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Formalized Therapist Self-Reflection: Validity and Reliability of the Therapist Learning Scale (TLS)

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Formalized Therapist Self-Reflection:

Validity and Reliability of

the Therapist Learning Scale (TLS)

by
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of Lehigh University
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To Freddy – Thanks for everything (and Go Yankees)

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ABSTRACT

Direct clinical work as a therapist is the most frequently identified factor for facilitating professional development (e.g., Orlinsky, Botermans, & Ronnestad, 2001; Rachelson & Clance, 1980). However, engaging in direct clinical work is insufficient for a professional to achieve expertise and mastery. A critical element in that process is self-reflection. Therapists who achieve expertise widely report that self-reflection is an essential part of that process (e.g., Ronnestad & Skovholt, 2003; Schoreder, Wiseman, & Orlinsky, 2009). It is therefore logical that therapists learn by engaging in direct clinical work and reflect upon that learning as a means of ongoing professional development.

A paucity of empirical research has investigated what therapists learn from engaging in clinical work. One study by Stahl et al. (2009) interviewed 12 pre-doctoral psychology interns about what lessons they have learned from their clients. Isenberg (2009) utilized the coded lessons from Stahl et al. to develop a formalized self-reflection tool, the Therapist Learning Scale (TLS). The present study utilized this 99-item measure for investigation of its psychometric properties and subjective benefit from novice therapists engaging in a formalized self-reflection process. Counseling programs from around the U.S. were contacted and 302 graduate students in counseling completed the study. The measure was subjected to an exploratory factor analysis, and a 19-factor solution emerged, accounting for 50% of shared variance. After examining the data, 52 items and 11 factors were retained. A Cronbach alpha of .69, a non-significant 56-participant test-retest correlation, and 9 of 11 factors being statistically unreliable, inform the conclusion that the TLS suffers from flaws in its design. However, qualitative data from study participants indicate that completing the TLS was generally a valuable experience and for most participants facilitated self-reflection.

Despite less than ideal psychometric properties, the TLS is revealed as a useful tool for the training and practice of novice therapists in the context of a self-reflection process. The revised 52-item version of the TLS improves upon identified drawbacks, including being shorter in length and having less redundant items.

The effective training of psychotherapists is a fundamental area of inquiry for

counseling psychology. However, the professional literature regarding how therapists learn

has not been included as an important aspect of training, and is in its infancy. Research on

helping skills (Hill, 2004), supervision (Bernard & Goodyear, 2009; Ladany, Friedlander, &

Nelson, 2005), professional development (Goldfried, 2001; Orlinsky & Ronnestad, 2005),

and therapist expertise (Skovholt & Jennings, 2004) each provide foundational elements

useful in training future counseling professionals. This existing literature examines the ideal

contexts that facilitate therapist learning (e.g., direct clinical practice; Freeman & Hayes,

2002) and the usefulness and benefits of examining what therapists gain from engaging in

clinical practice (e.g., professional development; Orlinsky et al., 2001). What the literature

lacks, however, are studies examining how and what therapists learn over the course of their

training, and how that learning influences therapist growth. The present study investigated

the psychometric properties and clinical usefulness of a guided self-reflection tool for use by

novice therapists. The intended use of this tool, the Therapist Learning Scale (TLS), is to aid

therapists in a self-reflection process about their clinical work to advance professional

development on the road to counselor expertise.

Learning Outcomes in the Process of Professional Therapeutic Growth

"The active therapist is always evolving, continuously growing in self-knowledge

and awareness. How can one possibly guide others in an examination of the deep structures

of mind and existence without simultaneously examining oneself?" (Yalom, 2002, p. 256). In

this quote Yalom highlights the importance of personal examination and learning, leading to

change throughout the therapeutic career. Although learning outcomes for psychotherapists may vary among practitioners depending upon individual strengths and weaknesses, the present study drew upon data collected in a recent qualitative examination of what pre-doctoral intern level therapists learned from their clients (Stahl, Hill, Jacobs, Kleinman, Isenberg, & Stern, 2009). Stahl et al. (2009) divided therapist learning among six categories, including (1) lessons about doing therapy, (2) lessons about self, (3) lessons about clients, (4) lessons about human nature, (5) lessons about the therapy relationship, and (6) the value of supervision, consultation, collaboration, and training. This study was the first of its kind, empirically investigating what therapists learn from their clients. Although preliminary in investigation, these categories identified important aspects of the therapy learning process for practitioners.

The present study utilized the preliminary categories from Stahl et al. (2009) as a guide for item development of the Therapist Learning Scale (TLS). However, identifying outcomes based on a categorical structure may not be as accurate as one organized by phases of growth. Ronnestad and Skovholt (2003) proposed that each counseling professional moves through a beginning student phase, which includes learning how to master straightforward counseling skills and learning about counseling models, fostering a sense of confidence and efficacy in the student. Later, counselors move through a novice professional phase. The authors proposed that movement through this phase is marked by understanding and mastering therapeutic relationship issues, and becoming more skillful at defining work roles and regulating boundaries (Ronnestad & Skovholt, 2003). The authors, however, did not utilize specific methods for measuring how a professional moves from one phase to another (beyond somewhat arbitrary maturation, such as going into graduate school or graduating

from it). The present study investigated the psychometric properties of a tool that may be used as part of the professional growth process, providing a formal method of self-reflection on clinical work and assisting novice therapists in moving effectively through the phases proposed by Ronnestad and Skovholt. They argued that self-reflection is the critical task for optimal growth (i.e., self-reflection) and the source that provides the greatest learning for therapists (i.e., clients).

Reflection upon What Clinical Work Contributes to Therapist Learning

Despite valuable knowledge and insight obtained from coursework, supervision, conferences, research, and other professional activities, clinical work appears to be the most significant contributor to what therapists learn about conducting therapy (Freeman & Hayes, 2002). Orlinksy, Botermans, Ronnestad, and the SPR Collaborative Research Network (2001) regarded direct clinical work as the most significant factor contributing to therapist learning. Some quantitative research exists that also emphasized clinical work as providing the most learning for a therapist. In a cross-sectional and longitudinal study of over 100 counselors and therapists, Ronnestad and Skovholt (2003) concluded that the direct experience of client work was one of the most significant sources of learning. Their results revealed that particularly memorable clients, either by their presentation in session or by the successful or unsuccessful nature of their treatment, provided the most significant lessons for therapists advanced enough to recognize them. They remarked, "Counselors at all levels of education and experience expressed in a unison voice that interacting with clients is a powerful source of learning and development" (Ronnestad & Skovholt, 2003, p. 33).

In an early study of the importance of direct experience, Rachelson and Clance (1980) interviewed 192 therapists, of whom 89% reported the category "experiences in a real-life

setting delivering needed services" as facilitating their professional development. The highest percentage of respondents (37%) also reported their clinical practice as the training component that taught them the most about how to be an effective therapist, followed by personal therapy (20%), and internship (16%). Similar evidence found by Morrow-Bradley and Elliott (1986) reported 48% of respondents finding "ongoing experience with clients" as the source of information most useful to their professional practice.

In a related study that interviewed over 4,000 therapists worldwide (Orlinsky et al., 2001), two thirds of respondents reported "experience in therapy with patients" the highest possible rating for salient positive influence on career development, and 89% of respondents marked the category above the scale midpoint. Direct experience with patients was rated consistently higher than all other possible influences, including formal supervision and personal therapy (which were consistently ranked second or third). This pattern held across a number of therapist variables, including nation (direct client work ranked first in six nations, third in Korea), professional background (first among medical, psychology, and other), theoretical orientation (first across seven types), and career cohort (first among participants with two or more years of clinical experience, second for participants with less than two years experience). (Orlinsky et al., 2001)

Results from these four empirical investigations (Morrow-Bradley & Elliott, 1986; Orlinsky et al., 2001; Rachelson & Clance, 1980; Ronnestaad & Skovholt, 2003) demonstrated that therapists consider direct client work as the most important element in how they learn about doing therapy, and that it is a major factor in professional development and competence. However, little research examines what exactly therapists learn from engaging in clinical work, and how aware they are of these lessons. The present study sought to

address this inadequacy by utilizing the practice of self-reflection. Regarding the practice of professional self-reflection, Schon (1983) wrote of benefits including increased awareness and examination of repetitive professional practice experiences, which lead to new understandings. Self-reflection is an important avenue for studying what therapists learn from direct clinical work. According to the existing literature, self-reflection is the critical task in which therapists should engage to improve professionally. Ronnestad and Skovholt (2001) stated adamantly, "We cannot emphasize enough that, to develop optimally, practitioners need to continually reflect on both their personal and professional experiences" (p. 186). Their conceptualization of this process is:

> Continuous personal reflection consists of a focused inquiry aimed toward attaining a comprehensive and nuanced understanding of the phenomena encountered in one's professional work. It presupposes an active exploratory stance and a supportive work environment, which encourages openness to the complexity of the client's reality (Skovholt, Ronnestad, & Jennings, 1997, pp. 365-366).

This study examined the psychometric properties of a measure, the content of which is a compendium of specific lessons identified by therapists that they learned through direct clinical contact in their training years. These lessons can help therapists build towards the comprehensive and nuanced understanding to which Skovholt et al. (1997) were referring. Therapists who engaged in reflection tasks, such as receiving client feedback, introspection, supervision, or colleague consultation (Skovholt et al., 1997) reported benefits from these experiences. An active reflection process can help therapists recognize how they are learning from working with their clients (Stahl et al., 2009) and what they can do to improve outcomes by modifying their therapeutic strategies or perspectives. This self-reflection

process illuminates what and how therapists learn from clinical work in a directed and strategic process, in turn facilitating professional development and fostering expertise.

Lessons From Engaging in Direct Clinical Work

A recent contribution to what therapists learn comes from a consensual qualitative research (CQR) study interviewing 12 graduate psychology students who recently completed their pre-doctoral internship (Stahl et al., 2009). These interns were asked in 60- to 75-minute interviews about the lessons they learned through the direct clinical work in their internships. Participants were instructed to identify a client from internship with whom they believed they had learned a great deal. Stahl conducted 15-30 minute follow-up interviews up to one week after the primary interview (see Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005; and Hill, Thompson, & Williams, 1997 and for detailed explanation of the CQR process).

Consistent with the CQR data analysis process, each step completed by the five-person research team in Stahl et al. (2009) required consensus across the group. In the first step of data analysis, topic areas (i.e., domains) were developed from reading a few transcriptions. The research team then modified and applied the domains to every participant speaking turn in the remaining transcripts, which produced a preliminary grouping of the data. The research team created core ideas (i.e., concise summaries of participant statements), which were grouped under the relevant domain. A senior auditor reviewed the core ideas and domains to ensure the data was properly organized, and that the core ideas appropriately reflected the raw data. The research team then completed a cross-analysis of the domains by independently examining domains across cases to look for underlying themes (i.e., categories). From this CQR process, six categories of lessons emerged – (1) lessons about doing therapy, (2) lessons about self, (3) lessons about clients, (4) lessons about human

nature, (5) lessons about the therapy relationship, and (6) the value of supervision, consultation, collaboration, and training.

Stahl and colleagues (2009) noted that the existing literature on what therapists learn from clients relies on self-directed, anecdotal accounts. Stahl et al. provided the first empirical study to capture lessons taught to therapists by clients, although anecdotal reflections from senior psychologists supported the value of articulating such lessons. For example, Bugental (1991) reflected on a 45-year career of doing therapy, teaching, and writing. He highlighted several lessons learned from his clients throughout his career, including: (1) there are always more possibilities in therapy, (2) each person's self-system is unique and personally discovered, and (3) the crippling experience of a smaller life results from trying to remain unchanging. In 1996, the peer-reviewed journal *Psychotherapy* published a special section of articles focusing on the lifelong lessons of six senior psychologists through their personal reflection. These six psychologists focused on different types of lessons, including those about healing and personality growth through interpersonal relationships (Strupp, 1996), the necessity of continuous personal change (Mahrer, 1996), learning to be an "authentic chameleon" (Lazarus, 1996, p. 143), the diversity of the world (Kaslow, 1996), and the challenges of helping clients get better (Ellis, 1996). However, when prompted to reflect upon learning as a therapist, each of the above masters highlighted the lessons taught to them by working directly with clients (Norcross, 1996). Consistent with the previously mentioned empirical studies, senior individual clinicians also considered working with clients as an invaluable source of learning. The lessons articulated by the senior psychologists offer valuable insights into what is important for a successful career in therapy. Similar to those identified in Stahl et al. (2009), therapists can reflect on such lessons and

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explore their effectiveness in applying them in their own clinical work. The present study examined the psychometric properties of a measure that could be used to guide therapists' reflection, and explore what they have learned from their clients.

What therapists learn from doing therapy is of considerable value, and supervision and clinical practice should emphasize reflection on these lessons. A majority of participants in Stahl et al. (2009) reported applying what they learned from their clients to current or subsequent clinical work, and some participants reported a greater appreciation of their lives after reflecting on their client. This point supports the idea that when therapists are aware of what clients teach them, subsequent professional development occurs. In the follow-up interview (Stahl et al., 2009), participants most reported realizing their lessons via discussion with others (i.e., supervision or consultation), and self-reflection. Stahl et al. and the senior psychologists' accounts teach us that self-reflection is an important factor in realizing valuable lessons and facilitating growth, as suggested by other writings (e.g., Ronnestad & Skovholt, 2003; Skovholt et al., 1997).

Reflection and the Development of Therapist Expertise

Professional expertise can develop as one implements reflection regularly within one's clinical practice. Respondents in Stahl et al. (2009) generally reported (i.e., 11 or 12 out of 12) applying or planning to apply what they learned from their clients after the qualitative interviews. Respondents also cited self-reflection as one action responsible for their realization of lessons learned from clients. These 12 therapists reported identifying lessons learned between the time they were contacted to participate in the study and the actual qualitative interview. They took the time in between telephone contacts to reflect on their clinical work, which became a vehicle for the realization of their learning.

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The habit of engaging in self-reflection, then, links with achieving optimal growth as a therapist. Lee and Sabatino (1998) echoed this sentiment by stating:

Researchers believe that reflection can enhance the [professional development] process and perhaps shorten it by teaching individuals how to critically reflect on knowledge and experience, linking the two together to enlarge the schema thus hastening the road to expertise and improving performance. (p. 164)

Several writers (i.e., Daudelin, 1996; Leung & Kember, 2003; Mezirow, 1998; Peters, 1991; and Schon, 1983) emphasized the importance of self-reflection being a path to break away from typical patterns of thought and behavior, and to challenge the beliefs, biases, assumptions, and feelings that govern one's perceptions and professional practice leading to expertise. While investigating characteristics of master therapists, Jennings and Skovholt (1999) posed the question of how therapists could use experiences (in and out of sessions) to increase competency and move towards expertise. These master therapists stated that they were, "Quite reflective and self-aware, and use these attributes to grow personally and professionally" (Jennings & Skovholt, 1999, p. 9). Ronnestad and Skovholt (1993) underscored the importance of supervision for professional growth, but qualified this idea by reinforcing the necessity for continuous professional reflection. The ability and willingness to engage in this reflection process, which is particularly difficult with challenging cases, they considered a prerequisite for optimal growth (Ronnestad & Skovholt, 2003). Such a self-directed and integrative process could minimize counselor rigidity and foster an internal focus for effective clinical work (Skovholt & Ronnestad, 1992). Similarly, Schroder, Wiseman, and Orlinsky (2009) found that a majority of the 1,040 therapist participants in their study thought about how to help resolve client issues or reflected on their feelings for

their client(s) between sessions. Intersession experiences highlighted the tendency for therapists to think reflexively about their clients, therefore a process of self-reflection should naturally fit into a therapist's routine.

Additionally, the self-reflection process may aid therapists as a scaffold to support learning from the clinical setting. By definition, a scaffold is "a temporary entity that is used to reach one's potential and then is removed when learners demonstrate their learning" (Lajoie, 2005, p. 542). The idea of scaffolding was developed in the late 1970s to describe the need for a child or novice to receive support when attempting to complete a task they may not be able to competently complete by themselves. Reflecting on one's clinical work in therapy has traditionally been a self-directed task outside of the supervision context. Supervision is an essential part of successful psychotherapy training, however a formalized self-reflection process likely provides benefits to assist novice therapists in identifying and exploring lessons from clinical work. Lajoie (2005) discussed that apprenticeship settings provide opportunities for novices to learn from experts, which directly relates to the supervision setting in therapy training. She continued by noting that scaffolding by experts and deliberate practice lead to the achievement of expertise. The present study proposes that a tool such as the TLS, while utilized in a process of self-reflection, will also provide scaffolding for a novice professional to identify lessons from therapy work and facilitate professional development leading to expertise. There is a lack of emphasis beyond supervision for a standardized approach to clinical self-reflection in therapist training, however the present study investigated the effectiveness of a specified process and tool (i.e., the TLS) to aid in this critical aspect of professional development.

Reflection as a Self-Care Strategy to Buffer Therapist Burnout

Learning from clients through reflective processes may also help prevent (or ameliorate) emotional exhaustion (Stahl et al., 2009), which is the component of burnout that mental health workers most often report (Savicki & Cooley, 1987). A commonly used definition of burnout by Maslach and Jackson (1981) is a syndrome marked by emotional exhaustion, depersonalization and cynicism, and diminished personal accomplishment, which occurs in people in helping professions (Kim & Ji, 2009). Savicki and Cooley (1987) highlighted factors associated with burnout, including loss of worker impact on procedural and policy issues, lack of worker autonomy, lack of clarity regarding work objectives and responsibilities, and intensity of work (i.e., number of clients and length of contact time with clients).

Burnout can become a potential barrier to achieving the goal of therapeutic expertise. Several professional hazards can bring about the emotional exhaustion, depersonalization or cynicism, and diminished personal accomplishment of burnout. Skovholt, Grier, and Hanson (2001) outlined seven hazards of the counseling profession, including "clients have an unsolvable problem that must be solved," "there is often a readiness gap between them and us," "our inability to say no," and others (Skovholt, et al., 2001, p. 169). These hazards parallel some items on the TLS, such as "I recognize my client's level of responsibility for therapy outcome" (item 13). A therapist will be more likely to consider these potentially overwhelming aspects of clinical work when prompted via a self-reflection process or tool, such as the TLS, than if they were engaged solely in an unstandardized reflection process.

Skovholt et al. (2001) outlined several strategies for personal and professional self-care, some of which include "maximizing the experience of professional success,"

"increasing professional self-understanding," and "focusing one's own need for balanced wellness" (pp. 172-174). These strategies may include self-reflection tasks, potentially facilitated by examining what therapists learn from their clients. Continual reflection on one's therapeutic work may reinvigorate therapists to develop new strategies and ways of thinking about their clients and their approach to clinical work, to reduce the likelihood of exhaustion and cynicism associated with conducting therapy. Combining the research on therapist reflection, professional development, and burnout, Stahl and colleagues (2009) believed focusing on what therapists learn from clients could be an additional protective factor against burnout or possibly alleviate the emotional exhaustion of the burnout experience.

Grosch and Olsen (1994) highlighted the importance of assessing one's own personal and professional lives to help identify potential signs of burnout. They specifically cited checking in with levels of enjoyment, satisfaction, enthusiasm, and optimism. Additionally, openness to learning, tolerance of ambiguity, and tendency to challenge oneself are important personality variables that serve as protective factors against burnout in master therapists (Skovholt, et al., 2001). These traits lead to highly engaged learning, which when reflected on, may serve therapists to recognize how they are performing and if there are particular areas in their repertoire that need improving. Other potential protective factors against burnout may be a supportive social environment, appreciation by administrators and supervisors, and the ability to focus on and enjoy positive interactions and outcomes (Grosch & Olsen, 1994). Using self-reflection on one's learning can be one method of reinforcing protective factors against burnout. Although much of the research emphasizes the value of continued personal reflection and learning from clients, this process tends to be individually

driven. To date, no standardized tool for clinical reflection exists, although Stahl et al. (2009) called for a measure of learning from clients to move the literature forward in this research area. The importance of a formalized reflection tool and process for psychotherapy professionals is reasoned from Schon (1983). He expressed that "in-action" reflection occurs, meaning "an increased awareness of present limitations or immediate needs that must be addressed" (p. 62) in the moment of professional practice. However, in this process the routine tasks and understandings of professional practice can be overlooked and neglected, leading to an increasing likelihood of reduced attention paid to critical or fundamental aspects of practice. This reasons that a standardized tool and process for self-reflection would provide benefit to the field of psychotherapy.

The Therapist Learning Scale (TLS): A Potential Instrument for Studying Therapist Learning

The current study expands the literature of therapist training by having examined the psychometric properties of a guided self-reflection tool, developed particularly for use by novice therapists during a self-reflection process, investigating what they learn from their clients through engaging in clinical practice. This study also investigated the utility of guided self-reflection as a process underlying therapists' learning using the perspective of the therapists themselves (i.e., what benefits therapists perceive from engaging in guided self-reflection).

The Therapist Learning Scale (TLS) was developed, with the permission of the authors, from the coded data of Stahl et al. (2009) by drawing upon the actual words of participants and the coded core ideas to create items. This study investigated if the TLS can

be a parsimonious measure, and if its factor structure was consistent with the six learning categories identified by Stahl and colleagues.

In 2009, Isenberg developed the TLS and subjected it to preliminary analyses. A total of 110-items were created from the coded data of the Stahl et al. (2009) study. An auditor with prior experience in scale development reviewed these items. Item lengths, stems, and wording were revised, and then expert raters were recruited to review the items. These raters either were licensed professionals with at least eight years of clinical experience, or were experts in the area of the topic (e.g., Jessica Stahl, first author of the foundational article for the present study). A pilot study with practicum students from counseling psychology programs followed, including analyses of subscale intercorrelations and internal consistency. Isenberg then engaged in a revision process based on the correlations and expert rater data to determine items for revision or removal from the scale, leaving a total of 99-items. A more extensive review of this process is present in the methods section of this document.

Validity and reliability of the TLS. Isenberg (2009) completed an analysis of internal consistency to examine the reliability of the TLS. Results indicated that the TLS had low-to-moderate internal consistency, with an overall Cronbach alpha of .78. According to literature regarding scale development (Clark & Watson, 1995), the TLS has adequate reliability.

Isenberg (2009) examined the content validity of the TLS (i.e., to ensure items were accurate representations of the data and categories from Stahl et al., 2009, from which they were created). He asked six expert raters to examine the preliminary TLS. One task required the raters to place each item into one of the six categories identified in Stahl et al. For 51% of the original items (56/110), at least three of the six experts placed the item into a category not specified by the Stahl et al. analysis. For example, three of the six raters correctly placed the

item, "therapists are just as flawed as their clients" (item 1) into the Lessons about Human Nature subscale. However, the other three raters placed the item in Lessons about Self, and Lessons about the Therapy Relationship categories. Since over 50% of the total items in the measure were placed by raters into subscales they were not developed from, these results may reflect the flexibility of the items to fit into multiple categories, or the lack of precise category definitions. Thus, two qualitative examinations (i.e., the CQR process in Stahl et al., 2009, and the raters in Isenberg, 2009) revealed distinctly different opinions about what category many items most appropriately fit into, therefore increasing the likelihood that a quantitative analysis of the lessons' factor structure may provide contrary organization. The use of an exploratory factor analysis may present a factor structure inconsistent with the Stahl et al. categories. From these analyses it appears that the lessons categories are more valuable for the purposes of item generation than they would be for statistical analysis and factor identification.

Isenberg (2009) also addressed the TLS's construct validity by instructing raters to identify items' appropriateness to the construct of learning. Raters were instructed to read each item and rate on a 4-point Likert scale if reflecting on that item would indicate learning something from engaging in clinical work. Items that received less than two-thirds positive rater feedback were removed from the scale (6 items). The present study took steps to further reinforce construct validity for the TLS. Because the initial data on the TLS were compiled from a pool of pre-doctoral interns, the lessons (and therefore items) may not be generalizable beyond the novice level; however, practicum and intern supervisors can use the TLS as a tool to help supervisees reflect on their learning, especially regarding particularly challenging or meaningful clients (Ronnestad & Skovholt, 2003). Additionally, the

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ambiguousness of therapeutic success can contribute to novice therapist anxiety and distort novice therapist perceptions of their own effectiveness. By engaging in a self-reflection process, advanced trainees may develop a more accurate perception of their counseling self-efficacy as they reflect on lessons they may have applied or failed to apply in their clinical work.

Although research has discussed the value of guided self-reflection (e.g., Lee & Sabatino, 1998; Peters, 1991; Ronnestad & Skovholt, 2003; Schon, 1983), the subjective helpfulness of completing the TLS by the respondents should provide construct validity for the measure, indicating that it illuminates areas of learning for novice therapists. Therefore, participants in the current study responded to a separate measure that asked them about their impressions of the scale's usefulness, after they initially completed the TLS. Participants were asked about their initial impressions after completing the measure, how much it helped participants better understand themselves as clinicians, its usefulness as part of a self-reflection process, its strengths, and its weaknesses. This mostly qualitative feedback will aid future research in determining how the TLS can be improved.

