press.

- Bohecker, L., Wathen, C., Wells, P., Salazar, B. M., & Vereen, L. G. (2014). Mindfully educating our future: The MESH curriculum for training emergent counselors. *The Journal for Specialists in Group Work*, 39(3), 257-273. Retrieved from http://digitalcommons.georgefox.edu/cgi/viewcontent.cgi?article=1003&context=gsc&sei_redir=1&referer=https%3A%2F%2Fscholar.google.com%2Fscholar%3Fq%3Dbohecker%2Bmindfully%2Beducating%2Bour%2Bfuture%26btnG%3D%26hl%3Den%26as_sdt%3D0%252C38%26as_ylo%3D2012#search=%22bohecker%20mindfully%20educating%20our%20future%22
- Borders, L. D. A. (1989). Developmental cognitions of first practicum supervisees. *Journal of Counseling Psychology*, 36(2), 163-169.
- Bowen, G. A. (2005). Preparing a qualitative research-based dissertation: lessons learned. *The Qualitative Report*, 10(2), 2012.
- Boysen, G. A. (2010). Integrating implicit bias into counselor education. *Counselor Education and Supervision*, 49(4), 210-227.
- Brammer., L. M. & Shostrom, E. L. (1977). *Therapeutic psychology: Fundamentals of counseling and psychotherapy*. Prentice-Hall, 1977.
- Brooks, J., Holttum, S., & Lavender, A. (2002). Personality style, psychological adaptation and expectations of trainee clinical psychologists. *Clinical Psychology & Psychotherapy*, 9(4), 253-270.
- Brotman, L. E., Liberi, W. P., & Wasylyshyn, K. M. (1998). Executive coaching: The need for standards of competence. *Consulting Psychology Journal: Practice and Research*, 50(1), 40-46.

- Brubaker, M. D., Puig, A., Reese, R. F., & Young, J. (2010). Integrating social justice into counseling theories pedagogy: A case example. *Counselor Education and Supervision, 50*(2), 88-102.
- Brymer, E., & Oades, L. G. (2009). Extreme sports: A positive transformation in courage and humility. *Journal of Humanistic Psychology, 49*(1), 114-126.
- Buchanan, T. (2002). Historically grounding the practice of psychology: Implications for professional training. *History of Psychology, 5*(3), 240-248.
- Buhler, C. (1971). Basic theoretical concepts of humanistic psychology. *American Psychologist, 26*(4), 378-386. doi:10.1037/h0032049
- Burina, E. A., Grandilevskaya, M. V. D. I. V., Rykman, L. V., & Trabczynski, P. K. (2015). Psychological Center as a Foundation for the Practical Training of Clinical psychologists at the Saint-Petersburg State University. *Archives of Psychiatry and Psychotherapy, 4*, 100-104. doi:10.12740/APP/61049
- Burnett, J. A., Long, L. L. & Horne, H. L. (2005). Service learning for counselors: integrating education, training, and the community. *The Journal of Humanistic Counseling, Education and Development, 44*, 158–167. doi:10.1002/j.2164-490X.2005.tb00028.x
- Cain, D. J. (2002). Defining characteristics, history, and evolution of humanistic psychotherapies. In D. J. Cain, D. J. Cain (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 3-54). Washington, DC: American Psychological Association. doi:10.1037/10439-001
- Cain, D. J. (2007). What every therapist should know, be and do: Contributions from humanistic psychotherapies. *Journal of Contemporary Psychotherapy, 37*(1), 3-10. doi:10.1007/s10879-006-9028-7

- California Department of Consumer Affairs. (2012). 2012/13 *Annual Report*, p. 115. Retrieved from http://www.dca.ca.gov/publications/12_13_annrpt.pdf
- Carkhuff, R. R., & Berenson, B. G. (1967). *Beyond counseling & therapy*. Buffalo, NY: Holt, Rinehart, & Winston.
- Carlozzi, A. F., Campbell, N., & Ward, G. R. (1982). Dogmatism and externality in locus of control as related to counselor trainee skill in facilitative responding. *Counselor Education and Supervision, 21*(4), 227-236.
- Carlsson, J., Norberg, J., Schubert, J., & Sandell, R. (2011). The development of therapeutic attitudes during and after psychotherapy training. *European Journal of Psychotherapy and Counselling, 13*(3), 213-229.
- Carroll, M. V. (2010). Supervision: Critical reflection for transformational learning (Part 2). *The Clinical Supervisor, 29*(1), 1-19. doi:10.1080/07325221003730301
- Carter, R. T. (2003). Becoming racially and culturally competent: The racial-cultural counseling laboratory. *Journal of Multicultural Counseling and Development, 31*(1), 20-30.
- Cartwright, C., Rhodes, P., King, R., & Shires, A. (2015). A Pilot Study of a Method for Teaching Clinical Psychology Trainees to Conceptualise and Manage Countertransference. *Australian Psychologist, 50*(2), 148-156. doi:10.1111/ap.12092
- Castonguay, L. G. & Beutler, L. E. (2006). *Principles of therapeutic change that work*. New York, NY: Oxford University Press.
- Coleman, M. (2006). Critical incidents in multicultural training: An examination of student experiences. *Journal of Multicultural Counseling and Development, 34*(3), 168-182.

- Collins, N. M., & Pieterse, A. L. (2007). Critical incident analysis based training: An approach for developing active racial/cultural awareness. *Journal of Counseling and Development: JCD*, 85(1), 14.
- Cormier, L. S. (1988). Critical incidents in counselor development: Themes and patterns. *Journal of Counseling & Development*, 67(2), 131–132.
- Council for Accreditation of Counseling and Related Educational Programs. (2001). *CACREP accreditation manual: 2001 standards*. Alexandria, VA: Author.
- Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 standards*. Retrieved from <http://www.cacrep.org/doc/2009%20Standards.pdf>
- Council on Social Work Education. (2008). *Educational policy and accreditation standards*. Retrieved from <http://www.cswe.org/File.aspx?id=13780>
- Crawford, L. (1996). Personal ethnography. *Communication Monographs*, 63(2), 158–170.
doi:10.1080/03637759609376384
- Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.
- Crethar, H., Torres-Rivera, E., & Nash, S. (2008). In search of common threads: Linking multicultural, feminist, and social justice counseling paradigms. *Journal of Counseling & Development*, 86(3), 269- 278.
- Crews, J., Smith, M. R., Smaby, M. H., Maddux, C. D., Torres-Rivera, E., Casey, J. A., & Urbani, S. (2005). Self-Monitoring and Counseling Skills: Skills-Based Versus Interpersonal Process Recall Training. *Journal of Counseling & Development*, 83(1), 78-85. doi:10.1002/j.1556-6678.2005.tb00582.x
- Csikszentmihályi, M. (1990). *The domain of creativity*. In M. A. Runco, R. S. Albert, M. A.

- Runco, R. S. Albert (Eds.), *Theories of creativity* (pp. 190-212). Thousand Oaks, CA: Sage Publications, Inc.
- Csikszentmihalyi, M., & Seligman, M. E. (2000). Positive psychology: An introduction. *American Psychologist*, *55*(1), 5-14.
- D'Amato, L. G., & Krasny, M. E. (2011). Outdoor adventure education: Applying transformative learning theory to understanding instrumental learning and personal growth in environmental education. *The Journal of Environmental Education*, *42*(4), 237-254.
- Darden, A. J., & Rutter, P. A. (2011). Psychologists' experiences of grief after client suicide: A qualitative study. *OMEGA-Journal of Death and Dying*, *63*(4), 317-342.
doi:10.2190/OM.63.4.b
- Delsignore, A. M., Petrova, E., Harper, A., Stowe, A. M., Mu'min, A. S., & Middleton, R. A. (2010). Critical incidents and assistance-seeking behaviors of White mental health practitioners: A transtheoretical framework for understanding multicultural counseling competency. *Cultural Diversity and Ethnic Minority Psychology*, *16*(3), 352-361.
doi:10.1037/a0018694
- Díaz-Lázaro, C. M. and Cohen, B. B. (2001). Cross-cultural contact in counseling training. *Journal of Multicultural Counseling and Development*, *29*, 41-56.
doi:10.1002/j.2161-1912.2001.tb00502.x
- Dickson, J. M., Moberly, N. J., Marshall, Y., & Reilly, J. (2011). Attachment style and its relationship to working alliance in the supervision of British clinical psychology trainees. *Clinical psychology & psychotherapy*, *18*(4), 322-330. doi:10.1002/cpp.715
- Dollarhide, C. T. (2013). Using a values based taxonomy in counselor education. *Counseling and Values*, *58*(2), 221-236.

- Donati, M., & Watts, M. (2005). Personal development in counsellor training: Towards a clarification of inter-related concepts. *British Journal of Guidance & Counselling*, 33(4), 475-484. doi:10.1080/03069880500327553
- Duncan, B. L., & Moynihan, D. W. (1994). Applying outcome research: Intentional utilization of the client's frame of reference. *Psychotherapy*, 31(2), 294-301. doi:10.1037/h0090215
- Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology*, 43(4), 456-460. doi:10.1037/0022-0167.43.4.456
- Dunning, D., Heath, C., & Suls, J. M. (2004). Flawed Self-Assessment: Implications for Health, Education, and the Workplace. *Psychological Science in the Public Interest*, 5(3), 69-106. doi:10.1111/j.1529-1006.2004.00018.x
- Duran, E., Firehammer, J., & Gonzalez, J. (2008). Liberation psychology as the path toward healing cultural soul wounds. *Journal of Counseling and Development*, 86(3), 288-295.
- Duthiers, L. J. (2005). *Countertransference awareness and therapists' use of personal therapy* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (Order No. 3189270)
- Egan, S. J., Haley, S. and Rees, C. S. (2014), Attitudes of clinical psychologists towards clients with personality disorders. *Australian Journal of Psychology*, 66: 175–180. doi:10.1111/ajpy.12068
- Ellis, M. V. (1991). Critical incidents in clinical supervision and in supervisor

- supervision: Assessing supervisory issues. *Journal of Counseling Psychology*, 38(3), 342-349. doi:10.1037/0022-0167.38.3.342
- Ellis, M. V. (2006). Critical incidents in clinical supervision and in supervisor supervision: Assessing supervisory issues. *Training And Education In Professional Psychology*, 5(2), 122-132. doi:10.1037/1931-3918.S.2.122
- Ellis, C., Adams, T. E., & Bochner, A. P. (2010). Autoethnography: An Overview. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 12(1). Retrieved from <http://nbn-resolving.de/urn:nbn:de:0114-fqs1101108>.
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal Of Advanced Nursing*, 62(1), 107-115. doi:10.1111/j.1365-2648.2007.04569.x
- English, P., & Sutton, E. (2000). Working with courage, fear and failure. *Career Development International*, 5(4/5), 211-215.
- Epstein, S. (1998). Cognitive-experiential self-theory. In D. F. Barone, M. Hersen, V. B. Van Hasselt, D. F. Barone, M. Hersen, V. B. Van Hasselt (Eds.), *Advanced personality* (pp. 211-238). New York, NY, US: Plenum Press. doi:10.1007/978-1-4419-8580-4_9
- Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *JAMA*, 287(2), 226-235. doi:10.1001/jama.287.2.226.
- Eva, K. W. & Regehr, G., (2008). “I’ll never play professional football” and other fallacies of self-assessment. *Journal of Continuing Education in the Health Professions*, 28(1), 14-19. doi:10.1002/chp.150
- Falender. (2014, October 1). Personal Communication.
- Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based*

approach. Washington, DC, US: American Psychological Association.

doi:10.1037/10806-000

Falender, C. A., & Shafranske, E. P. (2007). Competence in competency-based supervision practice: Construct and application. *Professional Psychology: Research And Practice*, 38(3), 232-240. doi:10.1037/0735-7028.38.3.232

Falender, C. A., & Shafranske, E. P. (2012a). The importance of competency-based clinical supervision and training in the twenty-first century: Why bother? *Journal of Contemporary Psychotherapy*, 42(3), 129-137.

