

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

COUNSELOR DEVELOPMENT AND SUPERVISION:

AN EXPLORATORY STUDY OF

THE INTEGRATED DEVELOPMENTAL MODEL OF SUPERVISION

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

Doctor of Philosophy

By

RACHEL HANSELMANN ASHBY

Norman, Oklahoma

1999

UMI Number: 9914420

UMI Microform 9914420
Copyright 1999, by UMI Company. All rights reserved.

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

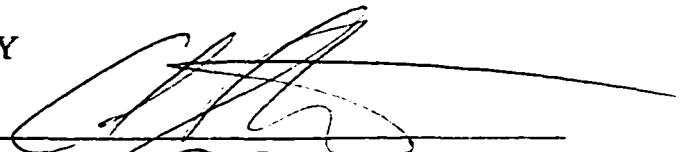
UMI
300 North Zeeb Road
Ann Arbor, MI 48103

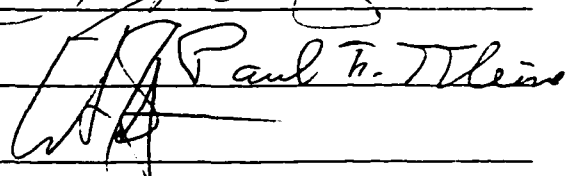
©Copyright by Rachel Hanselmann Ashby 1999
All Rights Reserved

COUNSELOR DEVELOPMENT AND SUPERVISION:
AN EXPLORATORY STUDY OF
THE INTEGRATED DEVELOPMENTAL MODEL OF SUPERVISION

A Dissertation APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

BY



 Paul H. Theiss

Abraham Scherman

Fred H. Wood

Acknowledgements

The magnitude of this project has demonstrated the need for help and support from others. Adequate recognition of them exceeds this format. However, I would like to briefly note some of those individuals who significantly contributed to its development and completion.

In the academic arena, the Chair of my dissertation committee, Dr. Cal D. Stoltenberg, has consistently and patiently guided this process. His professionalism, stimulation, and sense of humor have brought this project to maturity. Thank you Cal. Particular thanks go to Dr. Paul Kleine, who gave valuable time, as well as extremely constructive feedback and assistance regarding the method and analysis of this project. The remainder of my committee, Dr. Loreto Prieto, Dr. Avraham Scherman and Dr. Frederick Wood, has made important contributions as well. Thanks to Dr. Sandra Allen and Dr. Eric Dlugokinski who were both patient with and supportive of “whatever it took” to complete this project. Thank you to Dr. Janice Triplett for assisting me through the printing panic. The participants in this project are also greatly appreciated. They took the time to contribute some science back to the profession. To any colleague whom I might have inadvertently omitted, you have my thanks and apologies. A dissertation is rarely written by a single person, but represents a synthesis of wisdom arising from many sources.

Special thanks to my family, who gave immeasurable relief and assistance. My parents, Roger and Suzanne Hanselmann, have been invaluable friends and guides throughout my life. I thank you for the wonderful people you are and all the love, support, and patience you have offered over the years. My brother, Richard Hanselmann,

for your unconditional love, graphic assistance, and commitment to my entertainment needs. My dear friend and sister, Karen Hawbecker with whom I have shared so much personally and professionally. I have no words to express my deep appreciation and gratitude for your love. Your bright mind, big heart, and sense of humor are among life's greatest delights. My "little" brothers, David and Daniel Hanselmann, for your technical support and quiet reassurance. My Aunt Irm and Uncle Bob, for your patience as I finished writing over the Holidays and your readiness to "party." Thanks to my sister, Sarah Hanselmann and my brother, Fred Hanselmann, I cherish our friendship and look forward to more shared memories. I wish my grandparents could have lived to see the day, not that they didn't have interesting days of their own.

Finally, thanks to my husband, John Otis Ashby, Jr. who has always been there when I needed him. You are indeed the wind beneath my wings. Your willingness to cook lots of suppers, transcribe interview after interview, and especially your love have helped make this project a reality. Hopefully with the conclusion of this project, I can better reciprocate. Here's to an eternity together!