Research questions and hypotheses. The present study investigated the psychometric properties of the Therapist Learning Scale (TLS). The research plan called for the solicitation of at least 300 participants to complete the TLS and supplemental measures (Guadagnoli & Velicer, 1988). At least 30 participants completed the TLS again after at least two weeks to ascertain test-retest reliability. An exploratory factor analysis was utilized to develop an accurate factor structure for the TLS, and allow for the creation of a more parsimonious measure.

The research questions and hypotheses for this study were:

(1) Will the TLS conform to a six-factor structure as developed and proposed in Isenberg (2009)? The author predicted that the TLS would not conform to a six-factor structure due to the conflicting qualitative data of expert raters from Isenberg (2009) and the qualitative data coded from Stahl et al. (2009), as previously explained.

(2) Will the TLS have adequate test-retest reliability after at least a two-week follow-up? The author predicted that the TLS would have adequate test-retest reliability as evidenced by a high correlation between scores from the first and second administration of the measure.

(3) Will the TLS achieve convergent validity by correlating highly with the Psychotherapists' Professional Development Scales (PPDS: Orlinsky & Ronnestad, 2005)? The author predicted that there would be a significant correlation, indicating that the TLS measures a similar underlying construct that is measured in the PPDS (i.e., professional development).

(4) Will the TLS be highly correlated with the Marlowe-Crowne social desirability scale Reynolds Short Form A (MC-RSF-A: Reynolds, 1982)? The author predicted that the TLS would not be highly correlated with the MC-RSF-A.

(5) Will number of months doing supervised therapy be predictive of higher scores on the TLS? The author predicted that there would be a predictive relationship in scores on the TLS between more and less advanced student participants because research on professional development indicates that students experience much learning and change early in their clinical training (e.g., Ronnestad & Skovholt, 2003), and participants from the present study would likely span from one semester to perhaps six semesters of clinical training.

(6) Will participants find completing the TLS and the self-reflection process generally to be a useful and valuable process? If not, how will participants recommend the TLS change to be more beneficial as a tool to aid in the self-reflection process and continual professional growth? The author predicted that participants would find completing the TLS and the self-reflection process a valuable experience (Lee & Sabatino, 1998) as evidenced by responses on the included structured comments questionnaire. Specifically, the author expected participants to provide more global positive than negative or neutral reactions to completing the measure, significantly higher responses (i.e., more 6-10 than 1-4 scores) to the question about the usefulness of using the TLS, and significantly more strengths than weaknesses listed by participants. The author also expected participants to find the TLS too long and redundant at times. The length and perceived redundancy of the TLS were essential components in the development of the TLS in following with standard scale development procedures (Clark & Watson, 1995; DeVallis, 2003).

CHAPTER II

Literature Review

When investigating how and what therapists learn from conducting clinical work, additional contributing factors need consideration, including the optimal conditions for counselor learning, self-reflection and its importance on the therapist learning process, achieving expertise and the process of professional development, and burnout. Taken together, these factors explain how and what therapists learn from clients, the process of professional growth, and potential pitfalls encountered by therapists. As the present study evaluated a measure of therapist learning, it is critical that any relevant literature is reviewed for the topics of therapist learning, self-reflection, expertise and professional development, and burnout, as well as related material regarding test construction and validation.

Therapists Learning from Clinical Work

"You learn a lot from your kids just like you learn a lot from your clients" (Ronnestad & Skovholt, 2003, p. 24). Although research regarding therapist learning is in its relative infancy, studies that have investigated this topic clearly promote direct clinical work as contributing the most to therapist learning, followed by supervision, personal therapy, internship, workshop trainings, and graduate school generally (Orlinsky et al., 2001; Rachelson & Clance, 1980). These activities all lead to professional development and growth. The following section explores the circumstances that contribute to how therapists learn in their careers, including direct clinical work and supervision, as well as the categories of counseling learning, with examples from lessons articulated by intern-level and senior practitioners.

Supervision is an essential activity for therapists, and teaches therapists valuable lessons about clinical work. It particularly provides a modeling experience and can be an anchoring environment for students to help reduce the anxiety associated with being a beginning therapist (Ronnestad & Skovholt, 1993). The structure and didactic focus of supervision provide support and guidance. As students advance in their skills and understanding of therapy, supervision becomes more complex, where role ambiguity and conflict begin to present, despite students still needing the secure base of a supervisor to go to for help (Ronnestad & Skovholt, 1993). Few would argue the overall benefit of supervision and its necessity for appropriate professional development. After all, it is a requirement for all therapists until licensure is achieved, and recommended as a best practice afterwards. The research team from Stahl et al. (2009) developed supervision as one of the six categories of therapist learning from clients because respondents expressed the value of supervision in their interviews (e.g., "I do not find the idea of supervision very useful or helpful" (item 99, reverse scored; Isenberg, 2009). Despite the value of supervision, therapists seem to learn and grow the most due to engaging in the therapeutic process with clients. In Rachelson and Clance's (1980) study, a substantial majority of respondents (89%) indicated that direct clinical work was their leading source of learning, specifically learning information about psychotherapy that was useful in their practice. Similarly, the vast majority of respondents (over 90%) across theoretical orientations in a study conducted by Orlinsky and colleagues (2001), reported direct clinical experience as the most salient positive influence on their professional development.

Ronnestad and Skovholt (2003) highlighted client factors that contribute to learning, in particular, experiences with clients who may have a particularly successful or unsuccessful

course of therapy. Participants in Stahl et al. (2009) shared this experience, as they reflected on clients they felt they learned a lot from, which typically included those that had very successful or unsuccessful outcomes. Client reactions to therapist behaviors and attitude continually influence the practitioner. Ronnestad and Skovholt note that counselors at all levels of education and experience uniformly expressed that clients serve as a major source of influence, and as primary teachers. (Ronnestad & Skovholt, 2003)

In addition to working with clients, experienced practitioners, reported similar formative contributions to their development, including a shared diversity of experiences, and learned resourcefulness (Norcross, 1996). For experienced practitioners, using lessons from clinical work to disseminate to supervisees and/or students is another generative task. Teaching others served as a valuable activity of learning (Ronnestad & Skovholt, 2003), particularly when lessons from one's own therapy experiences are passed onto the next generation of therapists.

In addition to experience level, other therapist and/or career setting attributes can contribute to what and how much a therapist may learn from their clients. For example, Norcross (1996) identified theoretical training, clinical population, and career trajectory as contributing factors to therapist learning. Variations in personality factors, such as openness to experience and conscientiousness may affect learning as well. Therefore, it is likely that across a number of variables, therapists will learn different specific lessons from their clinical experiences at different times in their training and career. Despite that point, however, it appears that clients provide the best source of learning across various themes or categories.

Categories of therapists learning from clients. In a study that formed the basis for the TLS and the proposed investigation, Stahl and colleagues (2009) identified six categories of

therapist learning drawn from qualitative data. These categories are lessons about doing

therapy, lessons about self, lessons about clients, lessons about human nature, lessons about

the therapy relationship, and the value of supervision, consultation, collaboration, and

training. Even though the Stahl et al. data emerged from intern-level counselors, anecdotal

accounts of senior practitioners reflecting on their life of therapy work provided additional

lessons that could be coded to fit within these categories. Norcross (1996) discussed the

value of being flexible and integrative in one's clinical pursuits as a lesson he learned from

his career of doing therapy. This lesson fits well into the category from Stahl et al., Lessons

about Doing Therapy. Similar lessons from experienced practitioners can guide novice

therapists in self-examination of skills and perspectives to aid in professional growth. Some

of these examples that can be grouped by the categories identified in Stahl et al., include

knowing one's limitations (Strupp, 1996: Lessons about Self); understanding the value of

studying impressive therapy tapes (Mahrer, 1996: Lessons about the value of Supervision,

Collaboration, Consultation); needing to have a gender-sensitive and multicultural

perspective (Kaslow, 1996: Lessons about Human Nature); and the importance of helping

clients get better instead of just feel better (Ellis, 1996: Lessons about Clients). However, as

evidenced by the expert rater review of the TLS items (Isenberg, 2009), there appears to be

great fluidity and subjectivity across individuals regarding into what category a lesson should

be placed. It is for this reason that the lesson categories from Stahl et al. are considered most

useful for the purposes of item generation and not final subscale definitions.

Lessons articulated by senior practitioners sometimes appear different qualitatively

than those identified by intern-level therapists in Stahl et al. (2009), and modified into scale

items in Isenberg (2009). In discussing therapist learning, Strupp (1996) concluded that

compassion and skill resonating from therapists who genuinely care, needs to be at the core of an effective therapist's personality. Strupp wrote that the key factors for counselors to possess in providing quality care are, "Clarity of mind, tranquility of spirit, and a disciplined set of interventions that are competently and flexibly utilized as needed" (Strupp, 1996, p. 138). These lessons are broad and identify personality-based factors, while participants from Stahl et al. focused on lessons that seem more specific to experiences they had with an individual client. Perhaps reflecting on one's career overall leads to the realization of more general lessons, while focusing on specific clients leads to lessons of a more specific nature (e.g., "I know very little beyond what my client tells me", item 67).

Nevertheless, lessons articulated by senior practitioners provide an important roadmap for less experiences therapists, and relate to the categories identified in Stahl et al. (2009) in the following way. Some lessons fit into the category Lessons about Self. For example, Mahrer (1996) emphasized the value of undergoing personal change to achieve greater levels of professional development and expertise. Kaslow (1996) added that having a deep sense of self-awareness aids counselors in engaging in self-care, a critical component for good practitioners. Both experienced and novice therapists (Crawford, 1987; Strupp, 1996) reported that countertransference reactions are important to be aware of and process, and understanding one's emotions in the therapeutic context provides valuable information for the work. These lessons found their way into items on the TLS. For example, items generated with the Lessons about Self subscale in mind include "At times I do not recognize countertransference with clients" (item 35) and "Therapy has an impact on my personal well-being" (item 66) (Isenberg, 2009). Here we see both intern-level practitioners and senior practitioners highlighted the importance of self-reflection and awareness of events in therapy,

suggesting Lessons about Self is an example of what an important learning category across one's career looks like.

These senior therapists also articulated valuable Lessons about Clients, another category from Stahl et al. (2009). For example, Lazarus (1996) emphasized the importance of clients learning adaptive coping mechanisms in therapy to protect against relapse, whereas Ellis (1996) alleged that clients can disturb themselves in similar ways, while all being remarkably different. Ellis proposed that some clients might make choices that seem selfish, however, Freeman and Hayes (2002) counters that this may be due to spare others from suffering. Similar lessons that were developed into items on the TLS include, "Clients generally do not have appropriate reasons for behaving in their maladaptive ways" (item 87, reverse worded), and "Clients tend to be rigid" (item 32) (Isenberg, 2009). The similarity between the lessons expressed by the experienced practitioners and those by the intern-level therapists suggests that the TLS effectively captured a wide berth of lessons therapists learn from their clients.

Freeman and Hayes (2002) underscored the universality of human experience that therapists sometimes see, such as clients reminding therapists about the strength of the human spirit to overcome adversity (a corresponding lesson about clients is, "Clients tend to be strong", item 40). This is an example of the challenge that trying to group each lesson into one particular category presents, as this lesson can generalize to the value of psychotherapy for all people, a topic Bugental (1991) further explored in his reflections:

Psychotherapy is one of the ways we try to be more alive. The need for

psychotherapy arises from our being caught in ways of being alive that are too

cramped or distorted. The most frequent way we cripple our lives is through making

ourselves objects and thus being cut off from awareness of our unique individual

experiences, needs, and intentions (p. 31).

Bugental continued expounding the importance of opening oneself to examination, and

understanding that more courage, persistence, and determination can exist when it seems no

longer possible. A life-long career doing psychotherapy taught Bugental (1991) that

ambiguity, uncertainly, and incompleteness are important for living full lives, while

perfectionism and dichotomous thinking can cripple one in their life. Isenberg (2009)

developed items with similar feel in the Lessons about Human Nature category, including

"Therapy generally does not play an important role in a person's life outside of counseling"

(item 82, reverse scored), and "People are ambivalent to change" (item 73). These lessons are

present in the Lessons about Human Nature category; however, changing "persons/people" to

"clients" would quickly change its appropriateness to the Lessons about Clients category

instead, once again highlighting the ambiguous nature of strictly categorizing the lessons.

Results from intercorrelations in Isenberg (2009) supported this point, as Lessons about

Clients and Lessons about Human Nature subscales were significantly correlated with one

another. These subscales were only also significantly correlated with each other and Lessons

about Doing Therapy, to which all the individual subscales were also significantly correlated.

Yet there remains similarity between lessons articulated by senior practitioners and

intern-level therapists suggesting that the categories in Stahl et al. (2009) are robust to

therapist cohort effects and lessons therapists identify late in their careers. Even though the

lessons are similar, however, they are different enough that they may have value as individual reflection items for other therapists. Although it is beyond the scope of the present study, future research can investigate lessons from senior practitioners reflecting on their careers, and apply those to a clinical reflection tool similar to the TLS. These rich lessons from long-time practitioners help illuminate the importance of self-reflection and understanding how one's clinical work can lead to immeasurable personal change. As described, similar lessons and others are included in the TLS, reminding participants of the importance that these ideas and perspectives provide for therapists as checkpoints towards professional development and expertise.

Self-Reflection across Disciplines

Even though the present study explored the importance of self-reflection in the practice of psychotherapy professionals, it is important to note the writers across different disciplines that discuss the benefits of being a reflective practitioner in education, organizational, and management contexts. The most widely referred definition of reflection belongs to Dewey (1933):

> Reflective thinking, in distinction from other operations to which we apply the name of thought, involves (1) a state of doubt, hesitation, perplexity, mental difficulty, in which thinking originates, and (2) an act of searching, hunting, inquiring, to find material that will resolve the doubt, settle and dispose of the perplexity (p. 12).

Dewey's (1933) definition used education for its context. Other definitions include examining reasons and assumptions that drive behavior to improve effectiveness (Peters, 1991), and a process of asking questions, seeking alternatives, and seeing what others would do (Lee & Sabatino, 1998). Peters also called for openness by the practitioner who should be

systematic and analytical in his/her self-examination, the process of which is usually

prompted by a perplexing or challenging context for which the practitioner cannot determine

an immediately effective response. Writers from the management discipline professed similar

definitions, and value providing for a personal assessment of the validity of one's

assumptions, a reassessing of one's perceptions to solve problems (Gray, 2006), and

"privileges the process of inquiry, leading to an understanding of experiences that may have

been overlooked in practice" (Raelin, 2002, p. 66).

Schon (1983) emphasized the importance of breaking out of repetitive practice, which

too often becomes routine for many professionals. He related reflection to pitching in

baseball or playing in a jazz band, where slight adjustments, redirections, and paying

attention to others allow for one to shift their perception in greater ways. He believed that

becoming locked in repetitive practice without the benefits of reflection can to lead to

boredom, burnout, rigidity, and a likely decline in positive outcomes. Just as practitioners

expect clients to be open to the possibility of different perspectives, a practitioner must apply

the same principles to her/himself (Schon, 1983). The critical element in breaking out of

repetitive practice involves an openness to assimilate new information or perspectives into

our understanding of our professional practice, and accept less expertise regarding client

issues.

Mezirow (1998) discussed the importance of being aware of the tacit judgments

people make, and the choice of assimilating new information into one's worldview, or

accommodating new information into their already existing schemas. Mezirow argued, in an

educational context, the importance of empathy. He discussed the innate human inadequacy

of not understanding all the meaning behind feelings, values, ideals, moral decisions, and

intentions that are communicated between people. Therefore it is critical to not only understand the meaning of a person's words, but also the assumptions in the norms, truthfulness, and authenticity of their communication through careful examination of one's one beliefs and biases. He wrote that knowledge is context-based and one individual may not value the particular perspective that another individual values. An example from the counseling context would be seeing a client from a different cultural background that perceives eye contact towards a person in a position of power (i.e., the therapist) to be inappropriate, while the therapist perceives eye contact to be appropriate and important for effective communication. In this situation it is incumbent upon the therapist to examine their own assumptions about the use of eye contact and cultural differences. This is why reevaluation of biases and judgments by the professional is so critical. Peters (1991) agreed, stating that "learning and professional growth usually occur when practitioners critically reflect and act on revised assumptions" (p. 90). According to Leung and Kember (2003) reflective thinking should seek to understand the initial issue or doubt that triggered the process, including the recognition that "many of our actions are governed by a set of beliefs and values which have been almost unconsciously assimilated" (p. 69). Daudelin (1996) made a similar connection between absorbing information from another, filtering it through one's personal biases, and then learning from that experience. However, without reflection, Daudelin believed learning is less likely to occur. He argued from an organizational context that reflection could lead to the realization of new and important meaning, and help protect against "the latest in a series of new management gimmicks" (p. 39).

In the organizational perspective, Daudelin (1996) believed stopping and reflecting on important areas of company issue leads to improvements and innovations that can have

broad impacts on company success. Other benefits of critical self-reflection can include

awareness and insight into one's assumptions for how to address a problem and the

subsequent consequences (Mezirow, 1998). Mezirow related this to the very foundation of

psychotherapy, as a problem-posing and problem-solving process, which leads to an

examination of the sources of one's assumptions that govern feelings and actions.

Psychotherapists engage formally in the self-reflection process primarily in the

beginning years of their training through supervision with experienced practitioners, and

through case conferences with colleagues. Upon licensure, after 3-5 years of training,

additional supervision or consultation is not required beyond state-based continuing

education mandates, which does not focus on self-reflection of clinical work. It is thus the

clinician's responsibility to engage in her/his own process of self-reflection. Peters (1991)

outlined a four-step process to reflective practice:

> (1) Describe the problem, task, or incident that represents some critical aspect of
>
> practice needing examination and possible change. (2) Analyze the nature of what is
>
> described, including the assumptions that support the actions taken to solve the
>
> problem, task, or incident. (3) Theorize about alternative ways to approach the
>
> problem, task, or incident. And (4) act on the basis of the theory (p. 91).

Similarly, Lee and Sabatino (1998) described a three-step process that focus on questions

practitioners needs to ask of themselves to engage in guided reflection. They outlined (1)

describing the problem, event or situation by asking "what" questions, (2) analyzing the

thoughts and feelings described in step one by asking "why" questions, and (3) developing a

theory for how to improve practice by asking "how" questions. Lee and Sabatino had 12 part-

time graduate students engage in a guided self-reflection task about a recent learning

experience they had in their coursework. Participants were instructed to (1) think back to the experience, (2) describe and analyze the situation, (3) develop a theory about how the topic possibly influenced the situation, and (4) how they would act in the future.

The participants in the present study engaged in a self-reflection process that combined elements outlined by Peters (1991) and Lee and Sabatino (1998). They began by identifying a challenging client that they have worked with in therapy, and report 2-3 aspects of working with this client that were challenging. Participants then identified 2-3 reasons why these were challenges for them, and then completed the Therapist Learning Scale (TLS) to help participants identify aspects of their work with this client that they may or may not have considered (i.e., prompts to develop a theory). Finally, participants reported 2-3 changes they were planning to make in their approach to working with this client or similar clients in the future.

Collectively, researchers across disciplines find reflective practice to be an important and meaningful activity. Eighty-three percent of participants in the study by Lee and Sabatino (1998) reported the guided reflection task to be useful and enjoyable, and all recommended that they should continue to be used in the future. As the expectation of client personal change in psychotherapy persists, the openness of practitioners to personal self-scrutiny may be a contributing factor that distinguishes a practitioner's skill. Peters (1991) noted that, "Reflective practice is not always pleasant, but it is almost always rewarding. Professional development is one reward, and better service to others is another" (p. 95).

Self-Reflection and the Psychotherapist

Although the experience of engaging in direct clinical work is essential for developing expertise in psychotherapy, the critical element to bridging the experience-

expertise gap is self-reflection. Ronnestad and Skovholt (2003) defined self-reflection as, "A continuous and focused search for a more comprehensive, nuanced, and in-depth understanding of oneself and others, and of the processes and phenomena that the practitioner meets in his/her work" (p. 29). In their phases of therapist/counselor development, Ronnestad and Skovholt identified continuous reflection as a prerequisite for optimal learning and professional development at all levels of experience (Theme 3). Without it, stagnation and complacency can set in for therapists, and as will be explored later, burnout.

A study by Schroder et al. (2009) revealed that a majority of practitioners (61%) naturally think about or reflect on how to help resolve client issues when they are outside of the therapy office. Additionally, 54% of therapist respondents reflected on their personal feelings toward a client outside of session, while only 49% rarely or never imagined a conversation with their client. These "intersession" experiences also occurred more frequently with therapists that had been in practice longer (Schroder et al., 2009); therefore, it appears therapists have a natural tendency to reflect on their clients and therapeutic work. Unfortunately, in therapist training programs there appears to be a paucity of emphasis on fostering an internal orientation to reflect on client work. Too often novice therapists still in training or just finishing training assume an external orientation, waiting for professors or supervisors to prompt them about these issues, instead of focusing on personally based and integrative processes that occur through reflection on one's experiences (Ronnestad & Skovholt, 1993). Learning to focus on the changes that novice therapists experience in each practicum and later on internship, can facilitate an effective self-reflection process, potentially fostering a routine and leading to gradual and continuous professional development across the span of one's career. This is a task that can be facilitated and fostered

by supervisors or other professional practitioners as a part of the formal supervision process, as Gray (2006) discussed from an organizational context.

Skovholt and colleagues (1997) explored the benefits of reflection on one's personal and professional experiences. They commented that with reflection, domain-specific knowledge and an enhanced ability to improve skills takes place. For example, although the ability to form a strong working alliance is achieved by novice therapists, little data exists regarding the ability of novices to form strong working alliances with particularly challenging clients. According to Skovholt et al., a therapist needs more expertise to facilitate an alliance with clients presenting with severe issues or personality factors, and this is typically the job of the experienced practitioner. One who has obtained the domain-specific knowledge and skills to which Skovholt et al. (1997) were referring. The authors continued by stating that reflection upon interpersonal experiences in professional and personal realms are necessary. Although clients teach us the most about effective therapeutic practice, lessons outside of the therapy office can generalize about human nature and inform clinical work.

Skovholt et al. (1997) neglected to articulate a specific process for engaging in self-reflection, however. Fortunately researchers in the education discipline have explored this area of inquiry. Leung and Kember (2003) discussed three steps that are necessary for perspective change, which as articulated before, is often a goal of the self-reflection process. They stated that a person must (1) examine their existing frameworks (e.g., assumptions, biases), (2) experience a period of disequilibrium and conceptual conflict, and (3) reconstruct or reform a new conceptual framework (Leung & Kember, 2003).

Daudelin (1996) emphasized the use of questions for facilitating discovery in the self-reflection process. She wrote that, "what is needed is a process of analysis that explores

causes, develops and test hypotheses, and eventually produces new knowledge" (p. 37). Her

process involved four stages, including (1) articulation of a problem (asking "what"

questions), (2) analysis of said problem (asking "why" questions), (3) formulation and testing

a tentative theory (asking "how" questions), and (4) action or deciding whether to act (asking

"what" questions again). In the analysis phase, Daudelin emphasized the asking and

answering of "why" questions about the situation, trying to remember similar situations, and

reviewing past behavior. She believed the third phase (the hypothesis-testing phase) leads to

learning, which she defined as, "the creation of meaning from past or current events that

serves as a guide for future behavior" (p. 41). In her study, Daudelin had participants think of

a challenging work experience, reflect on it for one hour (using a set of guidelines for

effective reflection and questions provided), and then write down answers to those questions.

She found that participants learning were significantly improved about their chosen

challenging situations in just one hour of guided reflection.

Continuous self-reflection is a recommended activity for developing expertise, which

is a process that may take at least 15 years to achieve (Skovholt et al., 1997). Therapists

considered experts by their peers engaged in personal reflection and self-awareness activities

regularly, and embrace complexity. It is in the examination of the complexity of clinical

work that brings forth professional growth (Ronnestad & Skovholt, 2001; Skovholt &

Jennings, 1999). Several models and factors of professional development exist, some of

which are explored below.

Expertise and the Process of Therapist Professional Development

This section explored several aspects of professional development, including the

cycle of caring, phases of counselor/therapist development, themes in this development

process, challenges of being a novice therapist and the effect of critical incidents, the characteristics of master therapists, and therapy's effects on therapists.

The cycle of caring. Skovholt (2005) outlined a three-phase process that, if used correctly and repeated over the course of many clinical hours, should facilitate movement towards expertise. The model utilized attachment theory for its foundation, and describes a series of professional attachments and separations in the context of the therapeutic relationship. Skovholt emphasized the importance of building a strong working alliance, and articulated its repeated successful building as what defines mastery. He postulated that the quality of the therapist's engagement in the cycle of caring and their expert knowledge, are the two most controllable factors that will lead to positive clinical outcomes.