Falender, C. A. & Shafranske, E. P. (2012b). *Getting the Most Out of Clinical Training and Supervision: A Guide for Practicum Students and Interns*. Washington D.C.: American Psychological Association.

Farber, E. W. (2010). Humanistic–existential psychotherapy competencies and the supervisory process. *Psychotherapy: Theory, Research, Practice, Training*, 47(1), 28-34.

Fauth, J., & Williams, E. N. (2005). The In-Session Self-Awareness of Therapist-Trainees: Hindering or Helpful? *Journal of Counseling Psychology*, 52(3), 443-447.

Feist, G.J., & Feist, J. (2009). Rogers: Person-Centered Therapy. In (7th Eds.), *Theories of Personality* (pp. 308-339). New York: McGraw-Hill.

Feely, D., & Byrne, M. (2015). A profile of psychologists in clinical training caseloads in Ireland. *The Journal of Mental Health Training, Education and Practice*, 10(2), 85-90. doi:10.1108/JMHTEP-09-2014-0025

Fialkov, C., & Haddad, D. (2012). Appreciative clinical training. *Training and Education in*

Professional Psychology, 6(4), 204-210

- Fine, M., & Fenell, D. (1985). Supervising the supervisor-of-supervision: A supervision-of-supervision technique or an hierarchical blurring?. *Journal of Strategic & Systemic Therapies*, 4(3), 55-59.
- Flanagan, J. C. (1954). The critical incident technique. *Psychological Bulletin*, 51(4), 327–358.
- Folkes-Skinner, J., Elliott, R., & Wheeler, S. (2010). 'A baptism of fire': A qualitative investigation of a trainee counsellor's experience at the start of training. *Counselling & Psychotherapy Research*, 10(2), 83-92. doi:10.1080/14733141003750509
- Fouad, N. A., Hatcher, R. L., Hutchings, P. S., Collins, F. L. Jr., Grus, C. L., Kaslow, N. J., Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology*, 3(4), S5-S26.
- Fraser, G. J., & Hunt, D. E. (2011). Faculty diversity and search committee training: Learning from a critical incident. *Journal of Diversity in Higher Education*, 4(3), 185-198. doi:10.1037/a0022248
- Freud, S. (1912). *Selected Papers on Hysteria and Other Psychoneuroses*; Trans. by A. A. Brill. New York: The Journal of Nervous and Mental Disease Publishing Company. 1912.
- Freud, S. (1937). Analysis terminable and interminable. *International Journal of Psychoanalysis*, 18:373- 405.
- Freund, A., Blit-Cohen, E., Cohen, A., & Dehan, N. (2013). Professional commitment in novice social work students: Socio-demographic characteristics, motives and perceptions of the profession. *Social Work Education*, 32(7), 867-887. doi:10.1080/02615479.2012.717920

- Furr, S. R., & Carroll, J. J. (2003). Critical incidents in student counselor development. *Journal of Counseling and Development, 81*(4), 483–489.
doi:10.1002/j.1556-6678.2003.tb00275.x
- Gallegos, C., & Sortedahl, C. (2015). An exploration of professional values held by nurses at a large freestanding pediatric hospital. *Pediatric Nursing, 41*(4), 187.
- Gaubatz, M. D., & Vera, E. M. (2002). Do formalized gatekeeping procedures increase programs' follow-up with deficient trainees? *Counselor Education and Supervision, 41*(4), 294-305.
- Geller, J. D., Farber, B. A., & Schaffer, C. E. (2010). Representations of the supervisory dialogue and the development of psychotherapists. *Psychotherapy: Theory, Research, Practice, Training, 47*(2), 211-220. doi:10.1037/a0019785
- Gibbons, M. M., Cochran, J. L., Spurgeon, S., & Diambra, J. F. (2013). The human factor: Student reactions to the integration of personal dispositions into a counseling program. *Journal of Humanistic Counseling, 52*(1), 5-22
- Gibson, D. M., Dollarhide, C. T., & Moss, J. M. (2010). Professional identity development: A grounded theory of transformational tasks of new counselors. *Counselor Education and Supervision, 50*(1), 21-38.
- Givens, L. (Ed.) (2008). *The Sage encyclopedia of qualitative methods, volumes 1 and 2*. Thousand Oaks, CA: Sage Publications.
- Goldfried, M. R., Greenberg, L. S., & Marmar, C. (1990). Individual psychotherapy: Process and outcome. *Annual Review of Psychology, 41*, 659-688.
- Gone, J. P. (2014). Reconsidering American Indian historical trauma: Lessons from an early Gros Ventre war narrative. *Transcultural Psychiatry, 51*(3), 387-406.

doi:10.1177/1363461513489722

Goodyear, R. K., Crego, C. A., & Johnston, M. W. (1992). Ethical issues in the supervision of student research: A study of critical incidents. *Professional Psychology: Research and Practice, 23*(3), 203-210. doi:10.1037/0735-7028.23.3.203

Grafanaki, S. (2010). 'Counsellors in the making': Research on counselling training and formative experiences of trainee counsellors. *Counselling and Psychotherapy Research, 10*(2), 81-82.

Greenfield, B. H., Anderson, A., Cox, B., & Tanner, M. C. (2008). Meaning of caring to 7 novice physical therapists during their first year of clinical practice. *Physical therapy, 88*(10), 1154.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Technology Research and Development, 29*(2), 75-91.

Guse, T. (2010). Positive psychology and the training of psychologists: Students' perspectives. *SA Journal of Industrial Psychology, 36*(2), 6 pages.
doi:10.4102/sajip.v36i2.848

Haferkamp, C. J. (1989). Implications of self-monitoring theory for counseling supervision. *Counselor Education and Supervision, 28*(4), 290-297.

Haferkamp, C. J. (1994). Dysfunctional beliefs, self-monitoring, and marital conflict. *Current Psychology, 13*(3), 248-262.

Hanna, F. J., Bemak, F., & Chung, R. (1999). Toward a new paradigm for multicultural counseling. *Journal of Counseling & Development, 77*(2), 125-134.
doi:10.1002/j.1556-6676.1999.tb02432.x

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in

- clinical psychology: Findings from a systematic review. *Journal of Mental Health*, 13(3), 235-245.
- Haverkamp, B. E. (1994). Using assessment in counseling supervision: Individual differences in self-monitoring. *Measurement and Evaluation in Counseling and Development*, 27(1), 316-324.
- Heppner, P. P., & Roehlke, H. J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. *Journal of Counseling Psychology*, 31(1), 76-90. doi:10.1037/0022-0167.31.1.76
- Hersoug, A. G., Hoglend, P., Havik, O. E., von der Lippe, A., & Monsen, J. T., (2009). Therapist characteristics influencing the quality of alliance in long-term psychotherapy. *Clinical Psychology and Psychotherapy*, 16(2), 100-110. doi:10.1002/cpp.605
- Hewitt, S. E. (2014). *The unfolding heart: What is the nature of courage in the therapeutic domain from the dual perspective of counsellors' personal therapy and their clinical practice? A qualitative study evaluated by Interpretative Phenomenological Analysis*. Retrieved from <http://chesterrep.openrepository.com/cdr/bitstream/10034/326264/9/susan%20elizabeth%20hewitt.pdf>
- Higgs, J., & McAllister, L. (2007). Educating clinical educators: using a model of the experience of being a clinical educator. *Medical Teacher*, 29(2-3), e51-e57.
- Hill, V., Bond, C., Atkinson, C., Woods, K., Gibbs, S., Howe, J., & Morris S. (2015). Developing as a practitioner: How supervision supports the learning and development of trainee educational psychologists in three-year doctoral training. *Educational & Child Psychology*, 22(3), 118-130.

- Hill, C. E., Baumann, E., Shafran, N., Gupta, S., Morrison, A., Rojas, A. E. P., ... & Gelso, C. J. (2015). Is training effective? A study of counseling psychology doctoral trainees in a psychodynamic/interpersonal training clinic. *Journal of Counseling Psychology, 62*(2), 184. doi:10.1037/cou0000053
- Hill, C. E., Kline, K., Bauman, V., Brent, T., Breslin, C., Calderon, M., Knox, S. (2015). What's it all about? A qualitative study of meaning in life for counseling psychology doctoral students. *Counselling Psychology Quarterly, 28*(1), 1-26, doi:10.1080/09515070.2014.965660
- Hill, C. E., Sullivan, C., Knox, S., & Schlosser, L. Z. (2007). Becoming psychotherapists: Experiences of novice trainees in a beginning graduate class. *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 434-449. doi:10.1037/0033-3204.44.4.434
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*(4), 517-572. doi:10.1177/0011000097254001
- Holst, J. (2010). Social justice and dispositions for adult education. *Adult Education Quarterly, 60*(3), 249-260. doi:10.1177/0741713609354118
- Hopkins, A., & Proeve, M. (2013). Teaching mindfulness-based cognitive therapy to trainee psychologists: Qualitative and quantitative effects. *Counselling Psychology Quarterly, 26*(2), 115-130. doi:10.1080/09515070.2013.792998
- Horner, C. & Youngson, S. (2009). Personal development in clinical psychology training — 'The story so far...' In J. Hughes, S. Youngson (Eds.), *Personal development and clinical psychology* (pp. 46-61). Leicester, England: British Psychological Society.
- Howard, F. (2008). Managing stress or enhancing wellbeing? Positive psychology's

- contributions to clinical supervision. *Australian Psychologist*, 43(2), 105-113.
- Howard, E. E., Inman, A. G., & Altman, A. N. (2006). Critical incidents among novice counselor trainees. *Counselor Education and Supervision*, 46(2), 88–102.
doi:10.1002/j.1556- 6978.2006.tb00015.x
- Huppert, J. D., Bufka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2001). Therapist, therapist variables, and cognitive-behavioral therapy outcome in multicenter trial for panic disorder. *Journal of Consulting and Clinical Psychology*, 69(5), 747-755. doi:10.1037/0022-006X.69.5.747
- Hsieh, H., & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277-1288. doi:10.1177/1049732305276687
- 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. Poster presentation at the American Psychological Association Conference, Honolulu, HI.
- Ieva, K. P., Ohrt, J. H., Swank, J. M., & Young, T. (2009). The impact of experiential groups on master students' counselor and personal development: A qualitative investigation. *The Journal for Specialists in Group Work*, 34(4), 351-368.
- Irving, J. A. & Williams, D. I. (1999). Personal growth and personal development: concepts clarified. *British Journal of Guidance and Counselling*, 27(4), 517-526.
- Ivey, A. E., Normington, C. J., Miller, C. D., Morrill, W. H., & Haase, R. F. (1968). Microcounseling and attending behavior: An approach to prepracticum counselor training. *Journal of Counseling Psychology*, 15(5-2), 1-12.
- Jimenez, C., Navia-Osorio, P. M., & Diaz, C. V. (2010). Stress and health in novice and experienced nursing students. *Journal of advanced nursing*, 66(2), 442-455.