Table of Contents	Page
List of Tables	viii
List of Illustrations	ix
Abstract	x
Introduction and Review of the Literature	I
Method	32
Commonalities	41
The Integrated Developmental Model	62
The IDM Strengths, Inadequacies, and Implications for Further Research	94
References	118
Appendixes	
Appendix A-Prospectus	126
Appendix B-Informed Consent Form	175
Appendix C-Critical Incident Questionnaire (CIQ)	176
Appendix D-Supervisee Level Questionnaire-Revised (SLQ-R)	177
Appendix E-Supervisee Needs Questionnaire (SNQ)	180
Appendix F-Supervisory Working Alliance Inventory (SWAI)	183
Appendix G-Supervision Attitude Inventory (SAI)	185
Appendix H-Supervision Evaluation Scale-Revised (SES-R)	188
Appendix I-Alan's Themes Across Interviews 1 – 6	190
Appendix J-Dirk's Themes Across Interviews 1 – 6	194

Appendix K-David's Themes Across Interviews 1 – 6	198
Appendix L-Phil's Themes Across Interviews 1 – 6	202
Appendix M-Trainees' Scores on the SLQ-R, SNQ, SWAI, SES-R,SAI	206
Appendix N-Institutional Review Board Approval	210

List of Tables

Table	Title	Page
I1	Alan's Themes Across Interviews 1-6	190
I2	Alan's Themes Across Interviews 1-6 Categorized by the Integrated Developmental Model	192
J1	Dirk's Themes Across Interviews 1-6	194
J2	Dirk's Themes Across Interviews 1-6 Categorized by the Integrated Developmental Model	196
K1	David's Themes Across Interviews 1-6	198
K2	David's Themes Across Interviews 1-6 Categorized by the Integrated Developmental Model	200
L1	Phil's Themes Across Interviews 1-6	202
L2	Phil's Themes Across Interviews 1-6 Categorized by the Integrated Developmental Model	204

List of Illustrations

Figure	Title	Page
M1	Alan's Scores on the SLQ-R, SNQ, SWAI, SES-R, SAI	206
M2	Dirk's Scores on the SLQ-R, SNQ, SWAI, SES-R, SAI	207
M3	David's Scores on the SLQ-R, SNQ, SWAI, SES-R, SAI	208
M4	Phil's Scores on the SLQ-R, SNQ, SWAI, SES-R, SAI	209

Abstract

The purpose of this study was to explore Stoltenberg, Mc Neil, & Delworth's (1998) Integrated Developmental Model (IDM) by following two first-year and two second-year counseling psychology doctoral students across an academic year of experience. Six interviews were conducted with each trainee and his respective supervisor at four to five week intervals during the Fall 1996 and Spring 1997 semesters. All interviews focused on counseling and training experiences and the trainees' reaction to these experiences. The interviews were recorded and then transcribed for analysis. In the first level of analysis, the transcripts for each trainee were read and reread to identify the trainee's relevant counseling and training experiences. In the second stage, the author charted each theme and then wrote a short summary for the main commonalities identified. The experiences were then categorized according to Stoltenberg's et al. (1998) eight domains (Intervention Skills, Assessment Skills, Interpersonal Assessment, Client Conceptualization, Individual Differences, Theoretical Orientation, and Professional Ethics). Finally, the author examined transcripts for evidence concerning trainees' experiences inconsistent with or not predicted by the IDM. Results clearly indicate that Stoltenberg's et al. Intervention Skills Competence, Interpersonal Assessment, and Theoretical Orientation domains were most effective in predicting development across the structures. A dearth of support was found for the IDM Level 2 therapist in the Self and Other Awareness structure within the Assessment Techniques, Treatment Plans and Goals, and Professional Ethics domains, as well as the Level 1 therapist in the Client Conceptualization domain.

Introduction

Loganbill, Hardy, and Delworth (1982, p. 3) have defined clinical supervision as “. . . an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person.” Supervision is a key aspect of practice for clinical and counseling psychologists, as well as for applications of psychology within schools, industry, and organizations. Until the mid-1970s, there was limited literature on supervision within psychology journals (Baker, 1978). In 1980, the American Psychological Association established the educational requirement that clinical, counseling and school psychology trainees needed to receive supervised practicum and internship experiences as part of their education toward a doctoral degree (American Psychological Association, 1980). This emphasized the importance of supervision in the development of a counselor. In recent years, there has been a proliferation of articles, books, and entire journals addressing supervision and related issues of professional development. The greater interest in supervision has resulted in *Psychological Abstracts* adding professional supervision as a category.