The first phase of the cycle is Empathic Attachment, the goal of which is to create an optimal attachment with the client. It is important that the therapist differentiates self and others in this phase, and assesses the client's readiness for change. A therapist can face the challenge of caring too much in this stage, and must develop and adhere to clear relationship boundaries. The second phase is Active Involvement. The essence of this phase is to "share a vision together and work toward that" with the client (Skovholt, 2005, p. 88). In this phase, the emotional attachment needs to stay strong and reliable, while the therapist should deliver acquired knowledge and remain open to feedback from the client. Skovholt (2005) said that this support and challenge dynamic (i.e., encouragement and enthusiasm, and pushing and demanding performance) are the keys to change and development. This phase can produce a great deal of therapist fatigue, therefore self-awareness and self-reflection is critical in phase two. Phase three, Felt Separation, is the letting go of the professional relationship and the working through of the loss. Skovholt (2005) compared this to a process of grief, which can

be anticipated and then honored at the end of the work. Phase three can also produce emotional exhaustion, a factor in burnout. The cycle of caring is a process intended to foster depth and gradually improve one's skills in building and ending therapeutic relationships, moving towards expertise, and is recommended for use throughout one's career in each phase of therapist development.

Phases of therapist/counselor development. Ronnestad and Skovholt (2003) conducted a longitudinal qualitative study of 100 counselors and therapists, and from the data developed a six-phase model of therapist expertise. The first phase is the Lay Helper phase. Helping marks this phase in casual roles of life, such as talking to a friend when they need advice. Lay helpers tend to identify problems quickly, and provide advice based on their personal experiences and perceptions of commonsense solutions. The lay helper typically identifies with the person in distress in some ways, which can lead to becoming over-involved, thus impeding the helping process. Helpers at this initial level also have a difficult time differentiating between empathy and sympathy. (Ronnestad & Skovholt, 2003)

When a helper begins formal professional training, they are considered in the Beginning Student phase. Beginning Students experience a lot of anxiety; question whether they are suited to be therapists, and particularly worry about putting theory into practice. Supervision is critical during this phase, as Beginning Students experience dependency and vulnerability. A large study of psychotherapists across seven countries revealed that formal supervision was the leading factor in positive therapeutic influences for students with less than two years of clinical experience (Orlinsky et al., 2001). Straightforward and concrete skills are emphasized (e.g., helping skills), while counselor openness will determine the speed and degree of depth a counselor will master (i.e., students with an open attitude will

progress quickly, while rigid or closed students are more likely to experience stagnation). Students moving through this phase well will exhibit an active, exploratory, and curious attitude, guided by a long-term development goal. Stagnant students may present with a defensive, experience-limiting, and anxiety-reducing attitude (i.e., preferring to reduce personal anxiety rather than be challenged). When engaging in direct clinical work, Beginning Students frequently feel overwhelmed and highly challenged. (Ronnestad & Skovholt, 2003)

The goal of the next phase, the Advanced Student phase, is to function effectively at a basic professional level. Advanced Students tend to have internalized high standards of professional functioning; with an internal focus and appreciation for the influence their training has had on their abilities. Vulnerability and insecurity is still likely present at this stage, and supervision and modeling are still significant learning processes. To facilitate professional development through this phase, Advanced Student's require an attitude of openness, and an eagerness and commitment to learn. (Ronnestad & Skovholt, 2003)

The fourth phase in the Ronnestad and Skovholt (2003) counselor emergence model is the Novice Professional phase. Here the therapists find themselves reformulating at the conceptual and behavioral levels to confirm the validity of their graduate training. Frequently Novice Professionals experience a sense of disillusionment with their training and their own skills, which can fuel a sense of inadequacy. Moving forward through this phase requires intense self-exploration, including comfort with boundary regulation (e.g., responsibility for client's success, realistic goals for clients). In this phase, therapists begin to trust bringing their personality into session more often, and begin to value the therapeutic relationship more profoundly. (Ronnestad & Skovholt, 2003)

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The Experienced Professional phase is marked by the counselors creating a role that is congruent with their own self-perceptions (i.e., values, interests, attitudes), to apply professional competence in a genuine way. Here the therapists emphasize the value of the therapeutic relationship even more, and increase personal flexibility and working style. Therapists are more skilled at goal setting, have greater awareness of personal strengths and weaknesses, and have more trust in their professional judgments. These therapists are more effective at emotion regulation and their attentiveness towards clients, allowing for a re-focusing to engage with subsequent clients and feel refreshed at the end of the day instead of exhausted. Knowledge for these therapists is gradually becoming contextualized, as they learn to recall successful interventions with clients of similar presentation, drawing on a wealth of personal experiences, and ideally, a routine of self-reflection. (Ronnestad & Skovholt, 2003)

The final phase in the Ronnestad and Skovholt (2003) model is the Senior Professional phase. These therapists are well established, practicing for at least 20-25 years, and regarded in high esteem by peers. These therapists can experience feeling wisdom, but during what they consider too late a stage in their lives. Senior Professionals begin anticipating grief over future losses, but typically, experience continued commitment to growth, self-acceptance, work satisfaction, competence, and modesty. (Ronnestad & Skovholt, 2003)

Within the data from their longitudinal study, Ronnestad and Skovholt (2003) identified 14 themes of counselor development independent of the developmental stages, and are described below.

Themes of therapist/counselor development. Ronnestad and Skovholt (2003) developed the following themes from analyses of cross-sectional and longitudinal qualitative data across career cohorts of therapists. Each of these themes was developed independently from the phases of their model of professional development, and therefore may apply to therapists in several different stages of development. First, development involved a high order integration of the professional self and the personal self, translating to increased consistency between the therapist's personality and conceptual therapeutic strengths. Second, the ability to function as a therapist shifts over time from external (e.g., training, rigidity) to internal (e.g., flexibility, autonomy). Theme three is the only of the themes revisited by the authors in the conclusion, and that is, "Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience" (Ronnestad & Skovholt, 2003, p. 29). This is a critical point in their research, and contrasted the argument that with experience and age, expertise develops naturally. The authors re-emphasized that neglecting the reflective process means a stagnant and/or deteriorating process will likely result. (Ronnestad & Skovholt, 2003)

Theme four stated that an intense commitment to learn propels the developmental process, while theme five pointed out that the therapist's cognitive map changes over time (e.g., external to internal focus). The next two themes pointed out that professional development is a long, slow, continuous and life-long process. Theme eight pointed out that beginning therapists experience much anxiety, which is typically mastered over time. Theme nine, like theme three, is particularly relevant to the proposed study – "Clients serve as a major source of influence and serve as primary teachers" (Ronnestad & Skovholt, 2003, p.

33). The authors pointed out that this was consistent for therapists at all levels of education and experience. (Ronnestad & Skovholt, 2003)

Themes 10 and 11 spoke to the importance that personal life experience influences the professional role, and that interpersonal sources of influence (e.g., contact with friends, family, professional elders or peers) are of more value than impersonal sources (e.g., workshops, readings). Theme 12 stated that new members to the counseling field have strong affective reactions to professional elders and graduate training. Theme 13 pointed out that therapists' extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human diversity. Finally, theme 14 stated that for therapists, realignment from self-as-hero to client-as-hero occurs in the developmental process. (Ronnestad & Skovholt, 2003)

These 14 themes represented common experiences and requirements for therapists to encounter/engage in along the journey towards professional expertise. Several of these themes are relevant for therapists throughout their careers, such as theme 3 (i.e., the importance of continuous self-reflection) and theme 9 (i.e., clients are a major source of influence). However, other themes focused on particular phases of therapist development, such as theme 8 (i.e., beginning practitioners experience much anxiety). The novice counselor phase is a particularly difficult one, which poses its own unique roadblocks.

Challenges for a novice therapist. As previously stated, beginning or novice therapists experience great difficulties when first becoming acclimated to their role as a therapist, including anxiety and fear, role-ambiguity, dependence upon supervision, vulnerability, self-doubt, being able to bridge theory to practice, ethical and legal confusion, and others (Ronnestad & Skovholt, 1993; Skovholt et al., 2001). Students are aware that they

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lack competency at the beginning stages, which produces the anxiety and dependence they experience early on in their training (Ronnestad & Skovholt, 1993). Part of the difficulty comes from not having complete conceptual schemas for how therapy should work. Beginning therapists can have glamorized expectations or perceptions of the therapeutic process, leading to disappointment when they realize that change is slow, difficult, and not always likely with some clients (Skovholt et al., 2001). To overcome these challenges, Ronnestad and Skovholt (2003) proposed novices have an open attitude towards learning and be active and exploratory in their practice and study. More advanced students begin to experience some confidence and professional security, however; role conflict and dissatisfaction with supervision are also common issues (Ronnestad & Skovholt, 1993) and frequently exacerbated during critical incidents in counseling.

*The effect of critical incidents on professional development***.** In the Beginning Student phase, meeting clients for the first time can be a critical incident and have a profound effect on students (Ronnestad & Skovholt, 2003). Some students that have negative first experiences can become disillusioned or turned off from a client presenting with particular issues, from clients at a particular counseling setting, or from therapy altogether. Failures in therapy for Beginning Students can be potentially devastating, creating an intense feeling of inadequacy and a questioning of career paths since direct clinical work is typically inaccessible until the second year of a master's or doctoral program. Supervisors must provide positive feedback and an effective holding environment to calm Beginning Student anxieties, and provide negative feedback in a caring and careful manner (Ronnestad & Skovholt, 2003). As experience and feedback accumulate, one can identify the emergence of therapeutic mastery.

The characteristics of master therapists. In essence, this section reviewed what makes great therapists. In their qualitative study of therapists identified by peers as experts, Jennings and Skovholt (1999) uncovered several characteristics consistent with their participants. They included being voracious learners, being open to experience and non-defensive when receiving constructive criticism (Mahrer, 1996), and possessing emotional maturity and strength of character. These experts drew heavily on accumulated experience, value cognitive complexity and ambiguity, are emotionally receptive, mentally healthy and mature, engage in self-care, value self-awareness of emotional health, believe in the working alliance, have strong relationship skills, and use these relationship skills effectively in therapy (Jennings & Skovholt, 1999). Three domains of ability for these experts are identified as (1) relational (i.e., superb interpersonal skills), (2) cognitive (i.e., high intellectual ability and rich conceptual schemas), and (3) emotional (refined emotional maturity and personal stability) (Jennings & Skovholt, 1999; Ronnestad et al., 1997).

In addition to character traits common across experts, experience played a critical role in what makes a therapist a master, including accumulated clinical hours. At least 15 years and thousands of hours engaging in therapeutic practice is the standard, so the therapist has internalized a personal style (Ronnestad et al., 1997). Skovholt and colleagues (2001) reported experts still feeling stressed in clinical practice by issues that challenge their competency, unmotivated clients, breaches in personal or professional relationships, and intrapersonal life crises. Similarly, expert practitioners from a Ronnestad and Skovholt (2001) study identified experiences and events in personal and professional lives being influential for their professional growth. This appeared to be a lesson that cuts across experience and skill levels, similar to the value of self-reflection and the acknowledgement of

clients as the best teachers. Additionally, experts reported the processing of profound experiences as important for a high level of confidence, or, practitioners must reflect and process the potentially rich experiences of their personal and professional lives (Ronnestad & Skovholt, 2001). This theme is consistent throughout the literature and reinforces the need for the field to formalize the act of therapist self-reflection.

When asked how they use self-reflection in their work, experts reported engaging in introspection, supervision, client feedback, or colleague consultation (Skovholt et al., 1997; Skovholt et al., 2001). As voracious learners, experts worked to attain domain-specific knowledge by engaging in deliberate practice. These experts read a great deal of literature relevant to the field, and expanded their knowledge with an attitude of curiosity and interest in interdisciplinary topics. Stagnation likely occurs for therapists that are not open to personal challenges, do not work hard to improve their skills, or that work with the same populations or treatment facilities (Skovholt et al., 1997).

Introspection was the most commonly reported self-reflection task, which aided in developing self-awareness, increasing personal maturity, and enhancing professional effectiveness (Skovholt, et al., 2001). However, these introspection processes remain personally created, and thus require conscious effort by therapists to engage in. Without proper grounding of the importance of introspection and self-reflection, fewer therapists will engage in the practice than if there was a specified or well-known processes or tools to use to aid in this process. The proposed study can reinforce the value of clients as primary teachers by highlighting for practitioners what exactly they learn from engaging in clinical work, and how their clients are changing them.

The effect of accumulated therapeutic experience upon therapists. Therapy is not just a process that influences the lives and well being of clients, but it has an influence on therapists as well. As the above literature indicated, therapy is a process by which therapists change over time (i.e., move towards expertise, or become stagnant) just as clients do. Farber (1983) reported therapists become more increasingly psychologically minded by facilitating insight for others, increasing self-awareness for their clients, and engaging in a unique, affective social interaction. These therapist respondents reported that direct clinical work raised their personal issues and provoked introspection, while enhancing self-esteem and self-confidence. Therapists also reported improved assertiveness, self-reliance, self-disclosing, and reflectiveness. These personal changes typically were positive in nature, including improving the closeness of interpersonal relationships. These therapists reported a greater appreciation for human diversity and better understood universal human difficulties and vulnerabilities. Despite some of these positive effects of conducting therapy, however, therapists also reported feeling drained by their work or having too little time or energy for family and friends. These are potential signs of burnout, precipitated by risk factors that should be actively addressed by practitioners (Farber, 1983).

Risk and Protective Factors in Doing Therapeutic Work

The following section explored the risk and protective factors that can contribute to or protect therapists against the crippling effects of burnout.

Burnout. A danger that all people in helping professions must be vigilant about is burnout. There are several definitions in the literature for burnout. The most commonly used definition by Maslach and Jackson (1981), included emotional exhaustion, depersonalization and cynicism, and diminished personal accomplishment. Grosch and Olsen's (1994)

definition of burnout recognized that a combination of environmental and work circumstances contribute to variable feelings of emptiness or satisfaction, and personal drive, as well as a need to boost oneself in a disingenuous manner. Skovholt and colleagues (2001) defined burnout as, "The result of a decreased ability to attach with the next client because of the emotional depletion accumulated over a period of caring for others" (Skovholt et al., 2001, p. 171). This definition spoke more to mental health professionals, which research showed experiences less overall burnout than other human service jobs, such as police officers, nurses, teachers, and physicians (Raquepaw & Miller, 1989). This might be due to therapists consistently receiving positive feedback from clients, or being able to see the direct benefit in clients' moods and behavior (e.g., at the end of sessions). Each definition highlighted different aspects of the burnout experience, which may be felt or manifested differently depending on a helper's personality and job. Mental health professionals must be aware of the risk factors present in engaging in therapeutic practice if they are to minimize the likelihood of experiencing burnout.

Risk factors contributing to burnout. Despite the generally agreeable nature of therapists naturally wanting to help others, it is important that limits and an understanding of the risks of direct clinical work are prominent in therapists' minds. Skovholt and colleagues (2001) outlined several hazards of mental health professionals. First is the belief by therapists that clients have an unsolvable problem that must be resolved. This thinking can lead therapists to work harder than their clients, and assume that there is always more to be done for their client. Therapists also need to understand that not all clients are going to be easy to work with, and that there is a difference in readiness or their stage of change than that of the therapist. Frequently therapists can identify underlying issues that they believe would benefit

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clients to address or confront, however; clients also behave the way they do for a reason, and expecting them to change quickly because a therapist can identify the potential benefit of it is unreasonable.

Another risk factor is the effective and appropriate management of boundaries. Therapists are naturally people that want to help others, and therefore may have a hard time telling clients "no." Therapists need to be aware of the one-way caring, interpersonal sensitivity, and constant empathy that they provide with clients, and understand the effects that so much giving can have on them. Self-care is a critical component to protecting against burnout. Also, success in therapy can be elusive, and failure is a normative experience. Therapists have to accept that they cannot help everyone who walks into their office (Skovholt et al., 2001).

A clinician's work environment is another potentially noteworthy risk factor, and can have a major influence on the likelihood of burnout. When a lack of commitment to work, poor co-worker relationships, and unsupportive supervision is present, burnout is more likely to occur (Savicki & Cooley, 1987). Savicki and Cooley (1987) also pointed out that worker flexibility needed to be encouraged, that planning and efficiency needed to be present, and job expectations should be clear and unambiguous. Micromanaging employees also lead to lower work satisfaction and increase the likelihood of burnout. Depersonalization occured when employers treat workers with rigidity and with less focus on the individual, particularly when it comes to completing complex tasks and utilizing creative decisions. Some of these problematic experiences are typically consistent with community mental health centers or other agency-type settings (Savicki & Cooley, 1987).

Therapists working in agency-type environments reported having more feelings consistent with the experience of burnout, less frequency of personal accomplishment, and more instances of emotional exhaustion (Raquepaw & Miller, 1989). Large caseloads can be an issue at community agencies; however, it is the perception of one's caseload that is another risk factor contributing to burnout. Burnout is more likely to occur when therapists reported preferring smaller caseloads and perceives that their client load is too high. This perception of clinical overload can lead to emotional exhaustion, one generally accepted element of burnout. Factors that did not contribute to potential burnout included demographics, years of experience, number of clients, and theoretical orientation (Raquepaw & Miller, 1989). Clinicians must be aware of these risk factors for burnout, in addition to protective factors.

Protective factors against burnout. The role of self-care is critical in the helping professions to reduce the likelihood of burnout. "To be successful in the helping professions, we must continually maintain professional vitality and avoid depleted caring. Thus, balancing self-care and other-care seems like a universal struggle for those in the helping profession" (Skovholt et al., 2001, p. 168). One self-care strategy involved maximizing the experience of professional success. This included recognizing positive change in clients, receiving recognition by supervisors, co-workers, and others, and attaining expert knowledge content and relationship process skills (Skovholt et al., 2001). Achieving regular gains in clinical practice by successful terminations or client report of improvement can reinforce a therapist's belief in themselves and the clinical work. It can revitalize and reenergize clinicians, leading to improved professional growth.

For growth to occur, therapists should also create and sustain an active, individually designed process. Skovholt and colleagues (2001) recommended counselors increase their intellectual excitement, decrease boredom, use multiple roles, have multiple tasks within a role, and stay active in professional activities and organizations. Openness to feedback and self-reflection were also essential elements in this process. Ideally, feedback will come from clients and leadership at the workplace, which should be supportive, challenging, and provide a mentorship experience to promote success. Although failure with some clients is unavoidable, therapists need to minimize ambiguous professional losses, meaning that counselors should be careful about taking responsibility for their client's lack of growth (Skovholt et al., 2001).

One final protective factor is a strong sense of self-awareness and understanding of one's own need for balance (i.e., physical, spiritual, emotional, and social) while engaging in direct clinical work (Skovholt et al., 2001). Experts did this through nurturing and challenging connections with family, friends, and social groups. Personal therapy is another strategy, which contributed to improved resiliency and wellness as a helper. It is important as well for therapists to allow themselves time to enjoy activities and leisurely pursuits that are kept separate from the therapeutic environment, and safe places for counselors to relax and be disaffected from work (Skovholt & Jennings, 2004). Grosch and Olsen (1994) pointed out, however, that therapists need to be careful not to schedule leisure activities on a weekly basis (e.g., exercise). This can become a burdensome task or requirement in the mind of the therapist, and ultimately adds to stress. A better approach is to address the stressful aspects of a clinician's life (e.g., family, personality variables, patterns of functioning, etc.), and engage in the self-reflection process to create coping strategies and stress relief activities that are

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consistent with the needs of themselves while considering personality and environment (Grosch & Olsen, 1994). The experience of burnout does not have to be an inevitable one. Commonsense strategies and areas of consideration are presented in the literature to aid therapists in maintaining a high level of professional vitality and engagement.

Summary

The reviewed literature outlined the most relevant findings related to the present study. Therapists learned the most about how to conduct effective and competent therapy from their clients. Although therapists also learned valuable lessons from engaging in supervision, from teaching and supervising, and by way of their personality characteristics and individual experiences, direct clinical work provided the richest source of learning. Clinical cases that are particularly challenging or memorable provided some of the best lessons. The reviewed anecdotal lessons from experienced therapists were loosely applicable to the six-category structure of what therapists learned from their clients, as developed in Stahl et al. (2009). Intern-level therapists and senior practitioners reflected on lessons that could well be coded into the Stahl et al. categories (i.e., lessons about self, lessons about doing therapy, lessons about clients and client dynamics, lessons about the therapeutic relationship, lessons about human nature, and the value of supervision, collaboration, and consultation). These lessons were at times similar, however; it is possible that senior practitioners could generate enough lessons from client work to warrant the development of a scale separate from the TLS.

The benefits of self-reflection ranged across disciplines, including education, organization and managerial, and psychotherapy. A universal theme found among these disciplines included personal openness and a challenging of oneself to improve in

understanding and/or practice. Schon (1983) discussed the importance of breaking from repetitive practice for fear of stagnancy and loss of flexibility – an element critical to successful psychotherapy. Mezirow (1998) argued that the investigation of one's biases through the careful examination of interpersonal communication and one's personal thoughts and feelings about a particular interaction were critical for learning and growth. Daudelin (1996) argued that learning from experience after a filtering through one's biases was not likely to be meaningful if there is no reflection process. Peters (1991) and Lee and Sabatino (1998) explained such a process, including outlining the problem or task, analyzing associated thoughts and feelings, developing a theory for how to improve practice, and then acting on that theory. Participants in the present study completed the TLS as a tool to help formulate such a theory and action plan regarding how to improve clinical practice.

The TLS was developed with the idea that it could be used as a guided clinical reflection tool. Its preliminary analyses revealed adequate internal consistency, a rigorous item review process, and use of experts that accounted for content and construct validity. The use of the TLS could provide a guided method for therapist self-reflection, which the reviewed literature argued is an essential process for achieving therapist expertise. Recommendations are for therapists to reflect on personal and professional lives, but to attend closely to direct clinical work, as clients are the source that provided the most lessons when conducting therapy.

Continuous reflection should take place across the career, encompassing each phase of professional development. Ronnestad and Skovholt's (2003) six phases began with the Lay Helper, and culminated with the 20-25 year veteran senior practitioners. Each phase included challenges to overcome, and requirements for growth. Among the phases existed

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themes of professional development that can occur differentially throughout the career span. Most relevant to the present study are themes three (i.e., "Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience," Ronnestad & Skovholt, 2003, p. 29), and theme nine (i.e., "Clients serve as a major source of influence and serve as primary teachers," Ronnestad & Skovholt, 2003, p. 33).

Although most themes apply throughout the career phases, some are more relevant for example, to novice practitioners. Novices face different challenges than more seasoned therapists, which is why good supervision is critical to their development, in addition to effective self-reflection. Critical incidents early in one's therapy career can play a major factor in therapist development. Beginning therapists are particularly vulnerable, which is why an emphasis by supervisors to instruct supervisees to engage in the self-reflection process can help put novices on the right path to therapist mastery.

Master therapists shared many similar qualities, including being voracious learners, open to experience, non-defensive when receiving criticism, and others. They have superior interpersonal skills, strong intellectual abilities, emotional maturity, and personal stability. These experts reported the value of engaging in the self-reflection process, and do so primarily through introspection. Experts also reported utilizing supervision, client feedback, and colleague consultation as reflection tasks, but introspection is primary (Skovholt & Jennings, 1999). This self-guided process could be augmented by use of a psychometrically valid clinical tool, which is what the present study investigated with the TLS. The use of self-reflection by these experts was likely a significant factor in their achievement of clinical expertise, and a protective factor against burnout.

Therapists generally reported many positive effects from engaging in direct clinical work; however, many factors can put therapists at risk for the emotional exhaustion, depersonalization, and diminished personal accomplishment that mark burnout. Some of these risks included carrying the burden of believing one can help every client, failure to create effective boundaries with clients, a poor working environment (e.g., bad supervision and/or co-worker relationships), and the perception of an overwhelming caseload. However, there are many activities therapists can engage in to protect against burnout. Some of these included self-care and finding balance in one's life, maximizing the experience of professional successes, being active in different varied activities, and engaging in the process of self-reflection to foster greater self-awareness and learning.

The TLS has the potential value to be a bridge for how therapists realize the lessons clients teach, and can standardize a self-reflection process so it is not entirely self-guided. The present study examined if participants found completing the TLS a helpful task, and subjected the measure to an exploratory factor analysis. Results from Isenberg (2009) suggested that the TLS presently might not conform to the original six-subscale structure from Stahl et al. (2009). An exploratory factor analysis illuminated the optimal factor structure for the TLS, and helped reduce the item total, creating a more parsimonious and useful measure.

CHAPTER III

Method

The current study examined the validity and clinical utility of the Therapist Learning Scale (TLS). Previous research (i.e., Isenberg, 2009) developed the TLS via an iterative process supported by research on scale development (Clark & Watson, 1995) that included several periods of item writing and revising, and other processes including expert rater analysis, and analyses of internal consistency and intercorrelations. The development of the TLS is based upon the qualitative findings reported by Stahl et al. (2009) and the categories of lessons the authors developed from the data (i.e., lessons about self, therapy, clients, the therapy relationship, human nature, and the usefulness of supervision). Stahl et al. used the consensual qualitative research (CQR) methodology (Hill et al., 1997, 2005) to ask in 60 to 75-minute semi-structured interviews what 12 intern-level counseling trainees learned from working with a specifically memorable client seen during their internship year. From these data, at least six areas of learning for participants emerged, and these six areas formed the initial theoretical foundation for the proposed subscales of the TLS.