doi:10.1111/j.1365-2648.2009.05183.x

- Johns, H. (1996). *Personal development in counsellor training*. London, England: Cassell.
- Jordaan, I., Spangenberg, J., Watson, M., & Fouche, P. (2007). Emotional stress and coping strategies in South African clinical and counselling psychologists. *South African Journal of Psychology, 37*(4), 835-855. doi:10.1177/008124630703700411
- Kashdan, T. B., Rose, P., & Fincham, F. D. (2004). Curiosity and exploration: Facilitating positive subjective experiences and personal growth opportunities. *Journal of Personality Assessment, 82*(3), 291-305.
- Kashdan, T. B., & Silvia, P. J. (2009). Curiosity and interest: The benefits of thriving on novelty and challenge. *Oxford handbook of positive psychology, 2*, 367-374.
- Kaminker, J. (2014). Mindfulness in teaching resilience to mental health providers. *International Journal of Emergency Mental Health and Human Resilience, 16*(2). Retrieved from <http://www.omicsonline.com/open-access/mindfulness-in-teaching-resilience-to-mental-health-providers-1522-4821-16-e127.pdf>
- Karwowski, M. (2012). Did curiosity kill the cat? Relationship between trait curiosity, creative self-efficacy and creative personal identity. *Europe's Journal of Psychology, 8*(4), 547-557.
- Kaczmarek, Ł. D., Bączkowski, B., Enko, J., Baran, B., & Theuns, P. (2014). Subjective well-being as a mediator for curiosity and depression. *Polish Psychological Bulletin, 45*(2), 200-204.
- Kastberg, S. M., Jordan, R. A., Kiweewa, J. M., & Clingerman, T. (2014). Counselor as Client: Emerging Answers and New Questions. *Journal of Counseling and Professional Psychology, 3*(1), 1-16.

- Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist*, 12(3-4), 43-55. doi:10.1177/0011000084123005
- Kivlighan, D. J., Multon, K. D., & Brossart, D. F. (1996). Helpful impacts in group counseling: Development of a multidimensional rating system. *Journal of Counseling Psychology*, 43(3), 347-355. doi:10.1037/0022-0167.43.3.347
- Kiweewa, J., Gilbride, D., Luke, M., & Seward, D. (2013). Endorsement of growth factors in experiential training groups. *The Journal for Specialists in Group Work*, 38(1), 68-93. doi:10.1080/01933922.2012.745914
- Koepp, W. & Vaeth-Szuszdiara, R. (1996). Anmerkungen zur Bedeutung der Lehranalyse fuer die praktische, psychotherapeutische Arbeit [Some remarks on the importance of the training analysis of the practice of psychotherapy]. *Psychotherapie Psychosomatik Medizinische Psychologie*, 46, 43-46.
- Kolb, A. Y., & Kolb, D. A. (2012). Experiential learning theory: A dynamic, holistic approach to management learning, education and development. In S. J. Armstrong & C. V. Fukami (Eds.), *The Sage handbook of management learning, education and development* (pp. 42-68). Thousand Oaks, CA: Sage.
- Kornfield, J. (1993). *A path with heart: A guide through the perils and promises of spiritual life*. New York, NY: Bantam Books.
- Krathwohl, D. R., Bloom, B. S., Masia, B. B. (1964). *Taxonomy of educational objectives, the classification of educational goals, handbook II: Affective domain*. Upper Saddle River, NJ: Pearson Education.
- Kuyken, W., Peters, E., Power, M., & Lavender, T. (1998). The psychological adaptation

- of psychologists in clinical training: The role of cognition, coping and social support. *Clinical Psychology & Psychotherapy*, 5(4), 238-252.
- Ladany, N. (2007). Does psychotherapy training matter? Maybe not. *Psychotherapy: Theory, Research, Practice, Training*, 44(4), 392-396. doi: 10.1037/0033-3204.44.4.392.
- Lachman, V. D. (2007). Moral courage: a virtue in need of development?. *Medicine, Surgery, & Nursing*, 16(2), 131-133.
- Lambert, M. J., Shapiro, D. A., Bergin, A. E. (1986). The effectiveness of psychotherapy. In S. L. Garfield and A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 157-212). New York, NY: John Wiley.
- Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York, NY: Basic Books.
- Lauterbach, S.S., & Hentz, P.B. (2005). Journaling to learn: A strategy in nursing education for developing the person as nurse and the nurse as person. *International Journal for Human Caring*, 9(1), 29–35.
- Le, T. N. (2011). Life satisfaction, openness value, self-transcendence, and wisdom. *Journal of Happiness Studies*, 12(2), 171-182.
- Leong, F. T., & Kim, H. W. (1991). Going beyond cultural sensitivity on the road to multiculturalism: Using the intercultural sensitizer as a counseling training tool. *Journal of Counseling and Development*, 70(1), 112–118.
doi:10.1002/j.1556-6676.1991.tb01570.x
- Lennie, C. (2007). The role of personal development groups in counsellor training:

- Understanding factors contributing to self-awareness in the personal development group. *British Journal of Guidance & Counselling*, 35(1), 115-129.
doi:10.1080/03069880601106849
- Li, C., & Fiorello, C. A. (2011). Evolving practicum issues in school psychology preparation. *Psychology in the Schools*, 48(9), 901-910. doi:10.1002/pits.20601
- Lichtman, M. (2006). *Qualitative Research in Education: A User's Guide*. Sage.
- Lincoln, M., & McCabe, P. (2005). Values, necessity and the mother of invention in clinical education. *Advances in Speech Language Pathology*, 7(3), 153-157.
- Linley, P. A., Nielsen, K. M., Wood, A. M., Gillett, R., & Biswar-Diener, R. (2010). Using signature strengths in pursuit of goals: Effects on goal progress, need satisfaction, and well-being, and implications for coaching psychologists. *International Coaching Psychology Review*, 5(1), 6-15.
- Livesley, W. J. (2007). An integrated approach to the treatment of personality disorder. *Journal of Mental Health*, 16(1), 131-148. doi:10.1080/09638230601182086
- Luke, M., & Kiweewa, J. M. (2010). Personal growth and awareness of counseling trainees in an experiential group. *Journal for Specialists in Group Work*, 35(4), 365-388. doi:10.1080/01933922.2010.514976
- Lutz, L., & Spell Irizarry, S. (2009). Reflections of two trainees: Person-of-the-therapist training for marriage and family therapists. *Journal of Marital and Family Therapy*, 35(4), 370-380. doi:10.1111/j.1752-0606.2009.00126.x
- Malik, G., McKenna, L., & Plummer, V. (2015). Perceived knowledge, skills, attitude and

- contextual factors affecting evidence-based practice among nurse educators, clinical coaches and nurse specialists. *International Journal of Nursing Practice*, 21(S2), 46-57.
doi:10.1111/ijn.12366
- Malikiosi-Loizos, M. (2013). Personal therapy for future therapists: Reflections on a still debated issue. *The European Journal of Counselling Psychology*, 2(1), 33-50.
- Marmarosh, C. L., Nikityn, M., Moehringer, J., Ferraioli, L., Kahn, S., Cerkevich, A., & Reisch, E. (2013). Adult attachment, attachment to the supervisor, and the supervisory alliance: How they relate to novice therapists' perceived counseling self-efficacy. *Psychotherapy*, 50(2), 178-188. doi:10.1037/a0033028
- Maslow, A. H. (1968). *Toward a psychology of being*. New York, NY: Van Nostrand.
- Mathers, M. C. (2012). *The lived experience of personal and professional development in existential analysis* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (Order No. 1548974)
- Matthews, J. R. (2012). A students' guide to growth and development through psychotherapy supervision. *PsycCRITIQUES*, 57(33). doi:10.1037/a0029126
- Maxwell, J. A. (2012). *Qualitative research design: An interactive approach*. Los Angeles, CA: Sage.
- May, R. (1983). *The discovery of being: Writings in existential psychology*. New York, NY: Norton.
- May, D. R., Gibson, R. L., & Harter, L. M. (2004). The psychological conditions of meaningfulness, safety and availability and the engagement of the human spirit at work. *Journal of Occupational and Organizational Psychology*, 77(1), 11-37.
doi:10.1348/096317904322915892

- Mayring, P. (2000). Qualitative Content Analysis. Forum Qualitative Sozialforschung
 Forum: *Qualitative Social Research*, 1(2). Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/1089/2385>
- McLeod, J., & Julia, M. J. M. (2014). *Personal and professional development for counsellors, psychotherapists and mental health practitioners*. Berkshire, England: McGraw-Hill Education.
- McMinn, M. R., Vogel, M. J., Hall, M. E., Abernethy, A. D., Birch, R., Galuza, T., ... & Putman, K. (2015). Religious and Spiritual Diversity Training in Clinical Psychology Doctoral Programs: Do Explicitly Christian Programs Differ from Other Programs? *Journal of Psychology and Theology*, 43, 155-164.
- Meara, N. M., Schmidt, L. D., & Day, J. D. (1996). Principles and virtues: A foundation for ethical decisions, policies, and character. *The Counseling Psychologist*, 24(1), 4-7. doi:10.1177/0011000096241002
- Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. San Francisco, CA: John Wiley & Sons.
- Merriman, J. (2015). Enhancing counselor supervision through compassion fatigue education. *Journal of Counseling & Development*, 93(3), 370-378. doi:10.1002/jcad.12035
- Merryman, W., Martin, M., & Martin, D. (2015). Relationship between psychological well-being and perceived wellness in online graduate counselor education students. *Journal of Counselor Preparation and Supervision*, 7(1), 1-32. doi:10.7729/71.1073
- Mezirow, J. (2009). An overview of transformative learning. In K. Illeris (Ed.), *Contemporary theories of learning: Learning theorists...in their own words* (pp. 90-105). New York, NY: Routledge.
- Miles, M. B., & Huberman, A. M., (1994). *Qualitative data analysis: An expanded*

- sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Mikulincer, M. (1997). Adult attachment style and information processing: individual differences in curiosity and cognitive closure. *Journal of Personality and Social Psychology, 72*(5), 1217.
- Mintz, L. B., & Bieschke, K. J. (2009). Counseling psychology model training values statement addressing diversity: Development and introduction to the major contribution. *The Counseling Psychologist, 37*(5), 634–640.
- Mischel, W. (1990). Personality dispositions revisited and revised: a view after three decades. In L. A. Pervin (Ed.), *Handbook of Personality: Theory and Research* (pp. 111-134). Guilford, NY.
- Moldovan, R., Cobeanu, O., & David, D. (2013). Cognitive bibliotherapy for mild depressive symptomatology: randomized clinical trial of efficacy and mechanisms of change. *Clinical psychology & psychotherapy, 20*(6), 482-493. doi:10.1002/cpp.1814
- Moore, K. A., & Cooper, C. L. (1996). Stress in mental health professionals: a theoretical overview. *International Journal of Social Psychiatry, 42*(2), 82-89.
- Morrow, S. L. (2007). Qualitative Research in Counseling Psychology: Conceptual Foundations. *The Counseling Psychologist, 35*(2), 209-235. doi:10.1177/0011000006286990
- Moustakas, C. E. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications, Inc.
- Mwaba, K., & Pedersen, P. (1990). Relative importance of intercultural, interpersonal, and psychopathological attributions in judging critical incidents by multicultural counselors. *Journal of Multicultural Counseling & Development, 18*(3), 106 –118.
- Najavits, L. M., & Strupp, H. (1994). Differences in effectiveness of psychodynamic

therapists: A process-outcome study. *Psychotherapy*, 31(1), 114-123.

doi:10.1037/0033-3204.31.1.114

National Association of School Psychologists. (2009). *Standards for training and field placement programs in school psychology*. Retrieved from

<http://ncate.org/LinkClick.aspx?fileticket=tMFr0gOCa5c%3D&tabid=676>

National Council for Accreditation of Teacher Education. (2007). *NCATE*

defines dispositions as used in teacher education: Issues call to action. Retrieved 2014, from

<http://www.ncate.org/Public/Newsroom/NCATENewsPressReleases/tabid/669/EnrtyId/5/NCATE-Defines-Dispositions-as-used-in-Teacher-Education-Issues-Call-to-Action.aspx>

National Council for Accreditation of Teacher Education. (n.d.). NCATE glossary.