Although supervision is within the top five activities on which psychologists spend the most professional time (Garfield & Kurtz, 1976; Norcross et al., 1989) and more than two thirds of counseling psychologists provide clinical supervision (Fitzgerald & Osipow, 1986), few supervisors (less than 10 to 15 percent) have actually attended formal courses in supervision (Hess & Hess, 1983; McColley & Baker, 1982), and most lack training in supervision (Leddick & Bernard, 1980). Little is known about how supervisors assume the supervisory role (Loganbill, Hardy, & Delworth, 1982) and standardized rating scales for assessing supervisees' and supervisors' skills are wanting

(Hess & Hess, 1983; Matarazzo & Patterson, 1986). These data argue for the need for more research and a greater focus on issues relevant to the supervision of developing counselors.

The approach of the supervisor, what is taught, how fast it is taught, and what is assumed to be known by the trainee differs in accordance with the supervisor's assumptions about the trainees level of experience (Worthington, 1987). The manner in which supervision changes as counselors gain experience depends on the supervisor's beliefs regarding counseling and supervision (Bartlett, Goodyear, & Bradley, 1983). One of the most prominent explanations regarding supervision relies on developmental theory. The developmental perspective asserts that counselors and therapists change in abilities and needs as they gain counseling experience. Supervisors' interventions vary in accordance with perceptions of their trainee's developmental stage of counseling, rather than being based primarily on the content of the trainee's theoretical approach. Although counselors may not develop cleanly along precise developmental lines, it can be very helpful to a supervisor to be aware of expected developmental changes in organizing her or his supervisory approach.

Review of the Literature

Historical Perspective of Supervision and the Developing Counselor

The types of training that counselors with different levels of experience receive have changed over time (Leddick & Bernard, 1980). Early in the history of supervision, psychoanalysis dominated the field and supervisees underwent training analysis, presumably learning psychotherapy skills through experiencing the role of the client and through observing the training analyst at work. Later, it was thought that teaching the

theories of therapy and personality development occurred in the classroom, whereas training in counseling occurred at practicum sites or counseling agencies. As Carl Rogers, Robert Carkhuff, Charles Truax, Allen Ivey, and others developed technologies of training, “skills training” began to occur earlier in programs that trained therapists. Currently, counselors are expected to enter their first counseling practicum already knowledgeable of beginning counseling skills (Robiner & Schofield, 1990).

Much of the recent training and research on how supervision changes with time has been done by developmental theorists who have described supervision apart from the supervisor’s theory of counseling. Generally, in these theories an implicit stage theory of counselor development is assumed and supervisory behaviors that are thought to be consistent with the hypothesized level of development of the counselor are specified (Worthington, 1987; Stoltenberg, McNeill, & Crethar, 1994). Focus on counselor change over time serves as the critical difference between developmental theories and other theories of supervision. Major tasks of any developmental theory include: (1) describing changes within one or more areas of behavior over time, (2) describing changes in the relationships among areas of behavior; and, (3) explaining the course that the development has taken (Miller, 1989). A developmental theory that clearly describes and explains a path of development should not only provide organization and meaning to facts but also guide further research.

Stoltenberg and Delworth (1987) believe a theory of development must be able to “...describe behavior changes across time and across individuals and must then go on to explain why these changes occur in the order in which they are observed” (p. 2). They go on to state that a theory should also define an environment for encouraging the process of

development that the theory describes. Finally, such a theory should predict changes in both the counselor and the supervisory environment through the counselor's development.

History of Developmental Models of Counseling Supervision

Publication of theoretical articles in the 1950's by Fleming (1953) and Grotjahn (1955) serve as the roots to the history of a developmental perspective of counseling. Fleming's (1953) stages of development include: a) imitative learning, b) corrective learning, and c) creative learning. In the imitative learning stage, supervisors demonstrate methods of counseling and offer suggestions to the trainee. Anxious trainees, due to the novelty of the therapeutic experience, learn through imitating their supervisors. In the corrective learning stage less support is necessary because trainee self-confidence is relatively high. The supervisor primarily corrects inaccurate techniques and interpretations. The creative learning stage of trainee development is the most autonomous stage. In this stage, the supervisor permits the trainee optimal room to develop a therapeutic style while investigating personal reactions to the client and how these reactions affect counseling.