Items for the TLS were written utilizing coded data with permission from Jessica Stahl (Stahl et al., 2009) and by modifying responses for Likert-item format. Initially, 110 items across six subscales were developed from her data. Isenberg (2009) reviewed the initial items through a process consistent with principles of scale development outlined by DeVellis (2003). The items were revised and sent to six raters with experience in psychotherapy and/or therapist learning who rated the items on their appropriateness to the construct of learning (i.e., how suitable the item is to represent learning), the ease of response to the items, and the items' bias potential. The author then revised the items again under supervision of an

experienced scale development psychologist and administered the full scale (revised to 105 items) to counseling trainees, of whom 57 began the measure and 42 completed it. The scale was then subjected to an internal consistency analysis, a common method to eliminate erroneous or redundant items in scale development (Clark & Watson, 1995). Upon examination of subscale intercorrelations and internal consistency, each subscale was significantly correlated with the full scale ($p < .01$), and these preliminary tests of the TLS indicated an acceptable value of .78 for the total scale (Clark & Watson, 1995). A final revision of the scale was based on negative-item correction correlations (i.e., the improvement in alpha that would result for a subscale if an item were removed). Expert ratings of the appropriateness of items for each subscale were used to shift 16 items to alternative subscales and resulted in the removal of six items, leaving a 99-item TLS.

According to Clark and Watson's (1995) parameters for objective scale development, this initial investigation (Isenberg, 2009) yielded adequate reliability and validity for the TLS (i.e., internal consistency scores between .60 and .80). The individual subscales from the proposed six-subscale structure used in Isenberg (2009) from the Stahl et al. (2009) categories did not produce adequate internal consistency with scores ranging from .15 (Lessons about the Therapy Relationship) to .67 (Lessons about Supervision, Collaboration, Consultation, and Training). Only the five item Lessons about Supervision, Collaboration, Consultation, and Training subscale had an alpha score of .67, which was within the parameters of a minimally acceptable alpha score for scale consistency outlined by Clark and Watson (1995). Additionally, each subscale was significantly correlated with the Lessons about Doing Therapy subscale, suggesting that this subscale acts more like an overall

category than a distinct subscale. These results provided more evidence that the subscales are likely not distinct, suggesting a more unitary conception of therapist learning categories.

Clark and Watson (1995) described the creation of a large pool of items that is more comprehensive than may be necessary to describe the construct, but which is then reduced using empirical data. This winnowing process allows subsequent analyses to eliminate weak items from the scale and detect items that have greater construct and predictive validity. Isenberg (2009) developed items after a thorough examination of the raw qualitative data from Stahl et al. (2009), which resulted in 110 initial items. The item-removal process used by Isenberg resulted in a 99-item, TLS, which is likely too long to be useful as a training tool. For the intended purpose of supervisors engaging supervisees in the use of a guided reflection process, supervisees would likely experience fatigue completing such a long self-reflection measure. Subjecting the TLS to an exploratory factor analysis should clarify the measure's factor structure and further guide the elimination of weak and or redundant items to create a more parsimonious scale. Thus, the aim of the current study was to fine-tune the TLS in the interest of eliminating redundant and less useful items to provide a tool for use in facilitating the self-reflection process, a practice critical to optimal professional development (Ronnestad & Skovholt, 2003). This goal was achieved by utilizing item analysis, factor analysis, test-retest reliability, item-scale and subscale-scale correlation, convergent validity, and a social desirability analysis to reexamine various aspects of the TLS's reliability and validity.

Participants

When conducting a factor analysis, one sample size standard is the number of participants should be relative to the number of items in the measure, based on a subjects-to-

variables ratio. Five to ten participants per variable is a general guideline used for exploratory factor analysis (Gorsuch, 1983), meaning that the present study would require at least 495 participants. However, Guadagnoli and Velicer (1988) argued that there is no sound theoretical or empirical basis for the subject-to-variable ratio and factor loadings are more relevant for determining sample size. They proposed that stable factor loadings of .80 may require as few as 50 participants, while smaller loadings of .40 or lower require 300-400 participants. Because there is no way to know the TLS's factor loadings before conducting a factor analysis, the author assumed lower factor loadings and worked to obtain at least 300 participants for the current study.

The author contacted directors of clinical and counseling graduate school programs across the United States (n ≈ 1000) to recruit participants. Directors were contacted via email and received a letter requesting they forward the call for participation throughout their department listserve (see Appendix A). Participants were directed to a web link on SurveyMonkey.com where they were asked to consent to participation, read about the potential benefits and risks to completing the study, and contact information for the principal investigators (see Appendix B). Participants were potentially rewarded with a $25 gift card for being the 42nd, 158th, or 276th participant to complete the study. Another $25 gift card was awarded to the 15th participant who completed the test-retest portion of the study at least two weeks later. Inclusion criteria were that participants have experienced at least one full semester of supervised practicum and were still receiving supervision for their clinical work. (See Appendix C)

Procedure and Measures

Participants were invited to complete the study by first acknowledging their consent to participate. They then completed a demographics measure, followed by a four-part self-reflection process. The first step in this process involved identifying a challenging client with whom the participant has been working, and writing down 2-3 ways they find working with this client to be difficult. The rationale for identifying a specifically challenging client for this part of the study was two-fold. First, it was logical to utilize a single and challenging client for reflection purposes because this was the strategy employed in Stahl et al. (2009), the foundational study from which the present study and preliminary theoretical learning categories were derived. Second, research indicates that clients with a particularly successful or unsuccessful course of therapy are likely to contribute more to therapist learning (Ronnestad & Skovholt, 2003). The present study expanded on that rationale to include a client with whom the therapist had a difficult time working. Additionally, this step followed the process of self-reflection outlined by Lee and Sabatino (1998), including asking "what" questions at the beginning of the process (i.e., what was difficult or challenging to work with this client?).

The second step in the study instructed participants to write down the reasons they believed this person was difficult to work with. This step is also derived from the self-reflection process outlined in Lee and Sabatino (1998) – asking "why" questions. The objective of this step was for participants to begin examining their personal biases, beliefs, assumptions, or perception about why they personally struggled working with the difficult client. Third, participants were asked to complete the 99-item Therapist Learning Scale (TLS). This step coincided with the process step of developing a theory about what changes

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need to be made to improve one's clinical work. The process of completing the TLS was believed to highlight aspects of why participants found it difficult to work with their client and also illuminated areas of the therapeutic process, the dynamics of therapy, aspects of the therapist's perspective, etc., which the participants were unlikely to actively consider when in the therapy process. By identifying 99-lessons learned from other therapists, the TLS represents a checklist of sorts for participants to reflect on the work they did with their difficult client, helping them to develop the theory of how to improve therapeutic practice in the future. The last part of the self-reflection process asked participants to provide 2-3 ideas for how they thought they would change their work with this difficult client or clients generally. This finalized the process by providing an action step for participants.

Participants then completed a structured comments questionnaire intended to gather feedback from participants about their experiences completing the TLS. Participants were asked to complete this measure immediately after completing the self-reflection process because this qualitative data would reveal participants' feelings about the TLS – what was good and not good about it – and asked for ways to improve the measure for future use. Finally, participants completed the 21-item Psychotherapists' Professional Development Scale (PPDS: Orlinsky & Ronnestad, 2005) and the 11-item Marlowe-Crowne social desirability scale Reynolds Short Form A (MC-RSF-A: Reynolds, 1992). The PPDS was correlated with the TLS to investigate construct validity, while the MC-RSF-A was correlated with the TLS to investigate any social desirability embedded therein.

The Therapist Learning Scale (TLS). For the present study, the scale contained 99 items across six theoretic subscales identified by Stahl and colleagues (2009). At the conclusion of analyses of intercorrelations and internal consistency in Isenberg (2009), the

subscales were as follows: Lessons about Self ("self", 23 items, $\alpha = .54$); Lessons about

Doing Therapy ("therapy", 40 items, $\alpha = .57$); Lessons about Clients ("clients", 13 items,

$\alpha = .27$); Lessons about the Therapy Relationship ("relationship", 9 items, $\alpha = .15$); Lessons

about Human Nature ("human nature", 15 items, $\alpha = .39$); and the Usefulness of Supervision,

Collaboration, Consultation, and Training ("supervision", 5 items, $\alpha = .67$). As previously

stated, the overall scale alpha was .78. The author (Isenberg, 2009) then cross-referenced

items with negative corrected-item correlations to the expert raters' "appropriateness to

learning" score. If at least one-third of experts believed the item was better suited to a

different subscale, it was moved; however, if raters instead collectively gave the item an

"appropriateness to learning" score less than .80, the item was removed from the TLS. If

raters provided an "appropriateness to learning" score of at least .80, the item was retained

regardless if its removal improved the subscale's alpha score. The rationale used in this

procedure is that the goal of the TLS is not to create a measure that perfectly conforms to the

six-factor structure of Stahl et al. (2009), but to create as comprehensive a measure as

possible, with as many lessons that may be relevant to the novice therapist's experience.

      The response set used in the TLS in Isenberg (2009) was a Likert scale ranging from

1-5. The possible responses were Rarely True (1), Infrequently True (2), Occasionally True

(3), Generally True (4), and Persistently True (5). Much discussion took place between the

author (Isenberg) and a highly qualified auditor with many year of experience in

measurement scale development, regarding how to label the response set of the items on the

TLS in an attempt to properly tap the construct of therapist learning. The goal of this decision

was that a high score on the TLS would reflect a considerable amount of learning that the

participant had experienced in their training, realized through the process of self-reflection

with the TLS. The belief was that participants could then repeatedly use the TLS (or

subsequently developed forms of it) to check their learning on different skills or lessons

identified by the measure. Other response options discussed included a binary true-false

option, the inclusion of a "meaningfulness box" for each item which participants could select

if that lesson was particularly learned through working with the client they were reflecting on

(as opposed to a lesson they were already attending to), and the possibility of creating several

different response sets to more accurately reflect the language of the items. For this study, the

decision to use the single Likert response was influenced by the belief that it would (a)

provide the richest amount of data, (b) was the simplest and most consistent option to ease

participant response, and (c) was the most effective language developed to reflect learning

when responding to the items on the TLS.

The current study examined the TLS's construct validity via an exploratory factor

analysis. The six expert raters who reviewed each item of the TLS determined how well each

item adhered to the given content domain (Benson & Clark, 1982). Convergent validity was

examined using a measure derived from the Development of Psychotherapists Common Core

Questionnaire (DPCCQ: Orlinsky et al., 1999).

Development of Psychotherapists Common Core Questionnaire (DPCCQ). The

DPCCQ (Orlinsky et al., 1999) was developed over a decade and has been administered

throughout the world extensively to mental health professionals. The DPCCQ consists of 10

sections and 370 items. The overall purpose of the scale is to gather information about a

therapist's career experiences to determine their process of professional development.

Therapists were required to reflect on their experiences as a professional to respond to the

DPCCQ, a task similarly required by the TLS. Because the proposed usefulness of the TLS is

to promote professional development in novice trainees and because reflection on one's professional experiences is required, the scale developed from the original DPCCQ interview may be appropriate as a convergent scale. Orlinsky and Ronnestad (2005) had collected data from therapists for almost 15 years by the time of publication and reported continuing to do so in countries around the world. They analyzed the data in multiple phases using factor analysis to understand the meaningful dimensions within the facets of work experience and professional development. Factors were extracted using principal-components analysis, and the internal consistency of the resulting measures was examined using Cronbach alphas (Orlinsky & Ronnestad, 2005). One of the two measures they published is called the Psychotherapists' Professional Development Scales (PPDS).

Psychotherapists' Professional Development Scales (PPDS). The PPDS is a 22-item Likert-type scale, ranging in response from 0 (not at all) to 5 (very much). This measure assesses respondents' perceived professional development along four factors, including Overall Career Development (10 items, $\alpha = .88$), Currently Experienced Growth (6 items, $\alpha = .86$), Currently Experienced Depletion (4 items, $\alpha = .69$), and Motivation to Develop (1 item). In the present study, the PPDS was correlated with the TLS to determine if the measures investigate similar underlying constructs.

The Marlowe-Crowne Social Desirability Scale, Reynolds Short Form A (RSF-A). The Reynolds (1992) short form A (RSF-A) of the Marlowe-Crowne social desirability scale contains 11 items scored in a true-false response manner. Crowne and Marlowe (1960) used the Lie scale of the MMPI to inform the development of the items on their original measure. "The population from which items were drawn is defined by behaviors which are culturally sanctioned and approved but which are improbable of occurrence" (Crowne & Marlowe,

1960, p. 350). Validation of the scale revealed acceptable internal consistency (K-R = .88) and a significant correlation with the Edwards Social Desirability Scale ($p < .01$) (Reynolds, 1982), another non-pathology based scale, providing convergent validity. The RSF-A used items from the two- factor structure of the Marlowe-Crowne measure found by Loo and Thorpe (2000), of denial, and attribution. Examples of items for each factor include "It is sometimes hard for me to go on with my work if I am not encouraged," and "No matter who I'm talking to, I'm always a good listener" respectively. The RSF-A is considered a significant improvement in fit over the full 33-item measure (Loo & Thorpe, 2000) with good internal consistency scores ($\alpha = .59$, Loo & Thorpe, 2000; KR20 = .74, Reynolds, 1982). For the purposes of this study, the RSF-A was administered after the TLS to determine if participants may have responded to items in a manner that would make them appear to think and/or behave in a socially appropriate or desirable manner.

Structured comments questionnaire. It was important to evaluate the usefulness of the TLS for participants. The goal of the TLS was that trainees would utilize it to reflect on their work as clinicians with a specific client or for practicum overall and experience a deeper sense of understanding of clinical skills and growth edges. Therefore, the study contained a structured comments questionnaire asking participants the following: (1) What are your first reactions to completing the TLS? (2) On a scale of 0-10 (0=lowest, 10=highest), how much did the self-reflection process facilitate a deeper understanding of yourself as a clinician? (3) On a scale of 0-10, how useful do you think the TLS is as a tool to aid in the process of self-reflection? (4) One a scale of 0-10, how likely would you be to use a shorter version of the TLS on a regular basis (the participant's definition of "regular") throughout your clinical training? (5) What are the strengths of the TLS? (6) What are the weaknesses of the TLS? (7)

How could the TLS be improved? (8) Were there any negative aspects to completing the

TLS? Answers to these questions provided vital information to ensure the TLS was effective

in its purpose of facilitating self-reflection and professional growth as part of a self-reflection

process, and it provided additional construct validity.

Demographics. Each participant completed a demographics form inquiring about the

following information: age, sex and gender identification, race, degree sought, number of

months conducting supervised counseling, estimated number of different clients seen, and the

most recent treatment setting in which they worked. These data were used primarily for

descriptive purposes.

Analytic Strategy

Recruitment was the first phase of the study and involved sending emails to clinical

directors around the United States. The author's email asked them to forward the recruitment

letter to their students. A follow-up email was sent four weeks after the initial invite, and the

study was on SurveyMonkey.com until at least 300 participated were obtained. All

respondents were invited to participate in the test-retest portion of the study, two weeks later,

until fifty participants completed the test-retest portion. Following data collection, an

exploratory factor analysis was conducted to organize the items into a factor structure.

The author chose to utilize an exploratory factor analysis (EFA) instead of a

confirmatory factor analysis (CFA) for several reasons. An EFA is said to be theory-

generating with the goal of finding a good factor structure and a pattern of variable-factor

relationships and factor correlations, which are heretofore unknown for the TLS. As noted by

Kieffer (1999), "EFA…is very useful in examining the structure of data for which there is

either a paucity of research or for which no research has previously been conducted" (p. 84).

Generally, factor analyses seek to (1) determine the number of latent variables underlying a certain set of items, in the case of the present study categories of therapist lessons, (2) explain variation among original items into fewer newly created factors, and (3) identify groups of items that covary with one another and appear to define meaningful underlying latent variables (DeVellis, 2003). Specifically, the goal of an EFA is to find a model that fits the data and has theoretic support, while a CFA presumes the existence of a strong theory and seeks to fit an already proposed factor model.

In the present study, a preliminary theory of six learning categories by Stahl and colleagues (2009) was more useful for item generation than as a distinct factor structure. The reasoning behind this rationale was that over 25% of the total items in the first proposed TLS were miscategorized through qualitative ratings by experts in Isenberg (2009). Because such a large proportion of items were rated as fitting into different categories than those proposed in Stahl et al., the present author believed that the six category structure from Stahl et al. was unlikely to survive more conservative statistical analysis of its factor structure. Additionally, the subscale Cronbach alpha scores for the first proposed TLS in Isenberg (2009) revealed wide variability (i.e., .67 for Lessons about Supervision to .15 for Lessons about the Therapy Relationship). This suggested that some learning categories fit an underlying variable far better than other learning categories did, lending more weight to the argument that an EFA to determine a factor structure was more appropriate than a CFA to confirm factor structure.

Floyd and Widaman (1995) outlined three typical criteria for effectively deciding on the number of factors to use. First, the combined factors should account for at least 50 percent of the variance explained. Some authors believe a more conservative number, such as 70 percent is more appropriate, however due to the large number of items and the lower

items-to-participants ratio, the present study sought 50 percent of explained variance

(Stevens, 2002). Second, the Kaiser-Guttman criteria was utilized, meaning that factors

should have eigenvalues > 1. According to Kieffer (1999), "eigenvalues represent the amount

of factor-reproduced variance" (p. 79) and using eigenvalues that are at least > 1 is a

commonly utilized criteria in factor analysis. Third, the use of a Cattell-Nelson-Gorsuch

scree plot was appropriate. This step provided a visual representation of eigenvalues on a Y-

axis and corresponding ordinal numbers (descending from highest eigenvalue to lowest) on

the X-axis. The author also required that there were at least three variables per factor and

used a rule of thumb for salient loadings at > +/- .30 (Nunnally, 1978). Salient loadings at >

+/- .30 is a "highly conservative rule of thumb" designed to distinguish what factors are

likely to be present in a group of participants beyond that of the present study (Nunnally,

1978, p. 421). Stevens (2002) identified criteria to use when interpreting factor loadings and

stated that a factor with three loadings above .80 will be reliable. Additionally, Guadagnoli

and Velicer (1988) stated that factors with at least four loadings above .60 were reliable,

factors with around 10 loadings at about .40 were reliable with sample sizes greater than 150,

and factors with a few low loadings should only be interpreted with sample sizes of at least

300. An oblique Promax rotation was used as well. An oblique rotation allowed for factors to

be correlated, and as previously mentioned, Isenberg's (2009) results revealed different

interpretations between expert raters and the raters in Stahl et al. (2009) into which subscale

an item should fit. These differences provided evidence that the items can be interpreted

multiple ways, and therefore likely have significant correlations.

Criteria for item removal in this investigation were consistent with recommendations

made by Worthington and Whitaker (2006). They explained that researchers most often use

item-loading values and cross-loading values on factors to determine retention or deletion. This method is dependent upon the number of factors to be used, because removing items can influence the number of factors. Therefore, the authors recommended removing items as the very last step in the process. Worthington and Whitaker recommended deleting items with factor loadings < +/- .32 or cross-loadings (i.e., an indication that an item is influenced by more than one factor) < .15 differences from the item's highest factor loading. The authors emphasized caution when using cross-loading difference as removal criteria however, because "an item with a relatively high cross-loading could be retained if the factor on which it is cross-loaded is deleted or collapsed into another existing factor" (Worthington & Whitaker, 2006). The present study used the Nunnally (1978) criteria of salient loadings at +/- .30, instead of +/- .32. Also, low communalities (i.e., < .40) were used to delete items, which indicated that a low percentage of an item's variance was explained by the factors. Finally, the author examined items with negative item correction correlation, the item's possible redundancy within the factor, and the item's conceptual consistency relative to other items on that factor to determine item removal.

Additional quantitative analyses compared the TLS and the PPDS to investigate convergent validity. The author predicted these correlations would be high, as each scale was developed with professional development and self-reflection in mind, which may translate into lessons about client work, work involvement, and professional development (i.e., the subscales of the PPDS). The TLS and the RSF-A were examined for socially desirable responses, and the author predicted this would be a low correlation. In addition, a qualitative analysis of the structured comments questionnaire provided insight into specific modifications that author should consider when finalizing the TLS. The test-retest reliability

of the TLS was to be established by running correlations across a minimum of 30 participants that completed the TLS at least two weeks after the initial study. Finally, a simple regression was used to determine if the number of months doing supervised therapy was predictive of higher scores on the TLS. The author predicted that there would be a predictive relationship in scores on the TLS between more and less advanced student participants.

CHAPTER IV

Results

Demographics and Descriptive Statistics

A total of 302 participants completed the survey measures for the present study. Only 247 participants reported their age, however, with a mean age of 29.35 years old. The majority of participants were between the ages of 22-29 ($n = 168$, 68%), followed by participants between the ages of 30-39 ($n = 58$, 23.5%), then participants between the ages of 40-49 ($n = 13$, 5.26%), and finally participants between the ages of 51-64 ($n = 8$, 3.23%). The low reporting of age may be due to some participants not being comfortable disclosing that information on this free response item. The sex identification of the participants was largely female, with 83.4% ($n = 252$) compared to 16.6% ($n = 50$) female-to-male ratio. Similarly, gender identification was "female" with 249 participants (82.7%) identifying as female, 46 participants (15.3%) identifying as male, and 6 participants (2.0%) identifying as "genderqueer." The majority of participants also identified as European American/White/Caucasian ($n = 242$, 80.1%), followed by Hispanic/Latino/a ($n = 22$, 7.3%), African American/Black/African/Caribbean ($n = 16$, 5.3%), Asian American/Asian ($n=8$, 2.6%), Multi-racial ($n = 5$, 1.7%), American Indian/Alaskan Native ($n = 2$, 0.7%), Arab American/Arab/Persian/Middle Eastern ($n = 1$, 0.3%), Native Hawaiian/Pacific Islander ($n = 1$, 0.3%), and other ($n = 5$, 1.7%). Most participants were pursuing their doctoral degree, with 45.4% ($n = 137$) in a Psy.D. program, 29.1% ($n = 88$) in a Ph.D. program, and 25.5% ($n = 77$) in a Master's program. An equal number of participants ($n = 83$, 27.5%) reported the least possible number of months conducting counseling (i.e., 4-8) and the most possible number of months conducting counseling (i.e., 25 or more). The next most frequently

endorsed range was 21-24 months ($n = 40$, 13.3%), followed by 13-16 months ($n = 38$,

12.6%), 9-12 months ($n = 35$, 11.7%), and 17-20 months ($n = 21$, 7.0%). The highest

percentage of participants estimated that they had worked with 51 or more different clients (n

$= 115$, 38.2%), followed by 11-20 clients ($n = 51$, 16.9%), 1-10 clients ($n = 45$, 14.9%), 21-

30 clients ($n = 43$, 14.2%), 31-40 clients ($n = 32$, 10.6%), and 41-50 clients ($n = 15$, 5.0%).

Finally, participants reported most recently working at community mental health centers ($n =$

116, 39.1%), followed by college counseling centers ($n = 112$, 37.7%), hospital settings ($n =$

55, 18.5%), and private practices ($n = 14$, 4.7%).

Exploratory Factor Analysis

An exploratory factor analysis was conducted to attempt to clarify the underlying

factor structure of the 99-item TLS. Although items for the TLS were developed with the six-

factor structure in mind first identified in Stahl et al. (2009), the author predicted that the

TLS would not conform to the same factor structure due to conflicting qualitative data

examined in Isenberg (2009). In that study, over 25% of the items on the TLS were

qualitatively identified by raters to best fit into a subscale from which the items were not

originally developed in the Stahl et al. study. This result indicated how variable the

interpretation of these items were, and therefore increased the likelihood that a more

conservative statistical analysis (i.e., exploratory factor analysis) would provide for a

different factor structure than the one originally proposed by Stahl and colleagues.

Before analyses were conducted, linear interpolation was completed using SPSS to

correct for any missing data (94 missing of 29,898 possible responses, or 0.3%), and

negatively worded items were reverse scored for consistency. Initial assumption testing

revealed acceptable results via the Kaiser-Meyer-Olkin measure of sampling adequacy (.707)

where the recommended value is .6, which suggests the correlation contains actual factors and not chance correlations (Worthington & Whittaker, 2006). Also, a significant Bartlett's test of sphericity was conducted ($\chi^2(4851) = 10387.88$, $p < .001$), indicating a strong enough correlation among variables to provide a reasonable basis for factor analysis (Leech, Barrett, & Morgan, 2005). A form of factor analysis (i.e., principal axis factoring) was used instead of a principal components analysis to ensure only shared variance was revealed, while parsing out unique variation from error variation (Costello & Osborne, 2005). An oblique factor rotation was utilized so that factors were allowed to correlate, which would be consistent with coding overlap in previous qualitative examinations of the items.