Retrieved from

<http://www.ncate.org/Standards/NCATEUnitStandards/NCATEGlossary/tabid/477/Default.aspx>

Nedeljkovic, M., Chaffey, L., Murray, G., & Brennan, C. (2014). Postgraduate clinical psychology placements in Victoria: The experience of students and supervisors.

Australian Psychologist, 49(6), 348-357. doi:10.1111/ap.12067

Nel, P. W., Pezolesi, C., & Stott, D. J. (2012). How did we learn best? A retrospective survey of clinical psychology training in the United Kingdom. *Journal of clinical psychology*,

68(9), 1058-1073. doi:10.1002/jclp.21882

Nelson, K. W., Oliver, M., & Capps, F. (2006). Becoming a supervisor: Doctoral student

perceptions of the training experience. *Counselor Education and Supervision*, 46(1), 17-31. doi:10.1002/j.1556-6978.2006.tb00009.x

- Newman, D. S. (2012). *Demystifying the school psychology internship: A dynamic guide for interns and supervisors*. Routledge.
- Newman, D. S., Nebbergall, A. J., & Salmon, D. (2013). Structured peer group supervision for novice consultants: procedures, pitfalls, and potential. *Journal of Educational and Psychological Consultation*, 23(3), 200-216. doi:10.1080/10474412.2013.814305
- Nino, A., Kizzil, K., & Apolar Claudio, F. L. (2015). Perceived professional gains of master's level students following a person-of-the-therapist training program: A retrospective content analysis. *Journal of Marital and Family Therapy*, 41(2), 163-176.
- Nissen-Lie, H. A., Havik, O. E., Høglend, P. A., Monsen, J. T., & Rønnestad, M. H. (2013). The contribution of the quality of therapists' personal lives to the development of the working alliance. *Journal of Counseling Psychology*, 60(4), 483-495. doi:10.1037/a0033643
- Norcross, J. C. (2001). Purposes, processes and products of the task force on empirically supported therapy relationships. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 345-356. doi:10.1037/0033-3204.38.4.345
- Norcross, J. C. (2002). *Psychotherapy relationships that work*. New York, NY: Oxford University Press.
- Norcross, J. C. (2005). The Psychotherapist's Own Psychotherapy: Educating and Developing Psychologists. *American Psychologist*, 60(8), 840-850. doi:10.1037/0003-066X.60.8.840
- Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York, NY: Oxford University Press.
- Nugent, F. A., & Jones, K. D. (2009). *Introduction to the profession of counseling* (5th ed.). Upper Saddle River, NJ: Pearson.
- O'byrne, K., Clark, R. E., & Malakuti, R. (1997). Expert and novice performance: Implications

- for clinical training. *Educational Psychology Review*, 9(4), 321-332.
doi:10.1023/A:1024742505548
- Oldham, G. R. (1975). The impact of supervisory characteristics on goal acceptance. *Academy of Management Journal*, 18(3), 461-475.
- Omeregbee, I., Morrison, B. W., & Morrison, N. M. (2016). A Case for Using Ability-Based Emotional Intelligence Measures in the Selection of Trainee Psychologists. *Business Perspectives and Research*, 4(1), 1-14. doi:10.1177/2278533715605425
- Orlinsky, D. E. (2013). Reasons for personal therapy given by psychoanalytically oriented psychotherapists and their effects on personal wellbeing and professional development. *Psychoanalytic Psychology*, 30(4), 644-662. doi:10.1037/a0034587
- Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, D.C.: American Psychological Association. doi:10.1037/11157-000
- Ottens, A. J., Shank, G. D., & Long, R. J. (1995). The role of abductive logic in understanding and using advanced empathy. *Counselor Education and Supervision*, 34(3), 199-211.
- Owen-Pugh, V., & Baines, L. (2014). Exploring the clinical experiences of novice counsellors working with LGBT clients: Implications for training. *Counselling and Psychotherapy Research*, 14(1), 19-28. doi:10.1080/14733145.2013.782055
- Pack, M. (2013). Vicarious traumatisation and resilience: An ecological systems approach to sexual abuse counsellors' trauma and stress. *Sexual Abuse in Australia and New Zealand*, 5(2), 69-76. Retrieved from https://www.researchgate.net/profile/Margaret_Pack/publication/259298046_'_Vicarious

_Traumatisation_and_Resilience_An_Ecological_Systems_approach_to_sexual_abuse_c
ounsellors'_trauma_and_stress'/links/544de0150cf24b5d6c42bef0.pdf

- Pack, M. (2014). Vicarious resilience: A multilayered model of stress and trauma. *Affilia: Journal of Women and Social Work*, 29(1), 18-29. doi:10.1177/0886109913510088
- Pakenham K. I. & Stafford-Brown, J. (2012). Stress in clinical psychology trainees: Current research status and future directions. *Australian Psychologist*, 47(3), 147-155.
- Parcover, J. A., & Swanson, J. L. (2013). Career counselor training and supervision: role of the supervisory working alliance. *Journal of Employment Counseling*, 50(4), 166-178. doi:10.1002/j.2161-1920.2013.00035.x
- Paulsen, B. L., Truscott, D., & Stuart, J. (1999). Clients' perceptions of helpful experiences in counseling. *Journal of Counseling Psychology*, 46(3), 317.
- Pelaccia, T., Tardif, J., Tribby, E., & Charlin, B. (2011). An analysis of clinical reasoning through a recent and comprehensive approach: the dual-process theory. *Medical education online*, 16.
- Peterson, C. (2006). The values in action (VIA) classification of strengths. In M. Csikszentmihalyi & I. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (pp. 29-48). New York, NY US: Oxford University Press.
- Phan, L. T., Rivera, E. T., Volker, M., & Maddux, C. D. (2009). Wisdom in multicultural counseling: The omitted ingredient. *Revista Interamericana De Psicología*, 43(1), 154-161.
- Pillay, A. L., & Johnston, E. R. (2011). Intern clinical psychologists' experiences of their training and internship placements. *South African Journal of Psychology*, 41(1), 74-82. doi:10.1177/008124631104100108

- Pillay, A. L., & Kramers-Olen, A. L. (2014). The changing face of clinical psychology intern training: a 30-year analysis of a programme in KwaZulu-Natal, South Africa. *South African Journal of Psychology, 44*(3), 364-374. doi:10.1177/0081246314535683
- Plaut, A. (1982). How do I assess progress in supervision? *Journal of Analytical Psychology, 27*(2), 105-107.
- Pope-Davis, D. B., & Coleman, H. L. K. (Eds.). (1997). *Multicultural Counseling Competencies: Assessment, education and training, and supervision*. Thousand Oaks, CA: Sage.
- Prati, G., & Pietrantonio, L. (2009). Optimism, social support, and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. *Journal of Loss and Trauma, 14*(5), 364-388.
- Rabinowitz, F. E., Heppner, P. P., & Roehlke, H. J. (1986). Descriptive study of process and outcome variables of supervision over time. *Journal of Counseling Psychology, 33*(3), 292-300. doi:10.1037/0022-0167.33.3.292
- Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among counseling paradigms. *Journal of Humanistic Counseling, Education and Development, 48*(2), 160-172.
- Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology, 19*(4), 255-267. doi:10.1177/153476512471144
- Remley, T. P., & Herlihy, B. P. (2005). *Ethical, legal, and professional issues in counseling* (2nd ed.). Upper Saddle River, NJ: Pearson.
- Roberts, M. C., Blossom, J. B., Evans, S. C., Amaro, C. M., & Kanine, R. M. (2016). Advancing

- the scientific foundation for evidence-based practice in clinical child and adolescent psychology. *Journal of Clinical Child & Adolescent Psychology*, 1-14.
doi:10.1080/15374416.2016.1152554
- Rodolfa, E., Bent, R., Eisman, E., Nelson, P., Rehm, L., & Ritchie, P. (2005). A Cube Model for Competency Development: Implications for Psychology Educators and Regulators. *Professional Psychology: Research and Practice*, 36(4), 347-354.
doi:10.1037/0735-7028.36.4.347
- Rogers, C. R. (1956). Becoming a person; some hypotheses regarding the facilitation of personal growth. *Pastoral Psychology*, 7(61), 9-13.
- Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston: Houghton Mifflin Company.
- Rogers, C. R. (1969). *Freedom to learn: A view of what education might become*. Columbus, Ohio: C.E. Merrill Pub. Co.
- Rogers, C. R. (1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology*, 60(6), 827-832.
doi:10.1037/0022-006X.60.6.827
- Rønnestad, M. H., & Ladany, N. (2006). The impact of psychotherapy training: Introduction to the special section. *Psychotherapy Research*, 16(3), 261-267.
doi:10.1080/10503300600612241
- Rønnestad, M. H., & Skovholt, T. M. (2001). Learning arenas for professional development: Retrospective accounts of senior psychotherapists. *Professional Psychology: Research and Practice*, 32(2), 181-187. doi:10.1037/0735-7028.32.2.181
- Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist:

- Research findings and perspectives on professional development. *Journal of Career Development*, 30(1), 5-44. doi:10.1023/A:1025173508081
- Rosenberg. (2012, November 15). Personal Communication.
- Rosenfeld, H. (2008). *Addressing personal issues in supervision: Positive and negative experiences of supervisees* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (Order No. 3405249)
- Roos, J., & Werbart, A. (2013). Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review. *Psychotherapy Research*, 23(4), 394-418. doi:10.1080/10503307.2013.775528
- Routh, D. K. (2000). Clinical psychology training: A history of ideas and practices prior to 1946. *American Psychologist*, 55(2), 236-241.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6(3), 412-415. doi:10.1111/j.1939-0025.1936.tb05248.x
- Rubin, N. J., Bebeau, M., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portnoy, S., ... & Kaslow, N. J. (2007). The competency movement within psychology: An historical perspective. *Professional Psychology: Research and Practice*, 38(5), 452-462. doi:10.1037/0735-7028.38.5.452
- Saito, N. (2005). *The gleam of light: Moral perfectionism and education in Dewey and Emerson*. New York: Fordham University Press.
- Saldana, J. (2009). An introduction to codes and coding. *The coding manual for qualitative researchers*, 1-31.
- Sandell, R., Carlsson, J., Schubert, J., Grant, J., Lazar, A., & Broberg, J. (2006). Therapists'