Grotjahn's (1955) developmental theory also describes three stages: a) period of preparation, b) period of elaboration on the therapist's knowledge of the client, and c) period of working through. Throughout the period of trainee preparation, the supervisor provides support, technical help, respect, and encouragement to the trainee. In the second phase, the supervisor focuses on the personality dynamics and psychopathology of the client. The working through phase of counselor development promotes a supervisory focus on the trainee's affect and conflicts in relation to the therapeutic process.

Hogan's (1964) two-page outline of a supervision process serves as the next influential theory of counselor development. Hogan's model proposed a progression through four stages of trainee development for psychotherapists and operationalized supervision behaviors ideal for each stage. The purpose of supervision in this model is to foster the growth of the trainee toward more independent functioning based on acquired skills and insight into the client and the trainee's own person. The roles of the trainee and the supervisor change over time as development occurs.

Hogan's first stage, characterized by trainee dependence on the supervisor, describes this novice counselor as neurosis bound, insecure, and uninsightful, although highly motivated. When working with this Level 1 trainee, Hogan assumes trainee imitation of the supervisor, thus teaching, support, interpretation, and self-awareness training are recommended.

Hogan's Level 2 trainee is characterized by a dependency-autonomy conflict regarding the supervisory relationship. The trainee, while experiencing a fluctuation in motivation, vacillates between feelings of confusion and overconfidence. Clarification of these feelings of ambivalence was added to the list of appropriate supervisory behaviors recommended for working with the Level 2 trainee.

The Level 3 trainee demonstrates increased professional self-confidence and only conditional dependency on the supervisor. The trainee possesses increased ability to be insightful and evidences more stable motivation. At Level 3, supervision progresses to a more collegial relationship, with the supervisor displaying a blend of sharing, example, and personal confrontation.

Hogan's Level 4 trainee is considered a master psychologist characterized by

security in self, autonomy from the supervisor, insightfulness with awareness of the limitations of insight, stabilized motivation. A master psychologist also possesses an awareness of the need to confront and focus on both personal and professional problems. The supervisory relationship, if one exists, is collegial, emphasizing what Hogan refers to as the peer supervisor model, which is comprised of sharing, confrontation, and mutual consultation.

Ard (1973) described a five-stage model. In the first stage, Perceptorship, the trainee has the need of orientation. Thus the supervisor orients this beginning student. Stage two, Apprenticeship, consists of the supervisor responding to the trainee's requests for specific instruction. During the Mentorship or stage three, the trainee demonstrates work and struggles with personal issues. Here the supervisor critiques the work of the student and facilitates trainee self-examination. By stage four, Sponsorship, the trainee is largely competent and the supervisor simply instills more confidence. Finally, in stage five, Peership, the trainee has emerged from training to full professional status. The supervisor establishes a coequal relationship after termination of formal supervision.

In 1974, Gaoni and Neumann proposed a four-stage model without complementary recommended supervisor behaviors for each stage. The stages were defined as follows: a) Teacher-student stage, b) Apprenticeship, c) Developing the therapeutic personality, and d) Mutual consultation among equals.

Littrel, Lee-Borden, and Lorenz's (1979) model emerged from the integration of four existing models of training for counselors: teaching, counseling/therapeutic, consulting, and self-supervision. These four models were seen as useful for various tasks that trainees must master to become competent professionals. The models were

combined into a sequence that offered a four-stage model of supervision based on the integration of models of counselor training designed to encourage counselor competency.

In Stage 1, the supervisor's goals include building a supportive and non-judgmental supervision relationship, exploring and setting goals, and developing a learning contract defining criteria for counselor competency. During Stage 2 the supervisor teaches specific skills in counseling and conceptualization while focusing on the actions, feelings, and thoughts of the trainee with the goal of overcoming therapeutic blocks. In Stage 3, supervision is characterized by consultation in which the goals are set by the trainee and self-evaluation is encouraged. Stage 4 of this model is distinguished by self-supervision.