Results from the exploratory factor analysis with a Promax rotation revealed an initial 33 factor solution accounting for 67.60% of shared variance where eigenvalues are > 1. The resulting factor loadings, however, made the solution very difficult to interpret. Communalities, or the proportion of each variable explained by the factors, were low-to-moderate for the majority of the items. Only 9 of the 99 items had communalities of .60 or above. Stevens (2002) recommended that the Kaiser criterion for factor retention should be used with a large sample size (> 250) and mean communalities greater or equal to .60. However, Stevens recommended using the scree test to interpret factors when there is a large sample size (at least 200), as long as most communalities are also large. In the case of the TLS, a large sample size was examined ($n = 302$), yet 90% of the items had moderate-to-low communalities (< .60). Therefore the scree plot (See Figure 1) was not a reliable device by which to determine the appropriate number of factors on the TLS. Instead, a 19-factor solution accounting for 50.82% of shared variance for the 99-item TLS was used. This

solution allowed for a more reasonable number of factors while still accounting for an acceptable amount of variance (Floyd & Widaman, 1995).

As previously stated, criteria for item removal included factor loadings < +/-.30 (Nunnally, 1978) or cross-loadings with a difference < .15 from the highest factor loading. Additionally, items with communalities < .40 were considered for removal (Worthington & Whitaker, 2006). Other less rigorous criteria for item removal included examining negative item-correction correlations, redundancy within factors, and conceptual consistency. Factor loadings for retained items are found on Table 1. Bivariate correlations for factors can be found on Table 2. Reliability analyses of the revised TLS are found on Table 3, and include factor names, the number of items in each factor, mean, standard deviation, skewness and kurtosis, and Cronbach alphas.

A total of 47 items were removed from the TLS upon further examination of the EFA results, while 52 items were retained. The resulting revised 52 item TLS with 11 factors (see Appendix D) had six proposed factors by the EFA eliminated due to having less than three items loading in each factor. Two factors were eliminated after items that had cross-loadings with a more appropriate factor were moved to those factors, resulting in the remaining factor having less than three items. Twenty-three items were subsequently removed (a) upon examination of cross-loadings (i.e., an item loaded on two factors with a difference < .15 between factors); (b) due to having a communality score < .40 (i.e., a low percentage of the item's variance was explained by the factors); (c) because they loaded on a factor that was eliminated due to not having enough items (i.e., less than three); or (d) due to redundancy (i.e., one item, "I do not need to improve at setting boundaries with my clients") (see

Appendix E). Twenty-four items were removed due to having factor loadings < +/-.30, meaning they did not load meaningfully on any of the proposed 19 factors (see Appendix F).

The factor labels were determined by examining the language and themes of the items loading highest on their particular factor. Consistency across the language of the items that loaded on each factor was considered when developing the factor labels, with more value being placed upon the language of the items with higher loadings. Full explanation of the items in each factor can be found in Appendix D, and factor loadings are all listed in Table 1. Factor 1 had salient loadings for seven items – item 3 (-.56), item 6 (.32), item 12 (.96), item 15 (.65), item 19 (.99), item 46 (.34), item 63 (.78). Four of the seven items had salient loadings above .60, suggesting it is a reliable factor (Guadagnoli & Velicer, 1988). Upon examining item content, this factor was labeled "Therapist Confidence"; for example, the highest loaded item (#19) was "I am unsure about my competence as a therapist" followed by the item (#12) "I question my effectiveness as a therapist."

Factor 2 had salient loadings for three items – item 28 (.73), item 75 (.81), and item 77 (.78). Based on the content of the items this factor was labeled "Boundary Setting"; for example, the highest loaded item (#75) was "I am good at setting boundaries with my clients" while the lowest loaded item (#28) was similarly "I find it difficult to set boundaries with clients." Factor 3 had salient loadings for five items – item 21 (.71), item 36 (.58), item 55 (.60), item 66 (.52), and item 85 (.62). With almost four loadings of at least .60, this factor is considered nearly reliable, and was labeled "Therapy Impacting the Therapist." For example, the highest loaded item (#21) was "Doing client work can motivate me to change in my own life" while the next highest loaded item (#85) was "Doing counseling has helped evolved my outlook on life."

Factor 4 had salient loadings for six items – item 9 (.69), item 18 (.40), item 23 (.36), item 25 (.55), item 48 (.67), item 90 (.51). The items with the highest loadings on this factor were most relied upon to develop the factor label, which became "Cultural Impact"; for example, the highest loaded item (#9) was "I know where I fall on cultural identity scales" while the second highest loaded item (#48) was "I am aware of cultural biases that I have (including race, ethnicity, socioeconomic status, sexuality, religion, physical/mental ability status, and citizenship status)". The lowest loaded item (#23) displayed similar content to other items – "A person's culture has a significant impact on their worldview."

Factor 5 had salient loadings for six items – item 5 (.42), item 22 (-.32), item 30 (.54), item 31 (.62), item 56 (.56), and item 57 (.30). Based on the content of the highest loaded items, this factor was labeled "Responsibility for Change"; for example, the highest loaded item (#31) was "I recognize the importance of my client taking responsibility for his/her actions" while the second highest loaded item (#56) was "A person's motivation to change significantly influences therapy work."

Factor 6 had salient loadings for six items – item 11 (.34), item 17 (.69), item 44 (.73), item 60 (.30), item 64 (-.32), and item 65 (.64). With a wide range of factor loadings, the highest loaded items (e.g., #44, "My reactions in therapy help me recognize what is happening with my client" and #17, "My clients' presentation in session is often a replication of their presentation with outside relationships") led this factor to be labeled "Clinical Perceptions." Factor 7 had salient loadings for seven items – item 7 (.42), item 27 (.41), item 82 (.30), item 83 (.48), item 87 (.32), item 92 (-.41), and item 93 (.51). This factor did not have very many highly loaded items, with the highest being (#93) "I do not think about the

importance of being patient as a counselor" and (#83) "A client's readiness to change does not dictate how I used interventions." This factor was labeled "Factors for Change."

The final four factors each had salient loadings for three items. Factor 8 had salient loadings for item 14 (.34), item 59 (.65), and item 88 (-.62). The content of these three items included (#59) "My like or dislike for a client will affect how I build the therapeutic relationship with him/her," (#88) "I can work effectively with a client I dislike," and (#14) "My approach to counseling tends to be flexible." This factor was labeled "Working with Clients." Factor 9 had salient loadings for item 52 (.31), item 54 (.74), and item 81 (.64). The content of these items included (#54) "Therapy is a long process," (#81) "Change is slow and gradual," and (#52) "Therapy as a confidential place where client can get support is very valuable." This factor was labeled "Therapy Process." Factor 10 had salient loadings for item 32 (-.42), item 39 (.57), and item 53 (.35). The content of these items included (#39) "I do not need to always be accepting of clients' behavior," (#32) "Clients tend to be rigid," and (#53) "There are things about my clients that I do not have unconditional positive regard for." This factor was labeled "Reflections about Clients." Factor 11 had salient loadings for item 33 (.53), item 89 (.40), and item 97 (.53). The content of these items included (#33) "I conceptualize my clients in a consistent manner based on my theoretical orientation," (#97) "It is ok to be rigid with my theoretical orientation," and (#89) "There is no formula for doing therapy." This factor was labeled "Theoretical Orientation."

Reliability

Internal consistency data were collected from each of the scales used in the present study. The 99-item TLS had adequate internal consistency of .73, suggesting that the items were likely examining a similar underlying construct. This result was slightly lower than the

Cronbach alpha result from the first analysis of the TLS in Isenberg (2009), where the overall score was .78. The change is likely attributable to the much larger sample size of the present study (302 compared to 42), despite 11 items being eliminated from the TLS in Isenberg (2009). However, the revised 52-item TLS resulted in an even lower alpha of .69. Factors 8 ("Working with Clients") and 10 ("Reflections about Clients") were likely the cause of the overall lower factor loading, as such factors have negative alpha scores.

The explanation for the negative alphas was possibly due to the issue of negatively worded items. During the item development process of the TLS, coded lessons were used from the data reported on in Stahl et al. (2009), which resulted in somewhat ambiguously worded items such as "My approach to counseling tends to be flexible." Because the original lesson from the Stahl et al. data was worded to imply the participant did not have a flexible approach to counseling, this response indicated a high score for the TLS. However, because the item was reverse-coded (as is standard practice for scale development), it became worded in a negative way so that participants who consider themselves flexible in counseling approach (a generally desired quality) would score very low on this item when the data were score-corrected. Thus, the item loaded with other items of relevance (i.e., "Working with Clients"), however due to reverse-wording and score-correcting, resulted in a negative score suggesting the item is inversely related to the others when in practicality may be positively correlated. Two Post Hoc EFAs were conducted to investigate if negatively worded items were in fact the problem that resulted in negative alphas (see Post Hoc Analyses below).

A test-retest correlation was calculated to determine if participants using the TLS at least two weeks after first taking it would score similarly. A total of 56 participants completed the guided self-reflection procedure (including the TLS) at least two weeks after

their initial completing of the study. The results, determined via a Pearson correlation, did not support the author's hypothesis that the scores on the TLS would be significantly correlated after at least two weeks of completing the initial study, r (56)= .225, p = .096. This result makes sense when examining the reliability of the 11 factors on the revised TLS. Guadagnoli and Velicer (1988) showed that reliable factors include those with four or more loadings above .60, or three loading of .80 or higher. The only factors on the revised TLS that conform to this requirement were factors one and two (i.e., "Therapist Confidence" and "Boundary Setting" respectively), comprising only 10 of 52 items. This suggests that most of the individual factors of the TLS do not have adequate reliability, thus providing a reasonable explanation for inadequate test-retest reliability in its present form. Additionally, the analysis may have suffered from low power; an issue that could be corrected with more participants. If a subject-to-variable ratio was used as a conservative measure for the number of participants needed for adequate power, then 495 participants would be necessary for the 99-item TLS (Gorsuch, 1983). Two additional reasons for the non-significant test-retest result are practice effects, and participants possibly thinking about a different client than the first TLS administration. This could have lead clients to endorse that they agreed with different lessons for a different client.

Validity

The TLS was predicted to be significantly positively correlated with the Psychotherapist Professional Development Scale (PPDS). In the current study the PPDS was revealed as a reliable measure, with a Cronbach alpha of .973. The author conducted a Pearson correlation, seeking possible convergent validity between the TLS and PPDS, and hypothesized that they measured similar underlying constructs (i.e., professional

development). Results indicated that the TLS and PPDS were significantly negatively correlated, $r(299) = -.287$, $p < .001$. These results suggest that the TLS and PPDS are measuring constructs that are significantly different from each other, and would be considered as divergently valid. This indicated that the TLS and the PPDS do not measure the same underlying constructs; specifically, the TLS does not measure professional development as the PPDS does.

A Pearson correlation was also calculated for the TLS and the Marlowe-Crowne social desirability Reynolds Short-Form A (MC-RSF-A). The MC-RSF-A was revealed as a reliable measure in the current study, with a Cronbach alpha of 1.00. The author predicted that the two scales would not be significantly correlated, which was supported, $r(296) = -.071$, $p = .22$). This result suggests that in its current form, participants completing the TLS are not likely to be responding based on social desirability in any significant manner.

Regression Analysis

A regression analysis was conducted to investigate whether participants with more clinical experience were likely to score higher on the TLS. The author predicted a positive slope would be present for participants with increasingly more clinical experience and their corresponding TLS scores. This hypothesis was supported, $F(1, 298) = 8.23$, $p = .004$, indicating that more experienced participants are likely to score higher on the TLS. The adjusted R squared value was .027, indicating that 2.7% of the variance for number of months conducting supervised counseling is explained by a high score on the TLS. This is considered a small effect (Cohen, 1992).

Structured Comments Questionnaire

        A structured comments questionnaire (SCQ) was presented to study participants after

they had completed all the steps in the self-reflection process, including the TLS and the

ideas participants had to improve their practice after having completed the study. The

purpose of the SCQ was to clarify the usefulness of the TLS (and self-reflection process), as

well as its strengths and weaknesses as a self-reflection tool. As a tool for use by

practitioners to facilitate self-reflection, the benefit of using the TLS is believed, for example,

to be in its efficiency, breadth, and perceived benefit to the user. Eight total questions were

asked of participants on the SCQ (three Likert-scaled quantitative and five open-ended

qualitative).

        The three quantitative questions inquired about the connection of the TLS to self-

reflection, the usefulness of the TLS, and the likelihood of participants using a shorter

version routinely in their clinical work. The author predicted that respondents would endorse

higher numbers significantly more often than lower numbers (i.e., more 6-10 than 1-4).

Descriptive statistics from the 302 participants revealed that a majority of participants

endorsed the quantitative questions in a positive direction for use of the TLS. Results for the

first quantitative question (i.e., "On a scale of 0-10, how much did the self-reflection process

facilitate a deeper understanding of yourself as a clinician?") revealed a mean of 5.81 ($SD =$

2.20), with 176 participants (58.5%) endorsing answers from 6-10; 79 participants (26.2%)

endorsing answers from 1-4; and 46 participants (15.2%) responding with a neutral answer of

5. Results from the second quantitative question (i.e., "On a scale of 0-10, how useful do you

think the TLS is as a tool to aid in the process of self-reflection?") revealed a mean of 6.35

($SD = 2.14$), with 212 participants (70.2%) endorsing answers from 6-10; 61 participants

(20.2%) endorsing answers from 1-4; and 29 participants (9.6%) responding with a neutral answer of 5. Finally, results for the third quantitative question (i.e., "One a scale of 0-10, how likely would you be to use a shorter version of the TLS on a regular basis throughout your clinical training?") revealed a mean of 6.41 ($SD = 2.78$), with 197 participants (65.2%) endorsing answers from 6-10; 82 participants (27.2%) endorsing answers from 1-4; and 23 participants (7.6%) responding with a neutral answer of 5. It is noteworthy to point out that when comparing very positive responses from participants (i.e., answers from 8-10), a much larger proportion indicated they would use a shorter form of the TLS in their clinical training (66%, or 130 of 197 responses between 6-10), compared to perceived usefulness of the TLS as a self-reflection tool (46%, or 98 of 212 responses between 6-10) or the self-reflection process as facilitating deeper understanding of self as a clinician (42%, or 74 of 176 responses between 6-10).

Upon analysis, answers to some of the qualitative questions were combined as responses were found to be very similar in character. The author analyzed the qualitative data by first deciding if the comment was positive or negative in tone (e.g. "Some of the questions were more complex than the Likert scale accounted for" was negative in tone), and then dividing them into one of those two categories (i.e., positive or negative). The first question asked about participants' first reactions after taking the TLS. Positive responses on this question were combined with responses from the question, "What are the strengths of the TLS?" and negative responses were combined with responses from the question, "What are the weaknesses of the TLS?". Additionally, the last two questions, "How could the TLS be improved?" and "Were there any negative aspects to completing the TLS?" were included in the negative response category again due to similarity of answers with previous questions.

Overall, three questions inquired specifically about negative aspects to the TLS with one question indirectly resulting in similar responses. Conversely, only one question specifically asked about positive aspects of the TLS with one question indirectly resulting in similar responses. The author predicted that participants would provide more global positive than negative or neutral reactions to completing the TLS. From the 302 participants, a total of 490 positive responses were coded, while 556 negative responses were coded. Therefore, this prediction was not immediately upheld. However, the author also predicted that participants would find the TLS too long or redundant at times, and the most frequently identified negative reactions to completing the TLS were that it was too long ($n = 199$) and had repetitive questions ($n = 66$). Therefore, if these two categories were controlled for statistically, then the number of global negative responses is reduced from 556 to 291, supporting the author's original hypothesis. This point should be interpreted carefully, however, as participants may not have tried thinking of a more complex weakness of the TLS beyond "too long" or "too repetitive", but could have done so if prompted not to indicate those as weaknesses in the SCQ directions. The author also predicted that participants would list significantly more strengths than weaknesses of the TLS in the SCQ; however, due to response similarity by participants across qualitative questions, this statistic became irrelevant and difficult to obtain upon qualitative coding, and therefore was not directly examined.

To develop categories from the qualitative data, responses were divided into positive and negative categories, and then separated into subcategories. Each qualitative question was examined one at a time, beginning with, "What are you first reactions to completing the Thearpist Learning Scale?" Each positive and negative participant response was assigned a

letter and given a category name. For example, the first participant responded to the first questions with, "User-friendly and intriguing, pertinent questions." This response was considered positive, and coded three ways – (a) user friendly, (b) intriguing, and (c) pertinent questions. Ultimately, 15 participants (4.92%) provided a response consistent with category A ("user-friendly/easy to follow"); 26 participants (8.52%) for category B ("intriguing/interesting"); and 51 participants (16.72%) for category C ("pertinent questions"). Similar with this example, many participant responses included statements that were placed into more than one subcategory; however the author controlled for duplicates and ensured that no responses from the same participant were coded into the same subcategory more than one time. For example, when commenting on the weaknesses of the TLS, one participant replied, "It's a bit long and redundant at some points." This response was given two codes, B ("too long"), and D ("repetitive questions"). However, the participant responded to the question, "How could the TLS be improved?" by stating, "Shorten it up and reduce the redundancy." Because this statement is similar to the statement of the previous question, it was not included in the category frequencies so as not to confound the data. This coding process was completed for all 302 participants and the five qualitative questions on the TLS. Table 4 provides details of each positive subcategory, including illustrative quotations. The most frequently endorsed subcategories of positive responses were "facilitated self-reflection" ($n = 95$, 31.15%), "comprehensive/good breadth of questions" ($n = 57$, 18.69%), "pertinent questions/appropriate content" ($n = 51$, 16.72%), "thought provoking" ($n = 49$, 16.07%), and "helpful, useful, or meaningful" ($n = 37$, 12.13%).

One participant commented that the TLS "made me reflect on several therapeutic processes that we don't talk about enough in my clinical courses or supervision," reinforcing the benefits of the TLS as a self-reflection tool. Another illustrative comment about self-reflection included, "I thought it revealed some interesting patterns concerning my beliefs about therapy that I might not have been as aware of previously." Many participants commented on the comprehensive nature of the measure, including, "Covers a lot of counseling competencies" and "It does tap into several areas clinicians should be aware of when conducting therapy. Clinicians could see where they fall short and seek supervision." In addition to the breadth of the measure, participants found the questions pertinent and appropriate, including "It hits many of the major issues that beginning therapists find to be difficult, such as conceptualizing clients through a cultural lens, working with silence, trusting my own effectiveness as a therapist." Another respondent commented, "Most of the questions were relevant to variables faced by therapists and promoted long-term learning and self-reflection." When considering how thought-provoking the measure was, participants commented, "Loved the way it made me think about the areas I am struggling with in a non-threatening way," and "Gets you to think about many aspects of therapy and particularly areas that you may neglect to consider." Thirty-seven participants commented on the helpfulness, usefulness, or meaningfulness of completing the TLS. Some stated, "The self-reflection piece forces the therapist to identify someone they have not performed up to par with, and forces them to think about what exactly is going or has gone wrong. This is a useful skill for all therapists." Another suggested that, "I think it could be very helpful for beginning and experienced counselors."

One could argue that the subcategories "self-affirming," "thought provoking," and "facilitated self-awareness" all could represent more specific ways that the TLS facilitated self-reflection, which was the positive subcategory endorsed most frequently. If these four subcategories were combined, then 58.69% of respondents ($n = 179$) commented that completing the TLS facilitated self-reflection in some manner. Two participants noted that the TLS, "Helps to see where you have personal strengths, weaknesses, and biases," and "I feel like there is a difference in how I do therapy in general versus how I am doing therapy with the difficult client…I wasn't aware of that until now!"

Four of the subcategories in the negative responses category had over 10% of the sample generate responses appropriate for those categories. See Table 5 for detailed descriptions of the negative subcategories and illustrative quotations. The majority of the sample ($n = 199$, 65.25%) identified that the TLS was "too long." This result was not beyond the expectations of the author, however, as 99-items for a measure intended for self-reflection purposes seems initially lengthy. The second most frequently generated subcategory responses were that there were "repetitive questions" ($n = 66$, 21.64%). This was also a standard element of the scale development process that the author anticipated might frustrate participants and be highly reported by participants on the SCQ. The next most commonly generated subcategories includes "instructions are better for therapy in general or multiple clients" ($n = 54$, 17.70%), and the presence of "confusing or unclear questions" ($n = 53$, 17.38%). Some comments by participants about the instructions included, "At times I was unsure if I were to answer the questions according to the specific case or to my skills in general," and "It's unclear whether these are 'exceptions' to holding that client in my head or whether I'm somehow supposed to talk about all of my counseling experience filtered

through my work with this client." Several participants also commented on the questions, including "Some questions were confusing and unclear," and "There are several items that are worded in a way that is either unclear or I was unsure what each choice endorsed."

Post Hoc Analyses

Upon examination of the exploratory factor results for the TLS, post hoc analyses were conducted to try and correct for the low overall internal consistency scores of the TLS, and negative internal consistency scores found on factors 8 ("Working with Clients") and 10 ("Reflections about Clients"). It was postulated that negatively worded items may have confounded results; therefore, Cronbach alphas were calculated separately for positively worded items, and negatively worded items from the proposed 11 factor, 52-item TLS (Snoek, Skovlund, & Pouwer, 2007). Thirty-one positively worded items had an alpha score of .73 while 21 negatively worded items had an alpha score of .58. The overall 52-item TLS alpha score was .69. Additionally, concerns were raised regarding the effect of negatively-loaded items in the factor structure of the TLS (e.g., items 3, 22r, 32r, 64, 88, and 92; See Table 1). Cronbach alphas were re-calculated with these items removed, resulting in alphas of .76 ($n = 28$) for positively-worded items, and .64 ($n = 18$) for negatively-worded items. When the six negatively-loaded items were removed from the TLS, the resulting full-scale Cronbach alpha was .76 ($n = 46$).

An additional exploratory factor analysis (EFA) was conducted while excluding items 3, 22r, 32r, 64, 88, and 92 with the idea that a more stable factor structure may emerge without the negatively-loaded items included. This analysis resulted in an initial 18 factor structure accounting for 50.25% of shared variance. After eliminating items due to cross-loading differences $< .15$, low communalities ($< .40$), and loadings on factors with less than

three items, a 13 factor, 53-item TLS with an overall Cronbach alpha of .75 emerged. Factors ranged in size from three to eight items, and with alpha scores ranging from -.06 to .81 (See Table 6). Although the overall alpha score improved compared to the 11 factor, 52-item TLS, 8 out of 53 items in the second EFA resulted in negative loadings (i.e., items 7r, 13r, 14r, 20, 26r, 35r, 50r, and 79r). This suggested that although the overall internal consistency of the TLS was improved by eliminating the initial six negatively loaded items, more items emerged as contributing to a less than optimal Cronbach alpha score. This result reinforced the conclusion that the TLS likely measures more than a single unitary construct and that the subscales maintain a degree of low reliability that may not be replicable in future studies. Additionally, this may suggest that there are more significant scale construction concerns for the TLS that could require fundamental revisions.

Correlations of the 11-factor, 52 item TLS found on Table 2 indicated that the factors were not as highly correlated as expected. An oblique factor rotation was used initially for two reasons. First, the vague language of the items suggested that they could be interpreted in several ways by respondents, and second, qualitative examinations of the lessons in Stahl et al. (2009) and Isenberg (2009) indicated a high percentage of variability for which of the six factors developed by Stahl et al. a lesson/item would appropriately represent. Therefore, a second Post Hoc EFA was conducted with a Varimax orthogonal rotation and only with positively worded items. Results from this analysis proved worse than prior EFA attempts. Specifically, an 18-factor, 54-item solution emerged accounting for only 42.86% of variance. Additionally, only 15 items had acceptably high communality scores (> .40), therefore 39 items did not have enough variance accounted for by the factors that emerged. This result may indicate that negatively worded items may not be the concern that has plagued the

TLS's psychometric properties. Thus, a fourth EFA was conducted with the full 99-item TLS, but with a Varimax rotation instead of a Promax. These results were also worse compared to the original oblique Promax rotated EFA, as a 33-factor solution emerged accounting for only 51.36% of shared variance. The Promax rotation accounted for 67.60% of shared variance with a 33 factor solution, and was more efficiently reduced to 19 factors accounting for 50.82% of shared variance, which was then ultimately reduced to 11 factors after examination of cross-loadings, communalities, and factors with less than three items. Therefore, the factor solution that presently best fits the data remained an oblique Promax rotation with positively and negatively worded items included.

CHAPTER V

Discussion

The present study drew upon research and theory in the areas of therapist learning (e.g., Freeman & Hayes, 2002; Isenberg, 2009; Stahl et al., 2009), therapist professional development and expertise (e.g., Orlinsky & Ronnestad, 2005; Ronnestad & Skovholt, 2003; Skovholt et al., 1997), and critical self-reflection (e.g., Lee & Sabatino, 1998; Leung & Kember, 2003; Peters 1991) to construct and to investigate the psychometric properties of a formal therapist self-reflection tool (the Therapist Learning Scale; TLS). Analyses were conducted to investigate the TLS's reliability (i.e., internal consistency, test-retest), validity (i.e., correlations with the PPDS and MC-RSF-A), predictability (i.e., a regression analysis), factor structure (i.e., exploratory factor analysis), and practicality (i.e., SCQ).