- therapies: The relation between training therapy and patient change in long-term psychotherapy and psychoanalysis. *Psychotherapy Research*, *16*(3), 306-316.
doi:10.1080/10503300500273110
- Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2007). Therapist attitudes and patient outcomes: II. Therapist attitudes influence change during treatment. *Psychotherapy Research*, *17*(2), 196-204. doi:10.1080/10503300600608439
- Sagiv, L., & Schwartz, S. H. (2000). Value priorities and subjective well-being: Direct relations and congruity effects. *European Journal of Social Psychology*, *30*(2), 177-198.
- Scaife, J., & Walsh, S. (2001). The emotional climate of work and the development of self. In J. Scaife (Ed.), *Supervision in the mental health professions. A practitioner's guide* (pp. 30-51). East Sussex, UK: Bruner-Routledge.
- Schaef, A. W. (1999). *Living in process: Basic truths for living the path of the soul*. New York: Ballantine Wellspring.
- Schaufeli, W. B. (2012). Work engagement: What do we know and where do we go. *Romanian Journal of Applied Psychology*, *14*(1), 3-10. Retrieved from https://www.researchgate.net/profile/Wilmar_Schaufeli/publication/230580677_Work_Engagement_What_Do_We_Know_and_Where_Do_We_Go_Work_Engagement_in_Everyday_Life_Business_and_Academia/links/0fcfd5019915fdeb1f000000.pdf
- Schneider, K. J. & Krug, O. T. (2010). *Existential-humanistic therapy*. Washington, DC: American Psychological Association.
- Schneider, K. J., & Längle, A. (2012). The renewal of humanism in psychotherapy: Summary and conclusion. *Psychotherapy*, *49*(4), 480-481. doi:10.1037/a0028026

Scholl, R. W. (2008). *Dispositions, attitudes, values, and personality*. Retrieved from University of Rhode Island:

<http://www.uri.edu/research/lrc/scholl/webnotes/Dispositions.htm>

Selby, L. A. (2003). *Felt shift as a function of dream interpretation process: A qualitative analysis* (Order No. 3098529). Available from Dissertations & Theses @ Pepperdine University - SCELIC; ProQuest Dissertations & Theses Global. (305225311). Retrieved from

<http://search.proquest.com/docview/305225311?accountid=13159><http://www.google.com/url?q=http%3A%2F%2Fsearch.proquest.com%2Fdocview%2F305225311%3Faccountid%3D13159&sa=D&sntz=1&usg=AFQjCNGAjQMoxFiFNyFCT4LZocwi2laD0g>

Seligman, M.E.P. (2002). *Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfillment*. New York, NY: Free Press.

Severinsson, E. I. (2001). Confirmation, meaning and self-awareness as core concepts of the nursing supervision model. *Nursing Ethics*, 8(1), 36-44.

Sexton, T. L., & Whiston, S. C. (1994). The status of the counseling relationship: An empirical review, theoretical implications, and research directions. *The Counseling Psychologist*, 22(1), 6-78. doi:10.1177/0011000094221002

Shanley, M. J. & Stevenson, C. (2006). Clinical supervision revisited. *Journal of nursing management*, 14(8), 586-592.

Sheldon, K., & Lyubomirsky, S. (2006). Achieving sustainable gains in happiness: Change your actions, not your circumstances. *Journal of Happiness Studies*, 7(1), 55-86.

Simpson, S. G., Rochford, S., Livingstone, A., English, S., & Austin, C. (2014). Tele-web

- Psychology in Rural South Australia: The Logistics of Setting Up a Remote University Clinic Staffed by Clinical Psychologists in Training. *Australian Psychologist*, 49(4), 193-199.
- Skovholt, T. M., & Jennings, L. (2004). *Master therapists: Exploring expertise in therapy and counseling*. Boston, MA: Allyn & Bacon.
- Skovholt, T. M., & McCarthy, P. R. (1988). Critical incidents: Catalysts for counselor development. *Journal of Counseling & Development JCD*, 67(2), 69 –72.
- Skovholt, T. M., & Rønnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, 30(1), 45-58.
- Smaby, M. H., Maddux, C. D., Richmond, A. S., Lepkowski, W. J., & Packman, J. (2005). Academic Admission Requirements as Predictors of Counseling Knowledge, Personal Development, and Counseling Skills. *Counselor Education and Supervision*, 45(1), 43-57. doi:10.1002/j.1556-6978.2005.tb00129.x
- Smith, N. A., & Castanelli, D. J. (2015). Measuring the clinical learning environment in anaesthesia. *Anaesthesia & Intensive Care*, 43(2).
- Smith-Adcock, S., Shin, S. M., & Pereira, J. (2015). Critical incident in learning child-centered play therapy: Implications for teaching and supervision. *International Journal of Play Therapy*, 24(2), 78-91. doi:10.1037/a0039122
- Snow, N. E. (1995). Humility. *The Journal of Value Inquiry*, 29(2), 203-216.
- Sockett, H. (2009). Dispositions as virtues: The complexity of the construct. *Journal of Teacher Education*, 60(3), 291-303.
- Sommer, C. A., Derrick, E. C., Bourgeois, M. B., Ingene, D. H., Yang, J. W., & Justice, C. A.

- (2009). Multicultural connections: Using stories to transcend cultural boundaries in supervision. *Journal of Multicultural Counseling And Development*, 37(4), 206-218.
doi:10.1002/j.2161-1912.2009.tb00103.x
- Spurgeon, S. L., Gibbons, M. M., & Cochran, J. L. (2012). Creating personal dispositions for a professional counseling program. *Counseling and Values*, 57(1), 96-108.
doi:10.1002/j.2161-007X.2012.00011.x
- Spruill, J., Rozensky, R. H., Stigall, T. T., Vasquez, M., Bingham, R. P., & Olvey, C. D. V. (2004). Becoming a competent clinician: Basic competencies in intervention. *Journal of Clinical Psychology*, 60(7), 741-754.
- Stafford-Brown, J., & Pakenham, K. I. (2012). The effectiveness of an ACT informed intervention for managing stress and improving therapist qualities in clinical psychology trainees. *Journal of Clinical Psychology*, 68(6), 592-513. doi:10.1002/jclp.21844
- Standish, P., Smeyers, P., & Smith, R. (Eds.). (2006). *The therapy of education: Philosophy, happiness and personal growth*. Springer.
- Stanley, P. (2015). Writing the PhD journey(s): An autoethnography of zine-writing, angst, embodiment, and backpacker travels. *Journal Of Contemporary Ethnography*, 44(2), 143-168. doi:10.1177/0891241614528708
- Stein, D. M., & Lambert, M. J. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced? *Journal of Counseling Psychology*, 63(2), 182-196.
- Stevens, H. B., Dinoff, B. L., & Donnenworth, E. E. (1998). Psychotherapy training and theoretical orientation in clinical psychology programs: A national survey. *Journal of Clinical Psychology*, 54(1), 91-96.
- Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: The

- counselor complexity model. *Journal of Counseling Psychology*, 28(1), 59-65.
doi:10.1037/0022-0167.28.1.59
- Strupp, H. H. (1958). The psychotherapist's contribution to the treatment process. *Behavioral Science*, 3(1), 34-67. doi:10.1002/bs.3830030105
- Strupp, H. H., & Hadley, S. (1977). A tripartite model of mental health and therapeutic outcomes with special reference to negative effects of psychotherapy. *American Psychologist*, 32(3), 187-196. doi:10.1037/0003-066X.32.3.187
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). Hoboken, NJ: John Wiley & Sons.
- Swierc, S. F., & Routh, D. K. (2003). Introduction to the special issue on international clinical psychology. *Journal of clinical psychology*, 59(6), 631-634.
- Szecsödy, I. (2003). To become or be made a psychoanalyst. *The Scandinavian Psychoanalytic Review*, 26(2), 141-150. doi:10.1080/01062301.2003.10592922
- Taubner, S., Zimmermann, J., Kächele, H., Moller, H., & Sell, C. (2013). The relationship of introject affiliation and personal therapy to trainee self-efficacy: A longitudinal study among psychotherapy trainees. *Psychotherapy*, 50(2), 167-177.
<http://dx.doi.org/10.1037/a0029819>
- Taylor, E. W. (2007). An update of transformative learning theory: A critical review of the empirical research (1999–2005). *International Journal of Lifelong Education*, 26(2), 173-191. doi:10.1080/02601370701219475
- Teegen, F., Frassa, M., & Honiger, S. (1979). Behavior of Therapists and Patients During Gestalt-Therapy. *Zeitschrift Fur Klinische Psychologie-Forschung Und Praxis*, 8(2), 148-155.

- Theriault, A., & Gazzola, N. (2010). Therapist feelings of incompetence and suboptimal processes in psychotherapy. *Journal of Contemporary Psychotherapy, 40*(4), 233-243. doi:10.1007/s10879-010-9147-z
- Thompson, F. (2009). The instruction and assessment of multicultural dispositions in teacher and counselor education. *Journal of Invitational Theory and Practice, 15*, 32-54.
- Thompson, J. M. (2004). A readiness hierarchy theory of counselor-in-training. *Journal of Instructional Psychology, 31*(2), 135-142.
- Tongue, C. K. (1989). Self-monitoring as a predictor of counselor and client empathic experience. *Dissertation Abstracts International, 50*, (9-A).
- Tesoriero, F. (2006). Personal growth towards intercultural competence through an international field education programme. *Australian Social Work, 59*(2), 126-140.
- Townend, M. (2008). Clinical supervision in cognitive behavioural psychotherapy: development of a model for mental health nursing through grounded theory. *Journal of psychiatric and mental health nursing, 15*(4), 328-339. doi:10.1111/j.1365-2850.2007.01235.x
- Trotter-Mathison, M., Koch, J. M., Sanger, S., & Skovholt, T. M. (2010). *Voices from the field: Defining moments in counselor and therapist development*. Hoboken, NJ: Taylor & Francis.
- Truell, R. (2001). The stresses of learning counselling: Six recent graduates comment on their personal experience of learning counselling and what can be done to reduce associated harm. *Counselling Psychology Quarterly, 14*(1), 67-89. doi:10.1080/09515070110059133
- Tryssenaar, J., & Perkins, J. (2001). From student to therapist: Exploring the first year of

- practice. *American Journal of Occupational Therapy*, 55(1), 19-27.
doi:10.5014/ajot.55.1.19
- Tsui, M. S., O'Donoghue, K., & Ng, A. K. (2014). Culturally-competent and diversity-sensitive clinical supervision: An international perspective. *Wiley international handbook of clinical supervision*, 238-254.
- VandenBos, G. R., & American Psychological Association. (2007). *APA dictionary of psychology*. Washington, DC: American Psychological Association.
- VanderVeen, J. W., Reddy, L. F., Veilleux, J. C., January, A. M., & DeLillo, D. (2012). Clinical Graduate student views of their scientist-practitioner training. *Journal of Clinical Psychology*.
- Veilleux, J. C., VanderVeen, J. W., January, A. M., Felice Reddy, L., & Klonoff, E. A., (2012). Differentiating amongst characteristics associated with problems of professional competence: Perceptions of graduate student peers. *Training and Education in Professional Psychology*, 6(2), 113-121. <http://dx.doi.org/10.1037/a0028337>
- Villalba, J. A., & Redmond, R. E. (2008). Crash: Using a popular film as an experiential learning activity in a multicultural counseling course. *Counselor Education and Supervision*, 47(4), 264-276.
- von der Lippe, A., Monsen, J. T., Rønnestad, M. H., & Eilertsen, D. E. (2008). Treatment failure in psychotherapy: The pull of hostility. *Psychotherapy Research*, 18(4), 420-432.
doi:10.1080/10503300701810793
- Walker, L. J. (2002). *The character of moral exemplars*. Columbia: University of British.
- Wambura Ngunjiri, F., Hernandez, K. C., & Chang, H. (2010). Living Autoethnography: Connecting life and research. *Journal of Research Practice* 6(1), E1.

- Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist*, 62(8), 57-873. doi:10.1037/0003-066X.62.8.857
- Warren, J., Morgan, M. M., Morris, L.-N. B., & Morris, T. M. (2010). Breathing words slowly: Creative writing and counselor self-care-the writing workout. *Journal of Creativity in Mental Health*, 5(2), 109-124. DOI:10.1080/15401383.2010.485074
- Watkins, C.E., Jr. (2012). Psychotherapy supervision in the new millennium: Competency-based, evidence-based, particularized, and energized. *Journal of Contemporary Psychotherapy*, 42(3), 193-203. doi:10.1007/s10879-011-9202-4
- Watt, S. K., Curtis, G. C., Drummond, J., Kellogg, A. H., Lozano, A., Nicoli, G. T., & Rosas, M. (2009). Privileged identity exploration: Examining counselor trainees' reactions to difficult dialogues. *Counselor Education and Supervision*, 49, 86-105.
- Wheeler, S. (2000). What makes a good counsellor? An analysis of ways in which counselor trainers construe good and bad counselling trainees. *Counselling Psychology Quarterly*, 13, 65–83.
- Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research*, 7(1), 54-65. doi:10.1080/14733140601185274
- Whiston, S. C., & Sexton, T. L. (1993). An overview of psychotherapy research: Implications for practice. *Professional Psychology: Research Practice*, 24(1), 43-51. <http://dx.doi.org/10.1037/0735-7028.24.1.43>
- Wilkins, P. (2006). Professional and personal development. In C. Feltham & I. Horton (Eds.), *The SAGE handbook of counselling and psychotherapy* (2nd ed.; 158-164). London, England: SAGE Publications.

- Winne, P. H. (1995). Inherent details in self-regulated learning. *Educational Psychologist, 30*(4), 173-187. doi:10.1207/s15326985ep3004_2
- Winterowd, C. L., Adams, E. M., Miville, M. L., & Mintz, L. B. (2009). Operationalizing, instilling, and assessing counseling psychology training values related to diversity in academic programs. *The Counseling Psychologist, 37*(5), 676-704.
doi:10.1177/0011000009331936
- Wiseman, H., & Shefler, G. (2001). Experienced psychoanalytically oriented therapists' narrative accounts of their personal therapy: Impacts on professional and personal development. *Psychotherapy: Theory, Research, Practice, Training, 38*(2), 129-141. doi:10.1037/0033-3204.38.2.129
- Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.
- Young, M. E. (2001). *Learning the art of helping: Building blocks and techniques* (2nd ed.). Upper Saddle River, NJ: Merrill.
- Youngson, S., & Green, D. (2009). Evaluating personal development in clinical psychology training. In J. Hughes, S. Youngson (Eds.), *Personal development and clinical psychology* (pp. 46-61). Leicester, England: British Psychological Society.
- Zerbe, W. J. & Paulhus, D. L. (1987) Socially desirable responding in organizational behavior: A reconception. *Academy of Management Journal, 12*(2), 250–264.
doi:10.5465/AMR.1987.4307820
- Zhang, J. W., & Chen, S. (2016). Self-compassion promotes personal improvement from regret experiences via acceptance. *Personality and Social Psychology Bulletin, 42*(2), 244-258.
doi:10.1177/0146167215623271

Zoellner, T., Rabe, S., Karl, A., & Maercker, A. (2008). Posttraumatic growth in accident survivors: Openness and optimism as predictors of its constructive or illusory sides. *Journal of Clinical Psychology, 64*(3), 245-263.

APPENDIX A

Institutional Review Board Approval

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

August 19, 2015

Lauren Armstrong, Albert 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@pepperdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

A handwritten signature in cursive script that reads "Thema Bryant-Davis".

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

6100 Center Drive, Los Angeles, California 90045 ☐☐ 310-568-5600

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 your 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: Lauren Armstrong (ID: 3710099)
- Email: lauren.armstrong@pepperdine.edu
- Institution Affiliation: Pepperdine University (ID: 1729)
- Institution Unit: GSEP
- Phone:

- Curriculum Group: Social and Behavioral Responsible Conduct of Research
- Course Learner Group: Same as Curriculum Group
- Stage: Stage 1 - Basic Course
- Description: This course is for investigators, staff and students with an interest or focus in Social and Behavioral research. This course contains text, embedded case studies AND quizzes.

- Report ID: 16279739
- Completion Date: 06/14/2015
- Expiration Date: N/A
- Minimum Passing: 80
- Reported Score*: 98

| REQUIRED AND ELECTIVE MODULES ONLY | DATE COMPLETED | SCORE |
|---|----------------|------------|
| Responsible Conduct of Research (RCR) Course Introduction (ID:1522) | 06/14/15 | No Quiz |
| Research Misconduct (RCR-Basic) (ID:16604) | 06/14/15 | 5/5 (100%) |
| Data Management (RCR-Basic) (ID:16600) | 06/14/15 | 5/5 (100%) |
| Authorship (RCR-Basic) (ID:16597) | 06/14/15 | 4/5 (80%) |
| Peer Review (RCR-Basic) (ID:16603) | 06/14/15 | 5/5 (100%) |
| Mentoring (RCR-Basic) (ID:16602) | 06/14/15 | 5/5 (100%) |
| Using Animal Subjects in Research (RCR-Basic) (ID:13301) | 06/14/15 | 5/5 (100%) |
| Conflicts of Interest (RCR-Basic) (ID:16599) | 06/14/15 | 5/5 (100%) |
| Collaborative Research (RCR-Basic) (ID:16598) | 06/14/15 | 4/5 (80%) |
| Research Involving Human Subjects (RCR-Basic) (ID:13568) | 06/14/15 | 5/5 (100%) |
| Responsible Conduct of Research (RCR) Course Conclusion (ID:1043) | 06/14/15 | No Quiz |

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:
 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: Lauren Armstrong (ID: 3710099)
- Email: lauren.armstrong@pepperdine.edu
- Institution Affiliation: Pepperdine University (ID: 1729)
- Institution Unit: GSEP
- Phone:

- Curriculum Group: Social and Behavioral Responsible Conduct of Research
- Course Learner Group: Same as Curriculum Group
- Stage: Stage 1 - Basic Course
- Description: This course is for investigators, staff and students with an interest or focus in Social and Behavioral research. This course contains text, embedded case studies AND quizzes.

- Report ID: 16279739
- Report Date: 06/14/2015
- Current Score**: 96

| REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES | MOST RECENT | SCORE |
|---|-------------|------------|
| Responsible Conduct of Research (RCR) Course Introduction (ID:1522) | 06/14/15 | No Quiz |
| Using Animal Subjects in Research (RCR-Basic) (ID:13301) | 06/14/15 | 5/5 (100%) |
| Research Involving Human Subjects (RCR-Basic) (ID:13566) | 06/14/15 | 5/5 (100%) |
| Authorship (RCR-Basic) (ID:16597) | 06/14/15 | 4/5 (80%) |
| Collaborative Research (RCR-Basic) (ID:16598) | 06/14/15 | 4/5 (80%) |
| Conflicts of Interest (RCR-Basic) (ID:16599) | 06/14/15 | 5/5 (100%) |
| Data Management (RCR-Basic) (ID:16600) | 06/14/15 | 5/5 (100%) |
| Mentoring (RCR-Basic) (ID:16602) | 06/14/15 | 5/5 (100%) |
| Peer Review (RCR-Basic) (ID:16603) | 06/14/15 | 5/5 (100%) |
| Research Misconduct (RCR-Basic) (ID:16604) | 06/14/15 | 5/5 (100%) |
| Responsible Conduct of Research (RCR) Course Conclusion (ID:1043) | 06/14/15 | No Quiz |

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:
 Web: <https://www.citiprogram.org>

Collaborative Institutional
 Training Initiative
 at the University of Miami

**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: Lauren Armstrong (ID: 3710099)
- Email: lauren.armstrong@pepperdine.edu
- Institution Affiliation: Pepperdine University (ID: 1729)
- Institution Unit: GSEP
- Phone:

- 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: 16279740
- Completion Date: 06/14/2015
- Expiration Date: 06/13/2018
- Minimum Passing: 80
- Reported Score*: 91

| REQUIRED AND ELECTIVE MODULES ONLY | DATE COMPLETED | SCORE |
|---|----------------|------------|
| Belmont Report and CITI Course Introduction (ID:1127) | 06/12/15 | 3/3 (100%) |
| Students in Research (ID:1321) | 06/12/15 | 8/10 (80%) |
| History and Ethical Principles - SBE (ID:490) | 06/14/15 | 5/5 (100%) |
| Defining Research with Human Subjects - SBE (ID:491) | 06/14/15 | 5/5 (100%) |
| The Federal Regulations - SBE (ID:502) | 06/14/15 | 5/5 (100%) |
| Assessing Risk - SBE (ID:503) | 06/14/15 | 5/5 (100%) |
| Informed Consent - SBE (ID:504) | 06/14/15 | 5/5 (100%) |
| Privacy and Confidentiality - SBE (ID:505) | 06/14/15 | 5/5 (100%) |
| Research with Prisoners - SBE (ID:506) | 06/14/15 | 5/5 (100%) |
| Research with Children - SBE (ID:507) | 06/14/15 | 4/5 (80%) |
| Research in Public Elementary and Secondary Schools - SBE (ID:508) | 06/14/15 | 5/5 (100%) |
| International Research - SBE (ID:509) | 06/14/15 | 5/5 (100%) |
| Internet-Based Research - SBE (ID:510) | 06/14/15 | 4/5 (80%) |
| Research and HIPAA Privacy Protections (ID:14) | 06/14/15 | 4/5 (80%) |
| Vulnerable Subjects - Research Involving Workers/Employees (ID:483) | 06/14/15 | 4/4 (100%) |
| Conflicts of Interest in Research Involving Human Subjects (ID:488) | 06/14/15 | 3/5 (60%) |

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:
 Web: <https://www.citi-program.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: Lauren Armstrong (ID: 3710099)
- Email: lauren.armstrong@pepperdine.edu
- Institution Affiliation: Pepperdine University (ID: 1729)
- Institution Unit: GSEP
- Phone: 949-412-4826