Based on Hogan's (1964) outline, Stoltenberg (1981) proposed the Counselor Complexity Model (CCM). Constructs from Hunt's (1971) Conceptual Systems Theory and the earlier work of Harvey, Hunt, and Schroeder (1961) which emphasized matching trainee development to particular environments were adapted. Hogan's stages were retained, but descriptions of optimum supervision environments were enhanced. The CCM asserts that the counselor trainee becomes more cognitively complex and therapeutically capable as the trainee develops.

Stoltenberg (1981) described supervisory methods to create growth-producing environments for the trainees as they develop through four levels of complexity. In level 1, the novice trainee imitates the supervisor, is lacking in both self- and other-awareness, and thinks categorically about the various elements of counseling. This dependency on the supervisor is appropriately addressed by encouraging autonomy through instruction, interpretation, support, awareness training and exemplification in a very structured

environment.

A conflict between dependency and autonomy from the supervisor characterizes level 2. Striving for greater independence, the trainee becomes more self-assertive and less imitative while increasing in self-awareness and experiencing fluctuating motivation. The supervisor for this level should provide a less structured and more autonomous environment. Supervisory methods include ambivalence clarification, support, exemplification, and less instruction to encourage trainee development in this level.

Level 3 is depicted as a period of conditional dependency. The trainee develops a personal counselor identity with increased insight, more consistent motivation, increased empathy, and more differentiated interpersonal orientation. At this level, the supervisor should treat the trainee more like a peer, relying on structure provided by the trainee. Sharing, mutual exemplification, and confrontation are recommended supervisory behaviors at this level.

In the final level, master counselor, supervision becomes collegial, if utilized at all. A counselor who attains this level of development has adequate self- and other-awareness in therapy, is insightful of her or his own therapeutic strengths and weaknesses, has been able to integrate personal identity with high professional standards, and is able to maintain willful interdependence with the supervisor.

In 1982, Hart, Yogev, Blount and Wiley all proposed developmental supervision models. Wiley (1982) expanded on Stoltenberg's model of counselor complexity but identified five critical issues that are behaviorally defined for each of Stoltenberg's four stages. Hart (1982) offered three stages of recommended supervisor behaviors: a) Didactic instruction, b) Feedback on trainee work and personal awareness, and c)

Integration of skill development with personal awareness. Yogeve (1982) presented a three stage developmental model, limited to first-year graduate trainees, with endorsed supervisor behaviors. The first stage, Role definition, is portrayed by the trainee's acknowledged commitment to becoming a therapist, demystification of therapy, and feelings of inadequacy, anxiety, but recognition of some strengths. The supervisor at this level helps the trainee with role definition, clarifying expectations in supervision and evaluation of the trainee. The trainee learns the skills of counseling in stage two, Skill acquisition. Here the supervisor observes the trainee and possibly engages in cotherapy with the trainee. Finally, the supervisor uses both emotional aspects and didactic and skill-practice aspects to facilitate stage three, Solidification and evaluations of practice. Blount's (1982) four stage model also included advocated supervisor behaviors. During the first stage, Adequacy versus Inadequacy, the supervisor should create a supportive relationship in which awareness training, modeling, and didactic skills instruction may occur. According to Blount, the Independence versus Dependence struggle of stage two is best supervised by exemplification and integration of dynamics and advanced skill development. In stage three, Conditional dependency versus Individuation, the supervisor allows greater autonomy, offers appropriate confrontation, and encourages a peer relationship. The fourth stage, Professional integrity versus personal autonomy, is characterized by collegial consultation, self-supervision, supervision of others, and mentoring.

Loganbill, Hardy, and Delworth's (1982) model of supervision was based on Chickering (1969), Erikson (1968), and Mahler's (1979) developmental models. Their model identified three stages of counselor development: stagnation, confusion, and

integration. These stages are similar to stages identified by Hill et al. (1981) as well as by Hogan (1964) and Stoltenberg (1981). However, Loganbill's et al. (1982) added twist was that trainees need to resolve eight critical issues before becoming master counselors: competence, emotional awareness, autonomy, theoretical identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics. The trainee is thought to resolve the issues independently of each other. Thus the trainee could be in any of the three stages (stagnation, confusion, or integration) with any issue. They go on to posit that trainees will recycle through the three stages for these eight issues in ever deepening levels.