Participants were recruited from emails to nearly 1000 different counseling programs around the United States and effectively represented individuals across the spectrum of graduate training (27.5% of participants had 1-2 semesters of clinical work, while another 27.5% had at least two full years of clinical work). The majority of participants were female identified (82.7%) and European American (80.1%) however, meaning that underrepresented groups in the sample had less influence on the results of the study, whereas greater influence by these groups could have altered the results. These results should not be generalized to students in pre-doctoral internships or beyond because the intensity of training during internship is intended to foster significant professional growth in students in a short time period and would therefore place them in a category separate from individuals in earlier graduate school training. The TLS was designed with novice therapists in mind, and because the data for the present study came exclusively from students in their second through fifth

year of graduate training, generalizing beyond to pre-doctoral internship students would not be recommended.

The labeling of the 11 retained factors of the TLS was first based on the highest loadings and then relevance to the other items. Significant correlations were found between many factors (see Table 2) indicating the appropriateness of the oblique rotation, however, taken in part with generally unreliable factors (according to Guadagnoli & Velicer, 1988), that means factors are unlikely to be replicated in future studies. Despite their low reliability, many factors clearly provided conceptual consistency and were easy to label. For example, the highest two factor loadings for factor one (i.e., "Therapist Confidence") are "I am unsure about my competence as a therapist" and "I question my effectiveness as a therapist", while the lowest item loading belongs to "I am hesitant to challenge or confront my client for fear of damaging the therapeutic relationship." Therefore, items across the loading range clearly relate to how confidence the participant feels as a therapist. Similarly, all three items in factor two (i.e., "Boundary Setting") clearly discuss boundaries with clients, while factors three and four (i.e., "Therapy Impacting the Therapist" and "Cultural Impact" respectively) also have clear items that fit their labels. Conceptually, the items on the 52-item TLS were effectively grouped by the exploratory factor analysis.

The statistical results of the exploratory factor analysis suggest that the TLS presently does not conform to a parsimonious factor structure, however. Factor analysis research suggests that a psychometrically valid measure should account for at least 50% of the variance for the latent variables being examined (Stevens, 2002), which is true for the initial TLS. In the present study, only 9.6% of the variance is explained by the first factor, 24.8% explained by the first 5 factors, and 50.82% explained by the first 19 factors. If using the

Kaiser-Guttman criteria (that is, retaining factors with eigenvalues >1), then the TLS would have 33 factors accounting for 67.60% of the variance. Additionally, the Cattell-Nelson-Gorsuch scree plot does not provide a natural visual cut-point for an effective factor structure (see Figure 1). Taken together, this information suggests that the TLS completed by participants in this study requires modifications to possess a reliable factor structure. It is unknown at this time if the revised 52-item and 11-factor solution of the TLS would perform more reliably and account for at least 50% of shared variance, which is one potential area for valuable future research.

Reasons for the poor factor structure may include an inadequate operational definition of therapist learning. The concept of therapist lessons was a broad term utilized in Stahl et al. (2009), which grouped identified lessons into six categories, which may be too vague to be psychometrically valid. Additionally, throughout the present study and the development of the TLS in Isenberg (2009), the author erred on the side of strict scale development methods. One example of this was creating and retaining as many items in the initial development process (DeVillis, 2003), and only eliminating items when they were determined to be particularly poor after being subjected to multiple analyses (i.e., expert raters and corrected-item correlations in Isenberg, 2009). The author (Isenberg, 2009) was also strict in his development of items solely and specifically from the data collected by Stahl and colleagues. This was done to maintain strict scientific rigor in the scale development process; however, it may have been more prudent to make such decisions based on assumed clinical relevance. The author may have been able to limit the length and redundancy of the TLS if he chose to rely somewhat more on the "art" of scale development than the pure science of it.

The TLS is also a different kind of scale than most typically used in psychological research. It is intended as a personally meaningful tool for therapists and not necessarily to inform research (although that would be an adjunctive benefit). The Likert response options ask participants to rate how true an item (i.e., a lesson) is for the particular client they are thinking about. The interpretation of these scores may be open to debate. Positive endorsement of some items, such as "clients tend to be strong" can be interpreted as a positive realization for a therapist about their client. However, if the therapist perceives the client they are thinking about to not be strong, they will say it is less true for their client. If the intended purpose of the TLS were to facilitate therapist self-reflection and professional development, then it would be irrelevant for a therapist to indicate their perceptions of their client's strength in either direction. However, this can be problematic psychometrically. If therapist participants are taking away the same positive benefit of using the TLS, but answering in significantly divergent ways, the items will not appear to measure any particular underlying variable. It is impossible to know if and how often this happened in the present study, yet it may be a confounding variable that would need to be addressed for future research. The Likert responses may need to be modified to include how significant each particular lesson is for the therapist participant.

Additional analyses indicate other concerns about the TLS, including an unacceptably low test-retest correlation. This result means that participants responded differently after two weeks of completing the TLS. As previously discussed, the factors and items therefore may not be stable over time. Although this result did not confirm the research hypothesis, it is possible that participants recognize or learn different things by using the TLS multiple times. This could reinforce the clinical benefit of using the TLS as part of a self-

reflection process. It is also possible that the study suffered from unacceptably low power and would require more participants, or participants did not think about the same client as when they initially completed the TLS which could have influenced their responses on the test-retest portion.

The TLS was also found to not correlate with the PPDS or the MC-RSF-A, meaning it is not measuring the same underlying construct as the PPDS (i.e., professional development), and it does not elicit socially desirable responses. The reasoning the TLS significantly differed from the PPDS may be twofold – (1) the TLS suffers from scale construction issues already identified, or (2) the TLS results in professional development but does not measure it. The TLS may be a unique scale in that its underlying construction may be less rigid in what it measures and instead more open about what it does for participants, such as illuminating areas of successful clinical progress or areas for future growth.

The qualitative responses from the SCQ included in the self-reflection process provided helpful information about how participants felt utilizing the TLS. The most meaningful of these data include that 58.5% of participants felt the TLS facilitated a deeper understanding of themselves as clinicians ($M = 5.81$); 70.2% of participants felt the TLS was useful as a self-reflection aid ($M = 6.35$); and 65.2% of participants said they would regularly use a shorter version of the TLS in their clinical practice ($M = 6.41$). Additionally, 130 of the 197 participants that said they would use a shorter TLS marked between 8-10 out of 10 on that question. Finally, there were 490 coded positive responses about the TLS from participants, while there were only 291 negative responses when accounting for length and redundancy. These are all exciting data points that reinforce the notion of the TLS being a valuable tool for clinicians. Despite mixed quantitative data via the present factor analysis,

the fact that participants had more positive things to say about the TLS than negative ones suggest further refinement and validation are warranted, and welcomed.

Limitations and Threats to Validity

The TLS in its present form may suffer from significant psychometric limitations, as evidenced by the lack of parsimony and difficult to interpret factor structure. One reason for this problem is that the TLS may not properly identify whether participants have learned the lessons they are responding to, due to poor answer options. The use of a 5-point Likert scale was believed to be the best option with participants indicating how true the lesson to which they were responding was for their experience with that particular client (Isenberg, 2009). However, participants reported on the SCQ that they believed the TLS included "confusing/unclear questions" ($n = 53$, 17.4%) and some said that they did not like the Likert response wording ($n = 26$, 8.5%). This issue may provide the best explanation for the difficult to interpret EFA results, because if participants did not reflect on whether learning had taken place as the item was inquiring (e.g., "I am uncertain how to work with clients that have different diagnoses"), then their responses would not indicate they had or had not learned by working with this client. Stating that a lesson was true or less true may not necessarily reflect if learning had taken place. Perhaps a more approriate item response set would have been a sliding scale (from 1-10) to provide a true ratio score, ranging from "I did not learn this by working with this client" to "I learned this by working with this client." These more direct response choices could have improved the clarity of the task for participants and better tapped into the construct of therapist learning than the response choices used in the present study and in Isenberg, 2009.

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Additionally, allowing participants to state that they did not learn something from a particular client corrects for the problem of positive or negative language of some item wordings. For example, in the current study the item, "I recognize the value of expressing empathy and compassion" is positively-worded and a high score on this item should indicate that this lesson was learned. However, a respondent commenting that this is "persistently true" may not actually be stating that they learned this lesson with this particular client, and is "penalized" in his/her score by saying that it is not true. The present response options may artificially communicate that one score ("rarely true" in the present example) is less desirable, when in fact that should not be the case. The goal of the using the TLS was intended to determine if and what participants were learning from their clients, not if they should or should not endorse an item based on their training, personal values, or anything else that a more-or-less "true" option might explain. If the responses instead directly used the language "I did learn" or "I did not learn," then there is no value judgment about whether a respondent chose correctly (in that the lesson was "persistently true" or "rarely true"). Thus, a primary revision for the TLS should be to re-examine the conceptual relationship between the goals of its use (e.g., realizing lessons from clinical work), and its ability to practically achieve those goals (i.e., having items and response choices that clearly relate to those goals).

A related limitation is the possible contrasting interpretations of the items by study respondents. In other words, participants with differential experiences or amount of experience may have perceived items differently. The amount, quality, and type of clinical experience may have influenced how participants completed the TLS. For example, answering the item "I conceptualize my clients in a consistent manner based on my theoretical orientation" was likely far more difficult for participants with only 4-8 months of

experience doing supervised counseling (27.5% of respondents) than those with 25 or more months of experience (27.5% of respondents), because participants with less experience are likely to have a less solidified understanding and application of a theoretical orientation. A large segment of participants may have therefore responded to several items in qualitatively different ways than other participants based on their training experiences, personality traits, and other factors.

Developmental differences between students in their later years of graduate training and those with only 4-8 months of clinical work may be meaningful. The discussion of individuals in the Beginning Student Phase by Ronnestad and Skovholt (2003) highlighted the early practitioner challenges, including, "Direct or subtle criticism, actual or perceived, can have detrimental effects on student morale. The vulnerability of students can parallel that of some clients who are particularly sensitive to how they perceive their therapists" (p. 12). This can be contrasted with individuals in the Advanced Student Phase who are able to be more accurately critical about what it means to be a therapist, despite still relying heavily upon supervision and external positive reinforcement (Ronnestad & Skovholt, 2003). This later degree of realistic self-efficacy might have helped advance participants in the present study to reflect more meaningfully on the items of the TLS and have a more accurate perception of their competence, positive or negative. It is possible that more beginning students struggled with feeling overwhelmed by the large volume of items on the TLS, and experienced negative perceptions about their competence. One respondent on the SCQ commented that "Self-reflection often highlights our weaknesses, so perhaps my confidence level has decreased after completing the form. Having supervision directly after completion would help regain the confidence." This participant raises an important point in that self-

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reflection, particularly with more beginning trainees, could have detrimental effects on their sense of self as a therapist. Therefore, despite significant emphasis on the value of self-reflection highlighted in the present study, trainees should be careful to include their supervisors in that process. Similarly, the present study does not differentiate between personal growth and professional growth. As previously noted, Ronnestad and Skovholt (2001) stated adamantly, "We cannot emphasize enough that, to develop optimally, practitioners need to continually reflect on both their personal and professional experiences" (p. 186). However, neither the TLS nor the self-reflection process of the current study difference between the two.

In addition to limitations already discussed, limitations of this study include the lack of a qualitative component to the TLS. Correspondingly, the TLS was developed specifically from one qualitative study with 12 participants. It is therefore very likely that the lessons included in the scale are not comprehensive, and that additional qualitative research would provide additional lessons and possible lesson categories. Instructions for the study request participants think about one particularly challenging client and continue referring to that individual throughout the self-reflection process. It may have been more appropriate for participants to consider their perceived learnings generally when responding to specific items, such as "I have high expectations for myself as a therapist." Such an item may have caused some confusion to participants in their responses. The TLS was also developed from lessons articulated by pre-doctoral intern-level therapists, and therefore may be less relevant to more novice therapists in their first, second, or third practicum experiences (i.e., selection bias).

The large number of items on the TLS (99) and the large sample size needed for adequate power (300-400) complicate the feasibility of the study, and increase the possibility of participant fatigue. Use of the MC-RSF-A also provided a limitation since participants are students familiar with psychological research, and are likely to be familiar with social desirability scales, threatening the validity of its use. However, the use of a social desirability scale is commonplace practice for a scale development study. It is also noteworthy that response rates are unobtainable due to the participant recruitment procedure. All data gathered is also self-report – not based on any direct observations of participants, therefore limiting the generalizability of the study's results.

Finally, sampling bias issues are possible by working with volunteer participants. Rosenthal and Rosnow (1975) parsed out the characteristics of volunteer participants, and identified with "maximum confidence" (p. 86) that educated, intelligent, sociable, approval-motivated, and individuals from higher social class are more likely to participate than their opposing counterparts. Additionally, participants who are female, unconventional, nonauthoritarian, arousal-seeking, nonconforming, and Jewish > Protestant or Protestant > Catholic are labeled to have "considerable confidence" in participating more as volunteer subjects. These characteristics may be even more likely in the present study's sample because of strict inclusion criteria (i.e., graduate students in a program with a counseling component having at least one semester of experience), illuminating the importance of not generalizing results beyond the appropriate groups.

This study may have suffered from several threats to validity. One threat to statistical conclusion validity was the potential for extraneous variance in the experimental setting. That means some participants may have completed the scale quickly, while others may have

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taken their time. This was a particular problem for the present study, as participants were instructed to take their time and think carefully about their answers, yet there was no way to be sure these directions were followed. Threats to construct validity included possible inadequate explication of constructs (i.e., therapist learning), construct confounding (i.e., more constructs might have been present in the TLS than therapist learning alone might), and mono-method bias (i.e., the use only of self-report measures). Finally, a threat to external validity was the interaction of a causal relationship with units. This means that respondents who possessed certain traits or demographic variables might have been overrepresented by particular responses on the TLS. (Heppner, Wampold, & Kivlighan, 2008)

The present 11 factor, 52-item solution of the TLS suffers from internal consistency problems (i.e., a moderate total score of .69 and a wide range of factor scores from -.48 to .84); a low-to-moderate (i.e., .40 - .60) amount of item variance accounted for by factors (i.e., communalities); generally low bivariate correlations between factors; low factor reliability (i.e., only factors 1 and 2 had adequate reliability); and an overall difficult to interpret structure. Additionally, 47 items were eliminated because they did not load appropriately to the 11 factor structure, which does not necessarily mean they are not useful items. The best present explanation for the lack of parsimony and psychometric support for the TLS seems to be the conceptual question of if the TLS was measuring what it was intended to. The TLS was meant to measure what therapists were learning from their clients, however, problems with the interpretation of the items and the response choices for participants likely confounded the results. If participants were provided the option of responding to items by directly stating whether they had learned lessons from working with their particular client or not, then the present study's results may have differed significantly. Fortunately, the majority

of participants reported a positive experience in using the TLS, and 43% of participants said they were very likely (8-10 out of 10) to use a shorter version of the TLS in their ongoing clinical training. The next steps of development for the TLS should be to revise the Likert item response choices, change item language to only be positively worded, and simplify the language of the items generally.

Strengths and Contributions

The development of the TLS followed rigorous scale development standards (e.g., Clark & Watson, 1995; DeVillis, 2003; Floyd & Widaman, 1995; Worthington & Whitaker, 2006). The scale's origins began with Isenberg (2009) developing items strictly from qualitative lessons of the data used in Stahl et al. (2009), which were then subjected to expert rater analysis, and a correlational examination. Items were modified or removed on the basis of statistical variation, resulting in a 99-item preliminary TLS. The present study continued to examine the TLS's psychometric properties through an exploratory factor analysis, and corresponding correlational measures. The steps followed throughout this process were consistent with those recommended in the studies mentioned prior. The development of the TLS can be viewed as a positive example in the empirical literature for how to rigorously and conservatively conduct and make decisions during the scale development process.

The process of the self-reflection outlined in the present study provides a formalized process that therapists-in-training can use for the benefit of self-reflection leading to professional development. The TLS was developed from actual lessons identified by pre-doctoral intern-level counseling professionals generated for Stahl and colleagues (2009). Use of the TLS in a guided self-reflection process can be considered a formalized, empirically examined method for assisting novice therapists in identifying lessons from their clinical

work, and does so using multidisciplinary research, from psychology and educational learning literature. Validation of the TLS provided an easy to understand and practical method to follow so that novice practitioners are thinking about their clients in a formal manner and not only during supervision or when writing clinical notes. Similar to students considering how to conceptualize clients, engaging in a self-reflection process with the TLS provides specific lessons previously identified by more advanced practitioners (i.e., pre-doctoral interns) as being valuable. Instead of only focusing on what is happening with their clients, novice therapists will be able to more directly consider what is happening within them, which can help foster professional development and potentially protect against burnout.

The qualitative data collected in the present study helps to reinforce the subjective value of the TLS and self-reflection processes. Nearly 60% of participants identified the use of the TLS as self-affirming, thought provoking, facilitating of self-awareness, or facilitating of self-reflection, including comments such as, "It made me think fairly deeply. I actually think completing this exercise routinely throughout one's career would be helpful to promote the concept of life-time learning and the idea that our training is always incomplete." And, "I really liked it! My immediate reaction was, 'Why aren't we using this in my Seminar class or at my internship site?'" These positive identifications with using the TLS indicate its beneficial use in clinical training. It is a unique tool that identifies lessons a therapist may not necessarily be thinking about as valuable or important until seeing that lesson on the measure. It reminds beginning therapists of the myriad elements that are relevant while engaging in therapy so that they can be more mindful of what details they are attending to with their clients, among other positive benefits.

Implications for Research, Practice, and Training

Contrary to initial assumptions about the TLS as a tool to measure therapist learning, the TLS may actually be better utilized as an instructional tool within an intervention, as it was used in the present study. Future use of the TLS may include an experimental design investigating if measurable professional development is facilitated through regular use of a formalized self-reflection process that includes the TLS. For example, one group of students could use the TLS for one semester while another group does not, whereby at the end of the semester both groups would take the PPDS (and/or related measures) to investigate if subjective scores of professional development were significantly different between the groups. The TLS could be used in a similar way to investigate any protective effects its use has against burnout. The same two groups could complete burnout measures to investigate if regular self-reflection (via the TLS and a formalized process) in fact protects one group of novice therapists against burnout more than another.

The use of the TLS or a similar measure by novice therapists in training would not only provide a method of formalized self-reflection, but it would emphasize to trainees that frequent self-reflection is an important and valued component of learning and professional development. In current psychotherapy training programs, students are encouraged to consult with supervisors and colleagues, and to read about different treatments or client issues on their own. Use of the TLS provides a method and measure for trainees to explore in a broad way what they are learning from clients. It can help therapists recall important aspects of doing therapy and allows them to check-in with their own growth. It is a subjective measure with an objective bent, as a therapist completing it may not be considering how boundaries are affecting work with a particular client until seeing an item on the TLS about boundary

setting. Supervisors could use the TLS throughout a trainee's development as an adjunct to supervision, which encourages trainees to take an active role in their own improvement without relying solely upon a supervisor's direction.

The TLS was designed as a general tool for a broad spectrum of lessons. However, a more efficient design for a formalized self-reflection tool may be best tailored specifically to a therapist's present concerns. For example, any number of TLS-like instruments could help therapists reflect on their degree of understanding about a client. If a client suffers from a major depressive disorder, a "TLS-depression" measure might include items regarding the client's history of depression, family history, significant life events, major traumas, and other specific issues that can contribute to depression. Additionally, the measure can include relevant questions from the current TLS, such as, "I feel pulled to nurture my client." More specific TLS-like measures can be tailored to a therapist's theoretical orientation or subject area that they are feeling unsure about, almost like a summary review for a textbook chapter. If a student is learning about psychodynamic therapy (or is their present theoretical orientation), an item example may be, "I find it difficult to recognize displacement with my clients." Any number of measures could be created to help therapists with particularly challenging clinical or learning situations.

Although the TLS may presently suffer from a lack of parsimony or a simple factor structure, it provides a significant direction for future research that can potentially provide great benefit to therapist novices and experts alike. In regards to the process of scale development, the next logical step in development is to revise the TLS in a manner that addresses concerns about what it measures, including the modification of response sets and

inclusion of an option for "not learned," along with revision of items to eliminate confusing

language, and collection of new data.

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Table 1

Factor Loadings for the 52 items on the Therapist Learning Scale

Item	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	Communality
3	-.56											.59
5					.42							.44
6	.32											.53
7							.42					.47
9				.69								.50
11						.34						.45
12	.96											.73
14								.34				.46
15	.65											.62
17						.69						.48
18				.40								.50
19	.99											.76

Item	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	Communality
21			.71									.56
22					-.32							.58
23				.36								.42
25				.55								.56
27							.41					.45
28		.73										.70
30					.54							.55
31					.62							.56
32										-.42		.51
33											.53	.44
36			.58									.56
39										.57		.43
44						.73						.66
46	.34											.54

Item	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	Communality
48				.67								.56
52									.31			.50
53										.35		.51
54									.74			.52
55			.60									.52
56					.56							.50
57					.30							.58
59								.65				.57
60						.30						.44
63	.78											.62
64						-.32						.47
65						.64						.60
66			.52									.47
75		.81										.69

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Item	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	Communality
77		.78										.74
81									.64			.50
82							.30					.47
83							.48					.46
85			.62									.59
87							.32					.47
88								-.62				.50
89											.40	.42
90				.51				.34				.50
92							-.41					.45
93							.51					.41
97											.53	.46

Note: Item loadings < +/-.30 are suppressed.

Table 2

Bivariate Correlations of the 11 factors on the Therapist Learning Scale

Factor	I	II	III	IV	V	VI	VII	VIII	IX	X	XI
I	1.00	.33**	.07	.22**	.18**	-.04	.13*	-.14*	-.01	-.10	-.06
II		1.00	-.01	.21**	.30**	-.02	.14*	.06	-.03	.01	-.11
III			1.00	.32**	.20**	.18**	.11	.10	.20**	.13*	.13*
IV				1.00	.15**	.24**	.12*	-.01	.08	-.01	.04
V					1.00	.06	.18**	.02	.16**	.02	.00
VI						1.00	.08	.07	.15*	.00	.04
VII							1.00	-.08	.04	-.14*	-.01
VIII								1.00	-.02	.10	-.12
IX									1.00	-.10	.11*
X										1.00	-.01
XI											1.00

*p < .05. **p < .01.

Table 3

Reliability Data for the 11 factors of the Therapist Learning Scale

Factor	No. of items	*M (SD)*	Skewness	Kurtosis	Alpha
1. Therapist confidence	7	21.83 (3.43)	-.17	.34	.58
2. Boundary setting	3	11.97 (2.14)	-.73	.86	.84
3. Therapy impacting the therapist	5	18.43 (3.08)	-.47	.57	.73
4. Cultural impact	6	23.79 (2.95)	-.44	1.08	.69
5. Responsibility for change	6	23.75 (2.10)	-.83	1.80	.40
6. Clinical perceptions	6	21.73 (2.58)	-.08	.21	.45
7. Factors for change	7	22.29 (2.19)	-.28	.40	.23
8. Working with clients	3	8.64 (1.23)	.07	-.08	-.48
9. Process of therapy	3	11.90 (1.42)	-.61	4.40	.56
10. Reflections about clients	3	9.49 (1.51)	.02	-.09	-.05
11. Theoretical orientation	3	10.21 (1.85)	-.32	.30	.37
Total	52	184.04 (10.37)	-.31	2.14	.69

Table 4

Positive Responses on Structured Comments Questionnaire

Subcategory	Frequency	Percent of *n*	Illustrative Quotation
Facilitated self-reflection	95	31.15%	It made me reflect on several therapeutic processes that we don't talk about enough in my clinical courses or supervision.
Comprehensive/ good breadth of questions	57	18.69%	This measure is relatively comprehensive and has many valuable items.
Pertinent questions/ appropriate content	51	16.72%	It highlights how many factors are at play in a therapeutic relationship and therapy in general.
Thought-provoking	49	16.07%	The questions were very thought-provoking.
Helpful, useful, or meaningful	37	12.13%	It made me think fairly deeply. I actually think completing this exercise routinely throughout one's career would be helpful to promote the concept of lifetime learning and the idea that our training is always incomplete
Facilitated self-awareness	32	9.85%	Makes me question myself at times but makes me aware of my strengths as well.
Intriguing or interesting	26	8.52%	Interesting. I have never taken a questionnaire of this nature before.
Scale is of high quality or is a good tool	22	7.21%	Great idea for an instrument!
User-friendly, or easy to follow/use	19	6.23%	Fairly straightforward, easy to understand.
Reminds of often missed therapy factors	18	5.90%	It caused me to think about things I hadn't specifically considered.