- 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: 16279740
- Report Date: 06/14/2015
- Current Score**: 91

| REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES | MOST RECENT | SCORE |
|---|-------------|------------|
| Students in Research (ID:1321) | 06/12/15 | 8/10 (80%) |
| History and Ethical Principles - SBE (ID:490) | 06/14/15 | 5/5 (100%) |
| Defining Research with Human Subjects - SBE (ID:491) | 06/14/15 | 5/5 (100%) |
| Belmont Report and CITI Course Introduction (ID:1127) | 06/12/15 | 3/3 (100%) |
| The Federal Regulations - SBE (ID:502) | 06/14/15 | 5/5 (100%) |
| Assessing Risk - SBE (ID:503) | 06/14/15 | 5/5 (100%) |
| Informed Consent - SBE (ID:504) | 06/14/15 | 5/5 (100%) |
| Privacy and Confidentiality - SBE (ID:505) | 06/14/15 | 5/5 (100%) |
| Research with Prisoners - SBE (ID:506) | 06/14/15 | 5/5 (100%) |
| Research with Children - SBE (ID:507) | 06/14/15 | 4/5 (80%) |
| Research in Public Elementary and Secondary Schools - SBE (ID:508) | 06/14/15 | 5/5 (100%) |
| International Research - SBE (ID:509) | 06/14/15 | 5/5 (100%) |
| Internet-Based Research - SBE (ID:510) | 06/14/15 | 4/5 (80%) |
| Research and HIPAA Privacy Protections (ID:14) | 06/14/15 | 4/5 (80%) |
| Vulnerable Subjects - Research Involving Workers/Employees (ID:483) | 06/14/15 | 4/4 (100%) |
| Conflicts of Interest in Research Involving Human Subjects (ID:488) | 06/14/15 | 3/5 (60%) |

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>

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.) _____

Socioeconomic 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

Coding Process

Theme 1. Increased self-efficacy. Journal entries from participating novice clinicians included self-reflections of critical incidents, of which demonstrated awareness, acceptance, or knowledge toward an increase in their self-efficacy. Table H1 displays journal entries that were a demonstration of either clinician awareness or knowledge of an increase in self-efficacy.

Table H1

Theme 1. Increased Self-Efficacy

| Critical Incidents of an Increase in Self-Efficacy | | |
|---|---|--|
| Awareness | Acceptance | Knowledge |
| 1. I gained an awareness of my true self, and that awareness allowed me to finally discover who I am; (deciding to stop listening to voices inside head) meant the start of my confidence and my career (A) | 4. So I gave [my past] some attention and slowly learned to trust my abilities and my feelings | |
| 2. I have just begun to grow | 10. The not doing things well is exactly what needs to happen because it's a step in the right direct[ion] | |
| 3. I stopped trying to be a 'good therapist' and I just settled for 'student' instead | 21. ...“reality testing” I believe it's called. I realized that this was my answer to understanding myself as a competent therapist...I had to take all this information and internalize it to create a new self-story that I was competent | 12. I've learned to keep much of what I think I know about family to myself in effort to leave doors closed |
| 5. [kicking parents out of the room] freed me up | 30. I had to experience the change before I could instill change | 15. I had to learn to trust myself without receiving validation from others before I could perform therapy, especially before I could confront any clients |
| 7. Walked into my next session with little or no fear and every session after that | 41. Being brave is now a motto that I live my life by. | 16. Being empathetic is to acknowledge the difficult situation...the client then recognizes their own ability to deal with |

| | | |
|---|---|--|
| <p>8. Now I have accomplished being physically present</p> <p>9. The therapist must endure their own helpless feelings to sit with this client</p> <p>13. [look at and comment on process] brings me comfort knowing that whenever I'm "stuck" in a room, 99% of the time commenting on the process will help me along</p> <p>23. Learning to trust myself for the first time was not easy, but it was a journey well worth it.</p> <p>26. Letting go is the only way to win the war</p> <p>33. [a paper sitting off to the side of a patient] was enough to cue me to know that there was something going on - and on a subconscious level it was enough to prompt me to ask</p> <p>37. I stepped into the room and I can't imagine what would have happened if I kept delaying the process. I found myself in that room, quite similar to the way we aim to help others find themselves</p> <p>42. Once I learned this I was able to realize that I am able to handle</p> | <p>43. I have found strength and resiliency from moving toward the vulnerability instead of away from it.</p> | <p>unpleasant affect because they see that you have faith in their emotional strength</p> <p>17. Sometimes neglecting aspects of yourself, no matter how much you think you have them "under control" can result in hurting your client...What I did (countertransference) was not ok</p> <p>18. ...take theories we've learned...make patterns...more clear so we can understand and reverse [patterns] when they continue to happen, in order to reverse them...I can understand it on a personal level</p> <p>19. I knew there was no evidence for the client thinking I was incompetent...because it was just silence</p> <p>20. I learned I had to become comfortable with my own experience of helplessness in order to sit with silent moments</p> <p>29. Through that [exponential] growth I could better assist my clients.</p> <p>34. I learned that my fear wasn't that I would yawn in front of a client. My fear was that I would disconnect from them, therefore being unable to help them</p> <p>39. You acculturate to the therapist culture. It's no longer about</p> |
|---|---|--|

| | | |
|--|--|--|
| <p>my feelings as I have been practicing doing so for several months</p> <p>44. I have felt more at ease stating my opinions with friends and colleagues, as well as sharing more in classroom and supervision settings</p> <p>46. I have found myself being much more in tune with myself and my surroundings</p> <p>48. I am still finding my voice, but as I keep challenging myself, I have found only reward from this process and no drawbacks</p> <p>49. I have been able to catch onto warning signals in my body much quicker than before</p> <p>50. In just a short time I feel I like I am becoming braver, wiser and more attuned to myself and others</p> <p>51. I am experiencing first-hand the benefit from doing things that require bravery (for me personally)</p> <p>54. [having access to my feeling of anger gave me much more insight into myself]...helped me navigate out of toxic relationship successfully.</p> | | <p>“interrupting” a client as they’re talking, or making statements or responding to questions. Now it’s about becoming involved in a conversation, rather than a monologue. I felt acculturated into my own career.</p> <p>47. One thing that I have learned through supervision is a concept that has propelled me through life: curiosity...I would call myself a quietly curious person. However this has changed ever since I have looked at it in a new way...being curious, in a kind way, is almost always received well and responded to enthusiastically</p> |
|--|--|--|

Theme 2. Increased engagement with work. Within journal entries, critical incidents that referred to an increase in engagement with work were noted. Of the 54 journal entries, only a few were identified as reflections of an increased engagement with work. Table H2 displays

journal entries that were a demonstration of clinician awareness, learning, or knowledge toward an increase in engagement with work.

Table H2

Theme 2. Increased Engagement with Work

| Awareness | Critical Incidents of Increased Engagement in Work | |
|--|---|---|
| | Learning | Knowledge |
| 3. Allowing me to try and be a therapist in the room | 7. I had built up this fear and psychological disorder of 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 feel again | 5. It's very clear to me that [problem solving], that it's the default approach to addressing conflict in life for so many people |
| 6. I feel a sense of urgency now to teach [riding the wave] to others | 12. This puts you as a trainee in an interesting position...you don't really know what you're talking about just yet but you want to help | 8. I finally learned how to sit in a room with a client |
| 47. ...I am much more likely to ask questions and I have found that I have many more questions about things than I had even realized...I am able to acquire much more detail about even my closest friends' experiences... | 23. I feel [because we experienced it first hand and could testify to its success] was the validation I needed as an emerging therapist.... | 23. This [connection to thoughts and feelings] allowed me to maintain the positive change within myself and then teach it to others |
| 50. ...want to contribute to others' lives and share with them a way to become more. This drive and desire to share and help others is what has inspired our work under our supervisor | 39. Now its about becoming involved in a conversation, rather than a monologue... within two weeks I was able to have dialogues, not monologues... | 45. I paid even closer attention, took more copious notes, spent more time outside reading and also attempted to apply all knowledge directly to experience I have had either in my personal or professional life |

Theme 3. Enhanced resilience. As part of self-reflections, participating novice clinicians were asked to share an experience or experiences of enhanced resilience. Table H3

displays journal entries that demonstrated awareness, humility, knowledge, or openness within experiences that led to enhanced resilience.

Table H3

Theme 3. Experiences of Enhanced Resilience

| Experiences of Enhanced Resilience | | | |
|--|--|--|---|
| Awareness | Humility | Knowledge | Openness |
| 1. ...no images of me as a psychologist. That's when I decided it was time to stop listening to the voices inside my head. | 19. I especially had trouble in therapy with silences, because I always filled the silence with the idea that I was incompetent as a therapist and that the client was perceiving me in that way...taught me a lot about my tendencies to doubt myself and helped me combat these thoughts | 2. Knowing why the psychological diagnosis is happening that makes it go away | 3. I can't learn if I don't make mistakes, and I can't make mistakes if I physically unravel every time an opportunity to try something new presents itself |
| | 22. I find it difficult to discuss because on one hand I want to defend them, but on another I cannot find a way to do it successfully with respect to making racist jokes...is a challenge to my ability to live a congruent life. But no one said it would be easy! | 4. So I kicked my parents out of the therapy room and decided to get to work | 10. sometimes you get things right and it's encouraging and then you get "knocked down" when you don't do something as well 23. Experiences of being truly connected to my thoughts and feelings was very new for me...I had to look to others to find a different standards for how to experience your thoughts and emotion, to determine if I was going about it in the best way |
| 5. How awful that the "expert" they've come to see is uncomfortable with facing the conflict | | 9. I am glad to be able to identify with [feeling disconnected] because I understand the disinterest and fog that comes with being disconnected from | 30. There was a moment I thought I had a clutch portion of my life under control, fully understood, |

| | | | |
|--|--|--|--|
| <p>6. Sat back in awe as I listened to my family talk about their state in a rigid, emotionless, matter-of-fact way...and felt so awful that they must not know how to access their feelings either</p> <p>7. I realized it was very unlikely that my next attempt at therapy would be as bad as the first</p> | <p>41. I am still unsure about many aspects of becoming a therapist but the difference is that I willing and actively making myself vulnerable...</p> <p>45. During the last class of the day, a professor...challenged us to make this change in attitude: to view our education...as a means to provide the best care for our clients. I realized I am no longer learning just for myself, I am learning for any client I may see this year or any year after. This attitude has greatly impacted the way I approached the program</p> | <p>your self</p> <p>10. [doctorate program] is where I hit the wall....try new things and mess them up, because it's the only way you start down the road to integrating them as new knowledge</p> | <p>developed and accomplished...allow myself the opportunity to experience what I had to experience</p> <p>35. I was filled with this tremendous amount of guilt knowing that I could answer so many of the questions that could have helped this clinician help their client, yet simultaneously learning things about my friend that I might have never learned otherwise...it wasn't until I absolutely had to make the choice to share it [with my supervisor]...that was only one in a litany of mistakes that I made. But here I stand with a second chance to teach my peers a lesson</p> <p>36. I drank in excess for four days in a row immediately after the semester ended....it was all about loss...but it was also the start of a new year</p> |
|--|--|--|--|