Enjoyable	15	4.92%	I really liked it! My immediate reaction was, "Why aren't we using this in my Seminar class or at my internship site?"
Covers client, therapist, and relationship factors	13	4.26%	Makes you think about you as a counselor/therapist and the role that clients play.
Focus on cultural identity	10	3.28%	Includes questions about the importance of culture in therapy relationships.
Repetitive, has validity checks	6	1.97%	I liked how several questions asked the same thing in an opposite manner
Forces therapist to consider process and content	5	1.64%	Forces the therapist to consider the process, rather than just content with a client
Applicable to all theoretical orientations	4	1.31%	It's general enough to that its applicable to all different theoretical orientations
Specifically targets one difficult client	4	1.31%	Encouraged thoughts related to one specific client
Self-affirming	3	0.98%	It makes me feel like I am doing a fine job as a learning therapist.
Provides a lot of data and/or different perspectives	3	0.98%	Items help therapist think differently about therapy and provide different perspectives on what therapeutic process does for both the client and therapy
Holds therapists accountable	3	0.98%	It causes the clinician to become accountable for the important aspects of therapy which are learned but not always applied
Focus on interpersonal process	3	0.98%	Good focus on interpersonal process
Non-threatening	2	0.66%	Loved the way it made me think about the areas I am struggling with in a non-threatening way

Self-reflection based open-ended questions	2	0.66%	I liked the open-ended questions at the end asking for two or three ways to address the issues with the difficult client
Transference and countertransference questions	2	0.66%	Awareness of transference/ countertransference
Good length	2	0.66%	Relatively good in length, not too cumbersome
Good for new therapists	2	0.66%	Touches upon very salient topics for a beginning counselor
No forced choices	1	0.33%	I liked that it was not force choice
Wants a copy of the assessment	1	0.33%	I want a copy of the assessment
Detects burnout	1	0.33%	I think it might also be able to detect burnout
Open and closed-ended questions	1	0.33%	Open and closed-ended questions
Helps with treatment planning	1	0.33%	Helps with treatment planning

Table 5

Negative Responses on Structured Comments Questionnaire

Subcategory	Frequency	Percent of n	Illustrative Quotation
Long	199	62.25%	It was long. A lot of questions
Repetitive questions	66	21.64%	There were lots of repetitive questions, which could easily be reduced
Instructions better for therapy in general or multiple clients	54	17.70%	It was difficult to think of the questions in terms of one client
Confusing or unclear questions	54	17.38%	I think some questions are unclear and have an indirect way of asking
Likert response wording	26	8.52%	I found the scale a bit confusing (Rarely true? Is that equal to Not True most of the time?). I would have preferred a scale that was clearer
Not specific, vague, or ambiguous	21	6.89%	Not specific to any generalizable population, questions may differ depending on clients and agency
Reverse wording	15	4.92%	The wording was confusing on some of the questions (double negatives)
No overall or summary score	13	4.26%	I was hoping it would be scored at the end, and tell me about norms
Unsure of its purpose	12	3.93%	I don't think there is anything wrong with it, just not sure about the benefit
Psychodynamic in nature and not relevant to theoretical orientation	11	3.61%	Many questions are worded according to a psychodynamic perspective, when they could be worded in an atheoretical way
Tedious or not	10	3.28%	I did not care for the scale

enjoyable

Not helpful or useful	10	3.28%	I cover most of this in supervision and in consultation with other therapists
No "N/A" option	8	2.62%	There is no N/A option, you are forced to pick something as if you experienced that issue, had that thought come up in the therapy process
Better as a qualitative or mixed scale	8	2.62%	Needs more open-ended questions
Too easy to fake good	6	1.97%	Some of the items seemed like they bias use to answer in a certain direction (like the "right" answer is obvious)
Items do not relate	6	1.97%	Would be better putting groups of questions together according to specific client or therapist skill set
Does not foster self-reflection	6	1.97%	Could potentially not provoke meaningful reflection and end up just being a further reflection of rigid beliefs about self and the process of therapy
Does not cover the breadth of therapy	6	1.97%	Does not capture the breadth of what therapy encompasses
Hard to use	5	1.64%	Hard to use
More useful broken up into pieces	5	1.64%	If I just got different pieces [of the scale] over time, it would be more manageable
Needs more diversity questions	5	1.64%	There could be more attention to issues of diversity (e.g., increasing awareness of out cultural identities, challenging biases/assumptions as part of the therapeutic process, etc.)
Better for novices	4	1.33%	I felt I have a good grasp on who I am as a counselor, so I thought it was too basic for my current experience, but felt that the questions on the TLS would have been helpful during my 1st and 2nd years

of training

Questions too concrete – need to be more open-ended	3	0.98%	Very concrete questions – at times self-reflection is more open ended (not just scaled responses)
Makes participants feel inadequate	1	0.33%	I am already acutely aware of what I DON'T know as a novice counselor and what skills I suck at, so just seeing list after list of these questions is a reminder of how incompetent I really feel
Vague instructions	1	0.33%	The instructions were vague
Biased towards internal theories of change, not environment	1	0.33%	I noticed a slight bias toward an internal theory of change rather than advocacy for environmental change

Table 6

Reliability Data for the Post Hoc 13 factor Therapist Learning Scale

Factor	No. of items	M (SD)	Alpha
1.	3		.81
2.	4		.15
3.	8		.35
4.	6		.56
5.	5		.67
6.	3		.71
7.	5		.10
8.	3		.54
9.	3		.50
10.	4		.10
11.	3		-.06
12.	3		.57
13.	3		.52
Total	53	194.53 (11.50)	.75

Figure 1 – Scree Plot of Exploratory Factor Analysis with oblique promax rotation of the

TLS
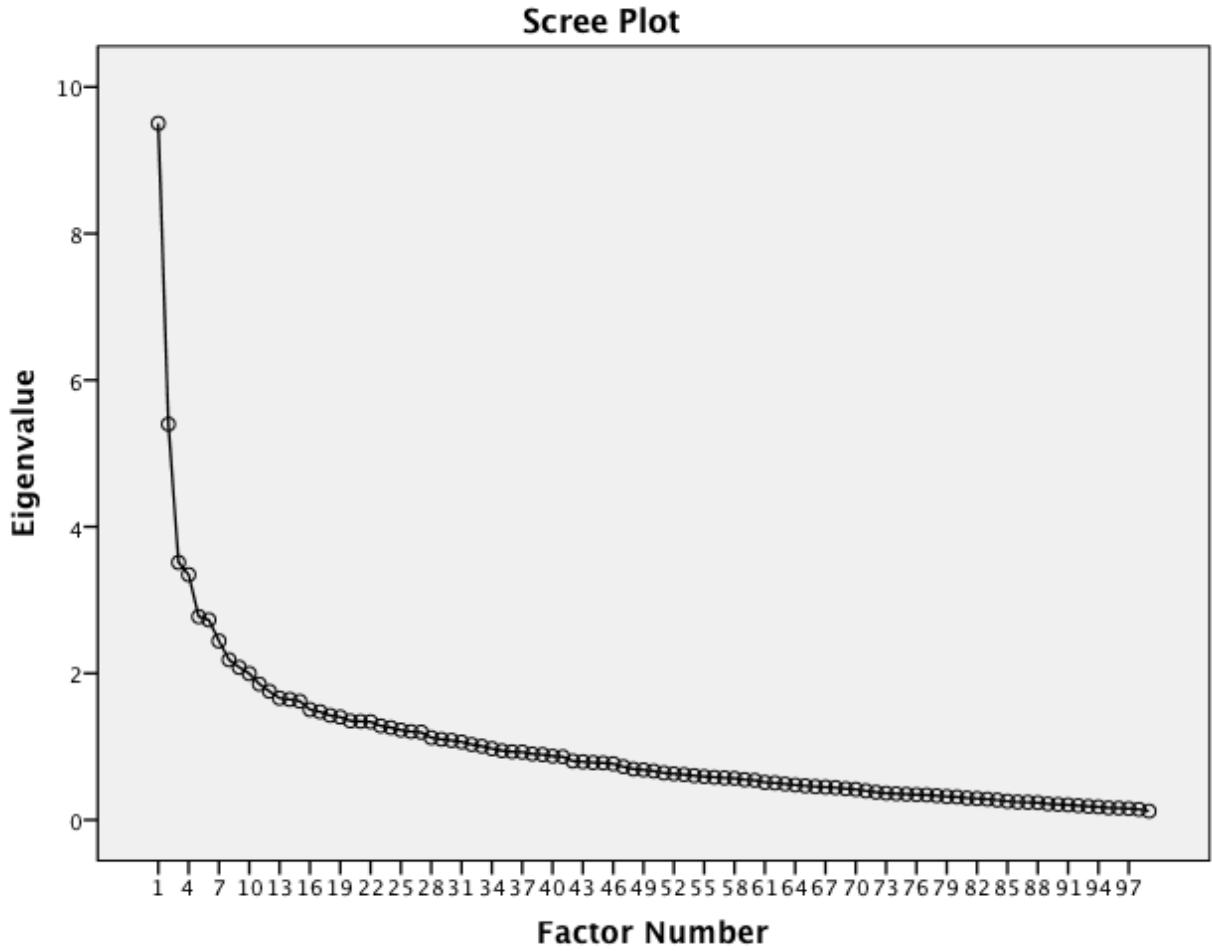
Appendix A:

Recruitment Email

Dear Training Director,

I am a counseling psychology graduate student at Lehigh University seeking participants for my dissertation research. My study is examining the psychometric properties of a new scale called the Therapist Learning Scale (TLS). The scale is designed to act as an aid for novice-level therapists to use in the self-reflection process of their clinical work. Research indicates that self-reflection is critical for therapist professional development, and such a tool may help novice-therapists reflect on the greatest source of their learning – clients.

The study calls for students that have had at least one semester of counseling experience complete four measures and three short answer questions, which should take between 20-25 minutes. Participants who are the 42nd, 158th, and 276th to complete the study will receive a $25 iTunes gift card. Additionally, participants can agree to participate in a test-retest portion of the study, where the 15th participant will receive a $25 iTunes gift card as well.

My advisor and the co-principal investigator for this study is Dr. Arnold Spokane. This study has been approved for data collection by the institutional review board at Lehigh University.

I would be very appreciative if you could forward this message to your students, who can follow the link: https://www.surveymonkey.com/s/3BFVZHH to the study. Please feel free to contact me with any questions or concerns at Dsi206@lehigh.edu.

Thank you very much.

Sincerely,

Daniel Isenberg, M.Ed.
Doctoral candidate
Lehigh University
Counseling psychology

CONSENT FORM
Formalized therapist self-reflection: Further Examination of the

Validity and Reliability of the

The Therapist Learning Scale (TLS)

You are invited to be in a research study examining the psychometric properties of the Therapist Learning Scale – a measure intended for use by novice therapists as a self-reflection tool to help foster professional development. You were selected as a possible participant because of your attendance in a therapy training program and at least one semester of practicum experience. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Daniel S. Isenberg, M.Ed., College of Education, Lehigh University, under the direction of Arnold Spokane, Ph.D., College of Education, Lehigh University. Data collection for this study has been approved by Lehigh University's Office of Research and Sponsored Programs. You are encouraged to contact Susan Disidore (610-758-3020 or Sus5@lehigh.edu) with any questions or concerns.

Background Information

The purpose of the present study is to test the TLS's psychometric properties to create a more parsimonious measure that provides to supervisors a tool for aiding supervisees in the self-reflection process. Previous research emphasizes self-reflection as the critical process for developing counseling expertise, despite little existing research in the counseling area describing how to engage in that process. The present study will propose a guided reflection method that utilizes the TLS as a tool to help supervisees reflect on the lessons learned from their clients as a way of facilitating professional growth.

Procedures

If you agree to be in this study, we would ask you to do the following things:

1. Complete a basic demographics form
2. Engage in a self-reflection process that involves -
    a. Three short answer questions
    b. The Therapist Learning Scale

3. Complete two more short measures
4. A test-retest portion to be completed 1-2 weeks after the initial study (optional)

Risks and Benefits of being in the Study

Risks: Risks associated with the study are minimal, but may include slight discomfort by participants who complete the Therapist Learning Scale and feel that they are not learning enough from their clients as they could. Participants should discuss any discomfort they have from the process with their clinical supervisors.

Benefits: The possible benefits from participation in this study significantly outweigh the risks, and they include positive self reflection regarding one's own recent clinical work, learning how you could benefit as a therapist from additional experience or exploration, critically thinking about previous counseling experiences, and possible feelings of improved competence. Completion of this study is intended to help you think about your effectiveness in counseling and what you has learned

Compensation

Three participants will receive $25 iTunes gift cards – The 42nd, 158th, and 276th participants that complete the study. Also the 15th participant that completes the test-retest part of the study will also receive a $25 iTunes gift card.

Confidentiality

The records of this study will be kept confidential and any information collected through this research project (demographic data) will not be voluntarily released or disclosed without your separate consent, except as specifically required by law.   In any sort of report we might publish, we will not include any information that will make it possible to identify a participant. Research records will be stored securely and only researchers will have access to the records.

Voluntary Nature of the Study

Participation in this study is voluntary:

Your decision whether or not to participate will not affect your current or future relations with Lehigh University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions

The researchers conducting this study are:

Daniel S. Isenberg, M.Ed. and Arnold Spokane, Ph.D. If you have questions at any time during or after the study, **you are encouraged** to contact them at Dsi206@lehigh.edu, or Ars1@lehigh.edu.

Questions or Concerns:

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact to Susan Disidore at (610) 758-3020 (email: Sus5@lehigh.edu) of Lehigh University's Office of Research and Sponsored Programs. All reports or correspondence will be kept confidential.

<u>Statement of Consent</u>

I have read the above information. I consent to participate in the study.

     O   Electronic Acceptance   Date: _____

Appendix C:

Participant Instructions

The following information represents the instructions provided to participants upon taking the present study.

Section 1:

Dear participant,

In this study, you will be asked to engage in a guided self-reflection process about what you learn from working with your clients, provide feedback about the self-reflection process, and complete two short additional measures. The entire study should take you no more than approximately 20-25 minutes. If you happen to be 42nd, 158th, or 276th participant to complete the study, you will be provided with a $25 iTunes gift card.

First, please complete the following demographics form:

Age –	
Sex –	Female Male Transgender
Gender identification –	Female Male Transgendered Genderqueer
Race -	African-American/Black/African/Caribbean American Indian/Alaskan Native Arab American/Arab/Persian/Middle Eastern Asian American/Asian European American/White/Caucasian Hispanic/Latino/a Native Hawaiian/Pacific Islander Multi-racial

	Other (please specify):
Degree sought -	Master's degree Psy.D. Ph.D.
Number of months conducting supervised counseling -	4-8 (about 1-2 semesters) 9-12 (about 3 semesters) 13-16 (about 4 semesters) 17-20 (about 5 semesters) 21-24 (about 6 semesters) 25 or more
Estimated number of different clients seen -	1-10 11-20 21-30 31-40 41-50 51 or more
Most recent treatment setting worked in and supervised -	College counseling center Community mental health center Hospital Private practice

Section 2:

The next part of the study will guide you through a self-reflection process about what you learn from working with your clients. Research indicates that the greatest source of learning for therapists is direct clinical work with their clients, and that continuous reflection throughout one's career as a therapist is essential for optimal learning and professional development – therefore participating may be as valuable to you as it is to your client!

1. To start the process, think of a challenging client that you worked with recently, or are continuing to work with. Spend 2-3 minutes thinking about your clients and choose one challenging client in particular.

2. Write down 2-3 ways in which you find it challenging to work with this client.

3. Next, to each response in item #2, write down the reasons you believe those things are challenges for you.

As you continue thinking about your challenging client, click onto the next page to go on to a questionnaire that asks you to respond to a series of questions about the possible lessons you may be learning from your client. For each item, indicate the extent to which you believe the lesson described applies to your work with this difficult client.

Section 3:

4. The Therapist Learning Scale

Each item below supplies a potential lesson that therapists may learn from their clients. With your challenging client in mind, indicate the extent to which you believe the lesson described applies to you in regards to this client by clicking on the most appropriate response.

In my ongoing relationship with this difficult client, I have learned that…

1. **Therapists are just as flawed as their clients**
    o Persistently true
    o Generally true
    o Occasionally true
    o Infrequently true
    o Rarely true

2. **I understand a great deal about my clients**
    o Persistently true
    o Generally true

- o Occasionally true
- o Infrequently true
- o Rarely true

3. **I am unsure of how responsible I am for therapy outcome**
   - o Persistently true
   - o Generally true
   - o Occasionally true
   - o Infrequently true
   - o Rarely true

4. **I find early relationships very significant in shaping a person**
   - o Persistently true
   - o Generally true
   - o Occasionally true
   - o Infrequently true
   - o Rarely true

5. **It is important to challenge clients**
   - o Persistently true
   - o Generally true
   - o Occasionally true
   - o Infrequently true
   - o Rarely true

6. **I am hesitant to challenge or confront my client for fear of damaging the therapeutic relationship**
   - o Persistently true
   - o Generally true
   - o Occasionally true
   - o Infrequently true
   - o Rarely true

7. **I do not feel the need to do outside research to work with a particular client**
   - o Persistently true
   - o Generally true
   - o Occasionally true
   - o Infrequently true
   - o Rarely true

8. **Relationship decisions are not always intelligent, healthy, or rational**
   - o Persistently true
   - o Generally true
   - o Occasionally true
   - o Infrequently true
   - o Rarely true

9. **I know where I fall on cultural identity scales**
   - o Persistently true
   - o Generally true
   - o Occasionally true
   - o Infrequently true
   - o Rarely true

10. **Therapy for one person can play an important role in a family or a community**
    - o Persistently true
    - o Generally true
    - o Occasionally true
    - o Infrequently true
    - o Rarely true

11. **I find it important to consult with other counselors regarding my clients**
    - o Persistently true
    - o Generally true
    - o Occasionally true
    - o Infrequently true
    - o Rarely true

12. **I question my effectiveness as a therapist**
    - o Persistently true
    - o Generally true
    - o Occasionally true
    - o Infrequently true
    - o Rarely true

13. **I recognize my client's level of responsibility for therapy outcome**
    - o Persistently true
    - o Generally true

o Occasionally true
o Infrequently true
o Rarely true

14. My approach to counseling tends to be flexible
o Persistently true
o Generally true
o Occasionally true
o Infrequently true
o Rarely true

15. I am unsure of the limits to how far I should push a client
o Persistently true
o Generally true
o Occasionally true
o Infrequently true
o Rarely true

16. I know how to work with or utilize services outside of my office to benefit my clients
o Persistently true
o Generally true
o Occasionally true
o Infrequently true
o Rarely true

17. My clients' presentation in session is often a replication of their presentation with outside relationships
o Persistently true
o Generally true
o Occasionally true
o Infrequently true
o Rarely true

18. I am conscientious regarding the power of being a therapist
o Persistently true
o Generally true
o Occasionally true
o Infrequently true

o Rarely true

In my ongoing relationship with this difficult client, I have learned that…

19. I am unsure about my competence as a therapist
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

20. The therapy relationship itself is curative
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

21. Doing client work can motivate me to change in my own life
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

22. My level of self-awareness in therapy is sufficient
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

23. A person's culture has a significant impact on their worldview
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

24. It is important not to pre-judge the potential strength of the therapeutic relationship based on the first few sessions
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

25. I conceptualize my clients based on culturally relevant dimensions
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

26. I have needs to be liked by my clients
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

27. I do not need a framework to work from with a client that has an issue I have not seen before
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

28. I find it difficult to set boundaries with clients
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

29. My client and I may have very different perceptions of how the therapy work is proceeding
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

30. Therapy is a negotiation and a collaborative process
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

31. I recognize the importance of my client taking responsibility for his/her actions
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

32. Clients tend to be rigid
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

33. I conceptualize my clients in a consistent manner based on my theoretical orientation
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

34. People are generally good at taking responsibility for their lives
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

35. At times I do not recognize countertransference with a client
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

36. My clients help me recognize what I am thankful for in my life
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

37. I am unsure how my theoretical orientation influences my counseling work
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

38. I recognize the value of expressing empathy and compassion
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

In my ongoing relationship with this difficult client, I have learned that…

39. I do not need to always be accepting of clients' behavior
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

40. Clients tend to be strong
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

41. Other people are very important in each person's life
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

42. It is not very important for my client to take responsibility for his/her feelings
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

43. A significant sense of belongingness in a person's life is not necessarily needed
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

44. My reactions in therapy help me recognize what is happening with my client
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

45. I have high expectations for myself as a therapist
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

46. I am skeptical about others' ability to change
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

47. I know what I dislike about clients
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

48. I am aware of cultural biases that I have (including race, ethnicity, socioeconomic status, sexuality, religion, physical/mental ability status, and citizenship status)
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

49. Clients manifest their readiness to change in ways similar to one another
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

50. I do not think a diagnosis or treatment plan for my clients would be valuable
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

51. My ability to build the therapeutic relationship varies from client to client
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

52. Therapy as a confidential place where clients can get support is very valuable
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

53. There are things about my clients that I do not have unconditional positive regard for
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

54. Therapy is a long process
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

55. Therapy is a curative process for the client and the counselor
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

56. A person's motivation to change significantly influences therapy work
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

57. I recognize the usefulness of techniques
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

58. Therapy is difficult work
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

In my ongoing relationship with this difficult client, I have learned that…

59. My like or dislike for a client will affect how I build the therapeutic relationship with him/her
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

60. The therapy relationship can be simple
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

61. I am unsure what I like about a client
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

62. I find it important to be trained to work with a particular client
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

63. I question what it means to be a good therapist
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

64. I can help all of my clients
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

65. My reactions in therapy help me know how to focus the counseling work with a client
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

66. Therapy has an impact on my personal well-being
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

67. I know very little beyond what my client tells me
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

68. I do not know how to appropriately work with silence
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

69. Meaningful change is generally achieved with limited difficulty
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

70. I struggle with self-disclosing in a clinically appropriate manner
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

71. I feel pulled to nurture my clients
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

72. I am unsure how I need to improve as a therapist
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

73. People are ambivalent about change
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

74. A client's compliant behavior in session is usually not representative of how they feel
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

75. I am good at setting boundaries with my clients
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

76. Clients display cowardice in session
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

77. I struggle setting effective boundaries with my clients
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

78. I can be competitive at times
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

In my ongoing relationship with this difficult client, I have learned that…

79. I do not need to improve at setting boundaries with my clients
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

80. The client's presenting issues always factor into the therapy relationship
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

81. Change is slow and gradual
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

82. Therapy generally does not play an important role in a person's life outside of counseling
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

83. A client's readiness to change does not dictate how I use interventions
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

84. Conceptualization of a client evolves throughout the course of treatment
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

85. Doing counseling has helped evolve my outlook on life
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

86. Therapy is generally predictable
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

87. Clients generally do not have appropriate reasons for behaving in their maladaptive ways
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

88. I can work effectively with a client I dislike
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

89. There is no formula for doing therapy
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

90. I see myself differently through a cultural lens
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

91. People have negative qualities (e.g., selfishness, greediness, criticalness, rigidity, secrecy, intolerance, etc.)
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

92. With good rapport, goals for therapy are unnecessary
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

93. I do not think about the importance of being patient as a counselor
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

94. I can tolerate ambiguity in therapy
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

95. I am uncertain of how to work with clients that have certain diagnoses
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

96. Trusting in the process of therapy is not a very important concept in my client work
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

97. It is ok to be rigid with my theoretical orientation
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

98. I question how important a parental/familial bond is for people
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

99. I do not find the idea of supervision very useful or helpful
- o Persistently true
- o Generally true
- o Occasionally true
- o Infrequently true
- o Rarely true

Section 4:

5. For the final part of the self-reflection process, provide 2-3 ideas for how you think you will change your work with this difficult client or clients generally in the future.

Section 5:

Structure Comments Questionnaire

Now that you have finished the formal self-reflection process about your client, please briefly respond to the following questions:

1. What are your first reactions to completing the Therapist Learning Scale (TLS)?

2. On a scale of 0-10 (0=lowest, 10=highest), how much did the self-reflection process facilitate a deeper understanding of yourself as a clinician?

   0   1   2   3   4   5   6   7   8   9   10

3. On a scale of 0-10, how useful do you think the TLS is as a tool to aid in the process of self-reflection?

   0   1   2   3   4   5   6   7   8   9   10

4. On a scale of 0-10, how likely would you be to use a shorter version of the TLS on a regular basis throughout your clinical training?

   0   1   2   3   4   5   6   7   8   9   10

5. What are the strengths of the TLS?

6. What are the weaknesses of the TLS?

7. How could the TLS be improved?

8. Were there any negative aspects to completing the TLS?

Section 6:

Please complete the following two short scales to finish the study.

<div align="center">The Psychotherapists' Professional Development Scale</div>

Since you began working as a therapist …   Not at all   Very
much

1. How much have you changed overall as a therapist?   0 1 2 3 4 5

2. How much do you regard this overall change as progress or improvement?   0 1 2 3 4 5

3. How much have you succeeded in overcoming past limitations as a therapist?0 1 2 3 4 5

4. How much have you realized you full potential as a therapist?   0 1 2 3 4 5

Overall, at the *present* time …

5. How much mastery do you have of the techniques and strategies involved   0 1 2 3 4 5
   in practicing therapy?

6. How well do you understand what happens moment-to-moment during   0 1 2 3 4 5
   therapy sessions?

7. How well are you able to detect and deal with your patients' emotional   0 1 2 3 4 5
   reactions to you?

8. How good are you at making constructive use of your personal reactions   0 1 2 3 4 5
   to patients?

9. How much precision, subtlety and finesse have you attained in your   0 1 2 3 4 5
   therapy work?

10. How capable do you feel to guide the development of other therapists?   0 1 2 3 4 5

In your *recent* psychotherapeutic work, how much …

11. Do you feel you are changing as a therapist?	0 1 2 3 4 5
12. Does this change feel like progress or improvement?	0 1 2 3 4 5
13. Does this change feel like decline or impairment?	0 1 2 3 4 5
14. Does you feel you are overcoming past limitations as a therapist?	0 1 2 3 4 5
15. Do you feel you are becoming more skillful in practicing therapy?	0 1 2 3 4 5
16. Do you feel you are deepening your understanding of therapy?	0 1 2 3 4 5
17. Do you feel a growing sense of enthusiasm about doing therapy?	0 1 2 3 4 5
18. Do you feel you are becoming disillusioned about therapy?	0 1 2 3 4 5
19. Do you feel you are losing your capacity to respond empathically?	0 1 2 3 4 5
20. Do you feel your performance is becoming mainly routine?	0 1 2 3 4 5
21. How important to you is your further development as a therapist?	0 1 2 3 4 5

MC – Reynolds Short Form A

1. It is sometimes hard for me to go on with my work if I am not encouraged

    True   False

2. I sometimes feel resentful when I don't get my way

    True   False

3. No matter who I am talking to, I'm always a good listener

    True   False

4. There have been occasions when I took advantage of someone

    True   False

5. I'm always willing to admit it when I make a mistake

    True   False

6. I sometimes try to get even rather than forgive and forget

    True   False

7. I am always courteous, even to people who are disagreeable

True   False

8. I have never been irked when people expressed ideas very different from my own

       True   False

9. There have been times when I was quite jealous of the good fortunes of others

       True   False

10. I am sometimes irritated by people who ask favors of me

       True   False

11. I have never deliberately said something that hurt someone's feelings

       True   False

Section 7:

That is the end of the survey. Thank you very much for your participation, I hope the

experience was a positive one for you. If you would like to be considered for one of the $25

iTunes gift cards, please include your email address below. Participants 42, 158, and 276 that

completed the study will receive a gift card. Also, please indicate below if you would like to

receive information about the results of this study when they are completed.

Additionally, another $25 iTunes gift card will be given to the 15th participant who

completes the test-retest part of this study within two weeks of today. Only 30 participants

are needed for this part of the study. Please create a unique username below that uses both

letters and numbers, and your email address to be invited to participate.

The 11 factor Therapist Learning Scale

The following is a list organized by factors of which items from the initial 99-item TLS loaded +/-.30 on the 11-factor, 52-item TLS. Item numbers followed by a lowercase "r" indicates items written in reverse-language from original lessons.

Factor 1: Therapist Confidence

3. I understand a great deal about my client

6r. I am hesitant to challenge or confront my client for fear of damaging the therapeutic relationship

12r. I question my effectiveness as a therapist

15r. I am unsure of the limits to how far I should push a client

19r. I am unsure about my competence as a therapist

46r. I am skeptical about others' ability to change

63r. I question what it means to be a good therapist

Factor 2: Boundary Setting

28r. I find it difficult to set boundaries with clients

75. I am good at setting boundaries with my clients

77r. I struggle setting effective boundaries with my clients

Factor 3: Therapy Impacting the Therapist

21. Doing client work can motivate me to change in my own life

36. My clients help me recognize what I am thankful for in my life

55. Therapy is a curative process for the client and the counselor

66. Therapy has an impact on my personal well-being

85. Doing counseling has helped evolve my outlook on life

Factor 4: Cultural Impact

9. I know where I fall on cultural identity scales

18. I am conscientious regarding the power of being a therapist

23. A person's culture has a significant impact on their worldview

25. I conceptualize my clients based on culturally relevant dimensions

48. I am aware of cultural biases that I have (including race, ethnicity, socioeconomic status, sexuality, religion, physical/mental ability status, and citizenship status)

90. I see myself differently through a cultural lens

Factor 5: Responsibility for Change

5. It is important to challenge clients

22r. My level of self-awareness in therapy is sufficient

30. Therapy is a negotiation and a collaborative process

31. I recognize the importance of my client taking responsibility for his/her actions

56. A person's motivation to change significantly influences therapy work

57. I recognize the usefulness of techniques

Factor 6: Clinical Perceptions

11. I find it important to consult with other counselors regarding my clients

17. My clients' presentation in session is often a replication of their presentation with outside relationships

44. My reactions in therapy help me recognize what is happening with my client

60r. The therapy relationship can be simple

64r. I can help all of my clients

65. My reactions in therapy help me know how to focus the counseling work with a

client

Factor 7: Factors for Change

7r. I do not feel the need to do outside research to work with a particular client

27r. I do not need a framework to work from with a client that has an issue I have not seen before

82r. Therapy generally does not play an important role in a person's life outside of counseling

83r. A client's readiness to change does not dictate how I use interventions

87r. Clients generally do not have appropriate reasons for behaving in their maladaptive ways

92. With good rapport, goals for therapy are unnecessary

93r. I do not think about the importance of being patient as a counselor

Factor 8: Working with Clients

14r. My approach to counseling tends to be flexible

59. My like or dislike for a client will affect how I build the therapeutic relationship with him/her

88. I can work effectively with a client I dislike

Factor 9: Therapy Process

52. Therapy as a confidential place where clients can get support is very valuable

54. Therapy is a long process

81. Change is slow and gradual

Factor 10: Reflections about Clients

32r. Clients tend to be rigid

39. I do not need to always be accepting of clients' behavior

53. There are things about my clients that I do not have unconditional positive regard

for

Factor 11: Theoretical Orientation

33r. I conceptualize my clients in a consistent manner based on my theoretical orientation

89. There is no formula for doing therapy

97r. It is ok to be rigid with my theoretical orientation

Appendix E:

Therapist Learning Scale items removed due to insufficient factors, cross-loadings,

communality, or redundancy

The following 23 items were not included in the 52-item TLS because (a) they loaded on a factor that was eliminated due to not having enough items (i.e., less than three), (b) because the item loaded on two or more factors with a difference of +/-.15 between its highest and lowest loadings, (c) they had a communality score < .40, or (d) due to redundancy. Item numbers followed by a lowercase "r" indicates items written in reverse-language from original lessons.

8. Relationship decisions are not always intelligent, healthy, or rational

10. Therapy for one person can play an important role in a family or a community

13r. I recognize my client's level of responsibility for therapy outcome

14r. My approach to counseling tends to be flexible

24. It is important not to pre-judge the potential strength of the therapeutic relationship based on the first few sessions

26r. I have needs to be liked by my clients

40. Clients tend to be strong

41. Other people are very important in each person's life

43r. A significant sense of belongingness in a person's life is not necessarily needed

47. I know what I dislike about clients

58. Therapy is difficult work

61r. I am unsure what I like about a client

62. I find it important to be trained to work with a particular client

71. I feel pulled to nurture my clients

72. People are ambivalent about change

74. A client's compliant behavior in session is usually not representative of how they feel

76r. Clients display cowardice in session

78. I can be competitive at times

79r. I do not need to improve at setting boundaries with my clients

86r. Therapy is generally predictable

95r. I am uncertain of how to work with clients that have certain diagnoses

96r. Trusting in the process of therapy is not a very important concept in my client work

99r. I do not find the idea of supervision very useful or helpful

Therapist Learning Scale items with loadings less than +/-.30

The following 24 items were removed from the final TLS as they did not achieve the minimum factor loading of +/-.30 to be included in the proposed factor structure. Item numbers followed by a lowercase "r" indicates items written in reverse-language from original lessons.

1. Therapists are just as flawed as their clients

2. I understand a great deal about my clients

4. I find early relationships very significant in shaping a person

16. I know how to work with or utilize services outside of my office to benefit my clients

20. The therapy relationship itself is curative

34r. People are generally good at taking responsibility for their lives

35r. At times I do not recognize countertransference with a client

37r. I am unsure how my theoretical orientation influences my counseling work

38. I recognize the value of expressing empathy and compassion

42r. It is not very important for my client to take responsibility for his/her feelings

45. I have high expectations for myself as a therapist

49r. Clients manifest their readiness to change in ways similar to one another

50r. I do not think a diagnosis or treatment plan for my clients would be valuable

51. My ability to build the therapeutic relationship varies from client to client

67. I know very little beyond what my client tells me

68r. I do not know how to appropriately work with silence

69r. Meaningful change is generally achieved with limited difficulty

70r. I struggle with self-disclosing in a clinically appropriate manner

73r. I am unsure how I need to improve as a therapist

80r. The client's presenting issues always factor into the therapy relationship

84. Conceptualization of a client evolves throughout the course of treatment

91. People have negative qualities (e.g., selfishness, greediness, criticalness, rigidity, secrecy, intolerance, etc.)

94. I can tolerate ambiguity in therapy

98r. I question how important a parental/familial bond is for people

Daniel S. Isenberg

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Education

Doctoral Candidate (Ph.D.)   Counseling Psychology, Lehigh University,

College of Education, Bethlehem, PA

Fall 2006 - present (expected graduation, August 2012)

Masters of Education (M.Ed.)   Counseling and Human Services, Lehigh University

Awarded on May 18, 2009

Bachelors of Science (B.S.)   Psychology, and Criminology/Criminal Justice,

University of Maryland, College Park

Awarded on May 20, 2004

Clinical Experience

- **Pre-doctoral Intern**   **August 2011 – present**

Virginia Polytechnic Institute & State University,

Thomas E. Cook Counseling Center, Blacksburg, VA

    <u>*Responsibilities*</u>
  - Individual counseling
    - About 15 college students per week
    - Caseload of about 30 total students
  - Co-lead two 75-minute therapy groups
    - Process group - trauma (female)
    - Community building group
  - Primary supervisor for doctoral practicum student
  - Outreach
    - Stress management and relaxation, study skills, depression/wellness screening, RA training, and grief (after recent student deaths), diversity dialogues (Spring)
  - On-call
    - One week in Fall semester; Two weeks in Spring
    - Assisted with crisis assessment of student in need of inpatient care
  - Research

- - Qualitative study investigating LGBT-student needs from the counseling center
  - o Clinical Procedures Committee
    - - Streamlined triage and intake process
    - - Improved referral and informational resources for students
  - o Received three hours of weekly individual supervision

- **Outpatient Counselor**   **June 2009 –**
  June 2011

  Step by Step, Inc.

  Outpatient Program, Allentown, PA

  Responsibilities

  - o Individual or couples counseling
    - - Clients with co-occurring (substance abuse & mental health) issues
    - - Between12-23 clients per week
    - - Clients from low-SES backgrounds, typically receiving Welfare and/or Social Security Disability
    - - Clients often mandated from county Parole/Probation
  - o Bi-monthly treatment plans
  - o 30-day counselor assessments
  - o Biopsychosocial assessment packet
  - o Case conference notes every three months
  - o Coordination with psychiatry, intensive case managers, Parole/Probation officers, Children & Youth services, etc.
  - o Received bi-weekly clinical supervision
  - o Monthly clinical consultation meetings

  Additional Experience

  - o Court witness in child custody hearing (2x)
  - o Provided outcomes management training (ORS & SRS; see *Consultation* section)
  - o Revised documents to improve organizational efficiency
    - - Session notes, treatment plans, discharge summaries
  - o Developed tracking system to organize client paperwork deadlines
    - - Implemented throughout the center for all clinicians

- **Counseling Associate**

  Angela Lutzi, LLC

  Licensed Professional Counselor, Nazareth, PA

  Responsibilities

    o Individual counseling with 2-6 adult clients per week

    o Received regularly scheduled clinical supervision

    o Built professional website and marketed services to local physicians

September 2010 – July 2011

- **Graduate Student Intern**

  Lafayette College Counseling Center

  Easton, PA

  Responsibilities

    o Individual or couples counseling

      ▪ About seven college students per week

    o Weekly case conference or professional development seminars

      ▪ Discussed book readings including, *The Heroic Client* (Duncan, Miller, & Sparks, 2004); and *The Loss of Sadness* (Horwitz & Wakefield, 2007)

    o Received one hour of weekly individual supervision

  Additional Experiences –

    o Lafayette Alcohol Initiative

      ▪ Assisted in data collection and organization of alcohol information, including history of collegiate alcohol use/abuse, physiological effects and consequences, socialization, education, best practices, social norms programs, and others

      ▪ Assisted in revisions of annual student alcohol survey, and subsequent data analysis

    o Provided updated training on use of ORS & SRS (see **Consultation** section)

September 2008 – May 2010

- **Graduate Student Supervisor**

  Counseling psychology program

  Lehigh University, Bethlehem, PA

  Responsibilities

    o Individual or group supervision

September 2008 – May 2009

- - Weekly supervision of four master's students on practicum
    - Local students face-to-face; and international students working in Argentina, Saudi Arabia, and Kuwait over the internet
  - Weekly case conferences and group supervision-of-supervision
  - Listened to counseling sessions weekly, completed transcriptions, provided clinical feedback to supervisees, and evaluated supervisee performance

- **Graduate Student Intern**   September 2007 –
  Moravian College Counseling and Learning Services   **May 2008**
  Bethlehem, PA
  - *Responsibilities*
    - Individual counseling
      - About six college students per week
    - Weekly case conferences
    - Received two hours of clinical supervision per week

- **Peer Counseling & Crisis Intervention Hotline Counselor & On-the-job Trainer**   March 2002 –
  Help Center Hotline at the University of Maryland   **May 2006**
  College Park, MD
  - *Responsibilities*
    - Weekly four-hour on-the-phone shifts
    - Weekly training and consultation meetings with shift staff
    - Conducted role-plays and provided feedback and evaluation for trainees
    - Interview, training, and testing committees (09/03-05/04)
    - External Public Relations Director, Executive Board (02/04-05/04)

Consultation

- **Lehigh University**   September 2010
  Counseling psychology program, Research Methods course
  - Presented to doctoral students examples of how to conduct research in discovery-oriented and consensual qualitative methods

- **Lafayette College Counseling Center**   August 2010
  - Presented to counseling staff methods for incorporating client feedback and tracking therapeutic outcomes using The Outcome Rating Scale (ORS) and the

Session Rating Scale (SRS)

- **Step by Step, Inc.**   **July 2010**
  Outpatient program
    o Presented to counseling staff methods for incorporating client feedback and
      tracking therapeutic outcomes using The Outcome Rating Scale (ORS) and the
      Session Rating Scale (SRS)
    o Organized implementation of regular use of ORS and SRS by center staff

Publications/Presentations

Soheilian, S. S., **Isenberg, D. S.**, Klinger, R. S., Kulp, L. E., Inman, A. G. (under review). Multicultural
supervision: A supervisee's perspective. *Training and Education in Professional Psychology* (article
submitted)

Stahl, J. V., **Isenberg, D.,** Garcia, J., Letendre, P., & Noblet, L (under review for, June, 2012). The Impact on
Counseling Trainees of Weekly Journaling About Learning From Clients. *Brief paper for 2012 annual
meeting of the Society for Psychotherapy Research,* Virginia Beach, VA. (proposal submitted)

Isenberg, D., Spokane, A. R. (2010, August). The counselor learning scale: A quantitative investigation of what
counselors learn from their clients. *Poster presentation for Division 17 (Society of Counseling Psychology) at
the 118th annual convention for the American Psychological Association,* San Diego Convention Center, CA.

Soheilian, S. S., **Isenberg, D**., Klinger, R., & Kulp, L. (2010, August). Multicultural supervision: Supervisee
perspectives of supervisor competence. *Symposium at the 118th annual convention for the American
Psychological Association,* San Diego Convention Center, CA.

Isenberg, D. & Stern, S. K. (2010, April). The effects of visibility and religious affiliation on Jewish identity: A
hierarchical linear regression. *Poster session at the 4th biennial cultural competency conference,* Georgia
State University, Atlanta, GA

Isenberg, D. (2009, Fall – 2010, Winter). A world of difference: A student's reflections on working at a college
counseling center and a dual-diagnosis community mental health clinic. *SAS Newsletter, 29(6)*, 9-11.

Stahl, J. V., Hill, C. E., Jacobs, T., Kleinman, S., **Isenberg, D**., & Stern, A. (2009). When the shoe is on the other
foot: A qualitative study of intern-level trainees' perceived learning from clients. *Psychotherapy Theory,*

Research, Practice, Training, 46, 376-389.

Isenberg, D., & Silvestri, T. (2009, November). Acute effects of alcohol consumption on specified brain regions. *Poster session presented at the Mid-Atlantic regional meeting of the Society for Psychotherapy Research,* University of Pennsylvania and Children's Hospital of Philadelphia, PA.

Tirpak, D. M., Soheilian, S. S., & **Isenberg, D. S**. (2008, August). Nonverbal behavior across cultures: Implications for counseling (sym6575). *Conversation hour at the 116th annual convention for the American Psychological Association,* Boston Convention and Exhibition Center, MA.

Stahl, J.V., Hill, C.E, Jacobs, T., Kleinman, S., **Isenberg, D**., & Stern, A. (2006, October). When the shoe is on the other foot: A qualitative investigation of intern-level trainees' perceived learning from clients. *Poster session presented at the annual meeting of the North American Society for Psychotherapy Research*, Burr Oak Resort, OH.

Research Experience

- **Dissertation – Scale development design**   **Expected**
Lehigh University, counseling psychology program   **defense,**
  - Title: *Formalized therapist self-reflection: Further examination of the validity*   **May 2012**
    and reliability of the Therapist Learning Scale (TLS)
  - Original research with over 300 participants
  - Quantitative and qualitative components

- **Qualitative – Consensual qualitative research**   **In process of**
Massachusetts School of Professional Psychology and Lehigh University   **data analysis**
  - Investigating the impact on counseling trainees of weekly journaling about
    learning from clients
  - Tasks include developing and co-writing the study, and acting as auditor for
    data analysis

- **Qualifying Research Project – Preliminary scale development**   **Presented**
Lehigh University, counseling psychology program   **October 2009**
  - Title: *The counselor learning scale: A quantitative investigation of what*
    counselors learn from their clients

- o Tasks included developing and revising items, recruiting expert raters, and recruiting over 50 participants for a pilot study

- **Qualitative – Discovery-oriented design**

  January 2009 – August 2009

  Lehigh University, counseling psychology program

  - o Investigated multicultural supervision from a supervisee's perspective
  - o Tasks included recruiting participants, data coding, writing the discussion section, and editing introduction, methods, and results sections

- **Data Collection Coordinator**

  January 2007 – July 2008

  Lehigh University, College of Education – Project Achieve

  - o Managed data for 5-year NIMH grant project investigating the effectiveness of preschool intervention behavioral programs for ADHD-like symptomatology
  - o Managed large database and oversaw graduate students involved in data collection to ensure data collection and entry was timely and correct
  - o Ran analyses and organized data to present to principal investigator
  - o Organized and oversaw after-school study skills program in collaboration with local middle school
  - o Coordinated with middle school principal and school psychologist

- **Qualitative – Consensual qualitative research**

  February 2007 – April 2007

  Lehigh University, counseling psychology program

  - o Research assistant for dissertation team investigating therapist trainee experiences providing crisis mental health care for Katrina survivors
  - o Duties included developing domains, coding data, and conducting cross analyses of data

- **Qualitative – Consensual qualitative research**

  September 2005 – August, 2006

  University of Maryland, counseling psychology program

  - o Research assistant for dissertation team investigating what post doctoral counseling interns learned from working with clients
  - o Duties included transcribing interviews, developing domains, coding data, and cross analyses of data, and proofreading drafts

- **Research assistant**

  February 2005 –

University of Maryland, Maryland Center for Anxiety Disorders **May 2005**
- o Acted as co-therapist for weekly social phobia group counseling
- o Trained as a confederate to participate in experiments
- o Completed data entry assignments

- **Research assistant** **September 2002 –**

University of Maryland, Child & Family Development Lab **August 2003**
- o Trained to follow strict coding manuals while rating conflict and helping behaviors between parents and their teenagers

Teaching Experience

- **Participant – Teacher Development Training Program** **February 2009 –**

Lehigh University, Bethlehem, PA **May 2009**
- o Learned teaching strategies for graduate students, including making a syllabus, assessment in the classroom, using technology, principles of learning, and writing across curriculums
- o Received certificate for completion of semester long training program

- **Teaching Assistant** **September 2007 –**

Lehigh University, Bethlehem, PA **December 2007**
- o Graduate class, Counseling and Therapeutic Approaches
- o Lectured on topics including Characteristics of Highly Successful Counselors, The Transtheoretical Model of Change, and Motivational Interviewing

- **Teaching Assistant** **February 2004 –**

University of Maryland, College Park **May 2006**
- o For undergraduate seniors, Basic Helping Skills
- o Lab leader & skills facilitator

Social Justice Activities

- **Disaster Mental Health Relief graduate course** **Summer 2008**

In Gulfport, MS (through Lehigh University)
- o Completed coursework with an emphasis on Hurricane Katrina
- o Engaged in social justice fieldwork including working in the community

(painting a victim's house), attending a local church service, and touring the
damage left by the hurricane

- o Began development of a plan for a disaster mental health relief shelter

- **Obama for America – volunteer**   **March 2007 –**
                                                                       November 2008

  Bethlehem and Allentown, PA

  - o Co-founded "Lehigh Students for Barack Obama" at Lehigh University
  - o Engaged in volunteer actions including managing online content, recruitment of
    members/volunteers, canvassing, voter registration, phone banking, conducting
    meetings and debate watch parties, and driving voters to polls on election day

- **Beyond Books Tutor/Mentor Program – volunteer**   **September 2006 –**
                                                                       December 2006

  Pinebrook Services for Children & Youth, Allentown, PA

  - o Tutored elementary age foster children after school on a weekly basis

Professional Development / Miscellaneous

Sex Therapy (in-service training)   **January 13,**
                                                                      2012

Virginia Tech, Blacksburg, VA

Comprehensive Portfolio Outline   **December 2011**

Lehigh University, Bethlehem, PA

- o Counseling psychology faculty officially implemented the outline I created to
  help future students manage completion of their comprehensive portfolio

Ethics (in-service training)   **December 2011**

Virginia Tech, Blacksburg, VA

- o Half-day training – topics included the process of ethical decision making, and
  several case vignettes

Diversity Day   **November 2011**

Veterans Administration, Salem, VA

- o Half-day training – topics included religion and psychotherapy, and working

with African American clients

Sexual Assault (in-service training) **October 2011**

Virginia Tech, Blacksburg, VA

- o Half-day training – topics included legal definitions & statutes, types of perpetrators, typical effects of and responses to sexual assault, rape trauma syndrome, and case vignettes

Prodromal Symptoms of Psychosis (in-service training) **October 2011**

Virginia Tech, Blacksburg, VA

- o Half-day training – topics included epidemiology, signs & symptoms, mood disorders, substance abuse and post partum, interventions, and recovery

A Conversation About Race **September 2011**

Virginia Tech, Blacksburg, VA

- o Half-day training – topics included whiteness & white privilege, race vs. ethnicity, biological vs. sociological definitions of race, and racial self-identification

Motivational Interviewing **September 2011**

Virginia Tech, Blacksburg, VA

- o Intensive two-day training

Conversations About Privilege **January 2011 – March 2011**

Weekly telephonic conferences

- o Discussions with fellow psychology professionals about experience with privilege, as part of Division 17 of APA (six weeks)

Awards

- **National** **August 2010**
  - o APA division 17 - Society of Counseling Psychology (August, 2010). Student poster award in supervision and training for, "**Isenberg, D.,** Spokane, A. R. The counselor learning scale: A quantitative investigation of what counselors learn from their clients." *Poster presentation for Division 17 (Society of Counseling Psychology) at the 118th annual convention for the American Psychological*

Association, San Diego Convention Center, CA.

Affiliations/Memberships

- American Psychological Association   Member since 2006

- American Psychological Association of Graduate Students   Member since 2006

- APA Division 17 – Society of Counseling Psychology, student affiliate   Member since 2006
    - Supervision and Training Section (STS), student affiliate
- American Board of Professional Psychology (ABPP) – Early entry option for graduate   Member since 2008
  students
    - o   American Academy of Counseling Psychology (AACOP), affiliate

Interests

- Clinical Expertise - I am interested in therapist learning experiences facilitating professional development, and the acquisition of therapeutic expertise across the career-span.

- Trauma – I am interested in how the experience of emotional, physical, or sexual trauma can impact a person's sense of self, their ability to form and maintain healthy interpersonal relationships, and the subsequent manifestation of PTSD symptoms.

- Multicultural psychology - I am interested in the broad application of education, individual experiences and perceptions of diverse groups, to reduce prejudice, illuminate individual biases, and enhance multicultural understanding.

- Social justice and systemic change – I am interested in research investigating how to bring about systemic change and effective implementation of equality/social justice-based policies in organizational and social contexts.

- Drug and alcohol effects and counseling – I am interested in the neurological effects of drug and alcohol use in an acute and chronic manner, and how these effects complicate general mental health and the achievement of positive outcomes in therapy.

- Client-directed, outcome-informed psychotherapy (CDOI) – I am interested in research emphasizing the use of common factors, clinical outcome measures, and clinical feedback in therapy.