| | | | |
|--|---|---|--|
| <p>13. [an interest in psychology is] a passion for life, an awareness of the impact you want to have on the world that permeates every aspect of your life. Not just school, not just work. And because of that it changes you.</p> <p>14. I doubted my perception of things. But when you doubt your own reality, you have no standard to live by...no foundation</p> <p>16. It was pointed out to me that I relayed pity to my client for their situation rather than expressing empathy...it never occurred to me that was an odd response</p> <p>17. I disregarded their shame and other feelings in response to being raped, and I didn't help them but rather induced additional shame by communicating through my tone that I was angry with them...the disappointment that ensued when I became aware of this a week later while transcribing the tape, was overwhelming</p> <p>18. I realized how accurately our childhood patterns follow us into adulthood</p> | <p>2. ...how could I have expected myself to see what my peer saw in my work when I do not have the height to see yet</p> | <p>21. The person taught the concept of updating your self-story to one that is positive, by recognizing all the evidence to the contrary</p> <p>32. ...the stare was a blank one for few moments, and I suspected I did a terrible job of explaining [the difference between content and process]. ... After the differentiation between the two we began cueing to conversations we could easily identify as content or process, making the experience significantly easier with other clients</p> <p>42. My supervisor described psychological disorder in such a way that I have been able to decompress much quicker than before when I feel psychological disorder.</p> | |
|--|---|---|--|

| | | | |
|---|--|--|--|
| <p>20. I found that tape after tape, I was talking a lot and not effectively.</p> <p>26. I felt a sense of defeat. I stopped fighting to be a therapist cause clearly I was failing. It was only then that I freed myself up to start doing therapy</p> <p>37. This was the first application of bravery came into place. It was time to step out of my comfort zone and be brave [to step into a room with my first client], and so I was</p> <p>39. It was impossible for me to “interrupt” someone or filter in key words or phrases where necessary....I sat in silence. I waited, waited. Like most other conflicts I’ve come across, it was simply a matter of insight, recognizing that I was doing something wrong that was not benefitting my clients, so I made the</p> | | <p>This involved riding the wave and allowing myself to experience and express my experiences.</p> <p>44. As I began to learn more about [vulnerability] and challenge my clients to move toward vulnerability, I began to look more critically into my mechanisms of avoidance...I experience the feeling and express it in the moment which provides me a sense of congruency and power I never thought possible</p> | |
|---|--|--|--|

| | | | |
|---|--|--|--|
| <p>change</p> <p>41. The shift in attitude [toward being brave] is what allowed me to go into the room on the first day with a client and to try new techniques with a client</p> <p>43. What I have come to realize is in the moments of vulnerability I have a choice to either be brave or to cower, I choose bravery</p> <p>51. I remind myself frequently to “be brave” in regards to sharing a mistake in supervision, attempting a new technique with a client, or in my personal life...</p> <p>53. When I would start to feel down I would remind myself of [that as you become more confident, you become more competent and the other way around] think about where I was a month ago, and see out a listening ear in one of my colleagues</p> <p>54. ...my supervisor challenged me on naming a particular feeling...they said something along the lines of “I wonder if this is a feeling you often avoid.” As soon as I actively started feeling anger when it was present, I was able to understand it more and use it to my advantage</p> | | | |
|---|--|--|--|

Theme 4. Restoring or maintaining one’s personal well-being. Among journal entries were reflections of experiences that restored or maintained clinicians’ personal well-being. Table H4 displays journal entries that were a demonstration of awareness, knowledge, or community from experiences toward restoring or maintaining their personal well-being.

Table H4

Theme 4. Experiences that Restore or Maintain One’s Personal Well-Being

| Experiences that Restore or Maintain One’s Personal Well-Being | | |
|---|--|---|
| Awareness | Knowledge | Community |
| 1. ...most exciting part was not that I opened the doors to my career for the first time, but that I opened my eyes to my life for the first time | 5. Didn’t know it [I was jaded] until I played the tapes for my supervisor and knew something was off and when the phrase “problem solving” came up, I have had “uh-oh” moment | 2. ...[talked to a classmate who pointed out participant’s peer is still growing) How could I have expected myself to see what my peer saw in my work when I do not have the height to see yet |
| 7. ...that my anxiety would no longer be a psychological disorder...but excitement | 18. ...to take some of the theories we’ve learned, and apply it to our own lives to provide explanations for some things | 6. ...[significant other] accepted my sorrow and the intensity of my pain in that moment 50. ... six of us have all felt a monumental shift in our growth and development (on a personal level)... |
| 9. ...as I watched tapes of clients who I was told in supervision were extremely disconnect[ed] from their experiences, I felt myself identifying with them | 26. I am grateful for my client’s relentless fight because the person showed me that sometimes letting go is the only way to win the war. | 51. From these relationships I have been more bold in trying new things, which is making me a more well-rounded person and also a happier one |
| 13. ...then you go home and you talk to your partner, friends, and/or family about [changes made that day in graduate school], because it’s profound as far as you can see. | 29. By having the “break” [the semester break] in the chaos....I didn’t have to work on 10 projects at one time to feel productive, if I focused my energy on a few limited projects I could grow exponentially. | 52. ...hearing my supervisor talk about change shifted my view... [from being rigid and avoid change to change is inevitable and should be embraced] has facilitated |

| | | |
|--|---|---|
| <p>14. I realized after a long time that I could tie [doubting my own perception of reality] back to how I was raised.</p> <p>21. ...to create a new self-story that I was competent...and that created this competence/confidence loop that allowed me to become more confident, and then more competent.</p> <p>23. I recall some of the most difficult times in my personal life were times I didn't feel that I was being heard, and/or when I felt I was being told my thoughts/feeling were not valid...we just need the find the "right" people to give it to us</p> <p>28. When my frustration towards a client would occur I came to realize that often time it was because I felt the sessions were not progressing....[becoming frustrated] is often of my own violation, my own doing.</p> <p>36. It took me a full week before I gathered the courage to discuss it with my supervisor, because I recognized it was something I should address sooner than later...with my own need for bravery</p> <p>44. By [speaking my mind in interpersonal relationships], I was able to create a sense of safety between</p> | <p>43. I decided to change this [avoiding vulnerability] about myself and I began to speak my mind in my interpersonal relationships</p> <p>48. Recently, I have come to a deeper understanding of shyness and that it is linked to the misuse of my voice. I have discovered that when I do speak up and contribute I am able to create and to add to a conversation in a way I hadn't before and this has given me a sense of agency and confidence</p> | <p>my ability to be less rigid in many areas...</p> <p>53. When I would start to feel down I would remind myself [when you become more confident, you become more competent and the other way around], think about where I was a month ago and seek out a listening ear in one of my colleagues</p> |
|--|---|---|

| | | |
|---|--|--|
| <p>myself and others that had not previously been there.</p> <p>49. ...when I learned that feelings are body sensations that last a short while, they come in like a wave and then they pass. All I had to do was ride the wave...I kept at it, with encouragement from my supervisor and colleagues, and I have now found myself to be much more in tune with my own process and moment to moment experience which in turn allowed me to make better decisions especially in my dating life</p> <p>52....hearing my supervisor talk about change shifted my view...this shift in my mindset has facilitated my ability to be less rigid...more open to improvisations and spontaneity</p> <p>54. ...my supervisor challenged me on naming a particular feeling...they said something along the lines of “I wonder if this is a feeling you often avoid.”...having access to my feelings of anger gave me much more insight into myself</p> | | |
|---|--|--|

Theme 5. Increased ability to help clients. Among journal entries were reflections of a perceived increase in the ability to help clients. Table H5 displays journal entries that were a demonstration of clinician awareness, knowledge, or competence toward an increase in one’s ability to help clients.

Table H5

Theme 5. Increased Ability to Help Clients

| Critical Incidents of an Increased Ability to Help Clients | | |
|---|---|--|
| Awareness | Knowledge | Competence |
| 1. ...awareness of truth and that truth is all we need to become the best version of ourselves. Now the | 5. This [kicking my parents out of the room] freed me up to slow down, listen, respond with empathy | 9. Sitting with them in their experience of hopelessness |

| | | |
|---|--|---|
| <p>challenge is to teach that to my clients</p> <p>4. I realized that my fear of confronting clients came from a fear that if I made them feel at all uncomfortable, I was doing something wrong and risking losing them as a client</p> <p>15. I had to learn to trust myself without receiving validation from others before I could perform therapy</p> <p>17. Become more aware of countertransference IN THE ROOM, and get it in check.</p> <p>23. Having a supervisor who was able to act genuinely while modeling this connectedness with their thoughts and emotions in supervision, gave me the confidence to also stay connected to myself, and the passion to believe I should be helping my clients do this as well</p> <p>37. ...after those first few weeks of training before seeing clients I couldn't possibly imagine a week going by without seeing some of my clients. They're now under my care, I have to be responsible.</p> <p>41. This bravery on my part is what makes me congruent with what I am ultimately asking of my clients</p> <p>43. [sharing concerns and feelings instead of shutting down and keeping to myself] had allowed me</p> | <p>and open-ended questions, and allow the client to discover their own "solutions"</p> <p>8. Having this ability [acknowledging client's affective states] to bring to light something that the client is not for whatever reason is an invaluable tool</p> <p>11. How I can use [knowledge] to help clients and gauge where they are at in their psychological growth</p> <p>18. ...this lesson [of understanding and recognizing bad patterns when they continue to happen] I've been able to take into therapy and use with my clients, because I can understand it on a very personal level</p> <p>20. ...know that I cannot and should not try and "fix" my clients feelings but rather should listen,</p> | <p>13. Sometimes your growth stretches other people..</p> <p>27. We adapt to every patient we see, we adapt our treatment plans, we adapt our diagnosis, and we adapt our procedures. There is no other way to do it</p> <p>31. Simultaneously we have to adjust for [new information] within the context of our treatment planning</p> <p>39. You engage with the client in conversation because it's what we do</p> <p>16. Being empathetic is to acknowledge the difficult situation the client is experiencing, recognize it aloud, and sit with the client in their discomfort of experiencing it</p> <p>17. Sometimes neglecting aspects of yourself, no matter how much you think you have them "under control," can result in hurting your client.</p> <p>23. ...showed me that we were not teaching our clients things that we</p> |
|---|--|---|

| | | |
|---|---|--|
| <p>to... model this behavior in the room with my clients.</p> <p>44. By reframing the delivery of curiosity in my mind...I am more at ease asking [clients] direct questions or making confrontations</p> <p>29. Through that growth [of doing less projects] I could better assist my clients in the room because I wouldn't have the distraction or time constraints.</p> <p>32. was through this growth ...that I began to apply and grow across the board to other clients</p> <p>46. I have found myself better able to adjust to changing moods and feelings...with clients</p> | <p>validate, and sit together with them.</p> <p>26. It was then I knew if the person couldn't win the battle, the person had to accept defeat</p> <p>33. It is by creating that safe space that we allow ourselves the opportunity to dig deeper into our clients challenges and in doing so, we can present opportunities to overcome these challenges</p> <p>38. We learn, because it will help our clients</p> | <p>ourselves were afraid to do, but rather we were teaching things that we knew worked to improve well-being</p> <p>31.even in that preparation we have to remember to be flexible</p> <p>33. By attending to those sensory acuities, we allow ourselves the opportunity to dig deeper into the content of a conversation and allow it to shift towards process</p> |
|---|---|--|