The first stage, stagnation, is characterized by a naive unawareness for the neophyte counselor, or "stuckness" for a more experienced counselor with little experience in the given area of content. The second stage, confusion, includes disorganization, conflict, and confusion and fluctuations in motivation. During this phase, the trainee seeks equilibrium while experiencing ambivalence. The third stage, integration, is made possible by the unfreezing of emotions, behaviors, and attitudes. At this time there is an integration of learning, reorganization of understanding, flexibility, and feelings of security based on awareness of areas of insecurity. In this stage, the counselor assimilates the intense emotional factors that were experienced in the second stage and integrates them with a cognitive conceptual learning.

The year 1982 concluded with models submitted by Miller and Sansbury. Miller (1982) describes a model with five stages: a) Quiescence, b) Early exploration, c) Imitation, d) Partial autonomy, and e) Autonomy. The supervisor's interventions across the stages are represented along three continua: a) intrusive -reflective, b) oppositional-

supportive, and c) prescriptive-elicitive. Sansbury's (1982) three-stage model begins with the Prepracticum stage. This stage consists of developing basic listening skills and assimilations of the counselor role. The supervisor facilitates with evaluative feedback, needs assessment, modeling good counseling skills, as well as, reinforcing and supporting the trainee. In stage two, Practicum, the trainee develops new therapeutic techniques, improves conceptualization, refines personal theory, develops competence, and establishes limits of responsibility for self and client. The supervisor analyzes cases, helps resolve counselor-client impasses, promotes counselor understanding through confrontation, role reversals, interpretation and feedback, as well as teaches the trainee to ask for help in supervision. During the final stage, Internship, the trainee broadens and refines understanding of clients, learns types of clients that are best helped, examines personal issues, and learns reliance of self. The Internship supervisor confronts the trainee on differences in talk and behavior, supports increased risk taking, helps the trainee with personal issues and assists trainee in self-evaluation. It is interesting to note that Sansbury's stages were defined by years of practicum experience and not individual development.

Friedlander, Dye, Costello and Kobos (1984) offered a three stage developmental model. In the first stage, the trainee possesses ambiguity. The supervisor helps the trainee deal with the demands for wide-ranging tolerance of ambiguity and emphasizes learning to learn. During stage two the trainee recognizes the limits of therapeutic conditions. The supervisor aids the trainee to see differences in theory and practice, and to accept mistakes and unanticipated client responses, and helps to deal with guilt over failures. The discovery of therapy as deep communication is introduced in stage three.

Here the supervisor helps to take the focus off techniques and onto human relationships. Finally, in stage four, the trainee uses eclecticism in light of client needs. The supervisor facilitates the development of a repertoire of interventions.

Hess's (1986) developmental model also included four stages: a) Inception, b) Skill development, c) Consolidation, and d) Mutuality. The Inception stage is characterized by confusion, anxiety, identity formation, unanchored experience, and adequacy versus inadequacy. Hess believes the supervisor should help to identify experience with cognitive maps for handling experience, as well as encourage, support and build trust. Working through the dependence versus independence conflict and choosing a theory make up the Skills development stage. The supervisor induces trainees to try out techniques, rehearses techniques with them, and gives corrective feedback. Throughout the Consolidation stage, skills become "owned," new skills develop, and the trainee may actually supervise less experienced colleagues. Here the supervisor simply encourages and facilitates the learning of new skills. Mutuality offers conditional dependency versus individualism and the establishment of a professional identity. Supervision takes the form of mentoring or collegial supervision and focuses on how the therapist's personality affects the case.

Stoltenberg and Delworth (1987) introduced the most comprehensive and detailed model of counselor development and supervision to date, the Integrated Developmental Model (IDM). The primary basis for this model includes the work of Hogan (1964), Stoltenberg (1981), Loganbill, Hardy, and Delworth (1982), Piaget (1970, 1971) as well as several empirical studies of counselor development conducted prior to 1987. The IDM uses three overriding structures to monitor trainee development through four levels across

various domains of clinical training and practice, thus integrating mechanistic and organismic models and providing markers to assess development across domains.

The three structures are Self and Other Awareness (Cognitive and Affective), Motivation, and Autonomy. The Self and Other Awareness structure indicates where the individual is in terms of self-preoccupation, awareness of the client's world, and enlightened self-awareness. The cognitive component includes the content of the thought processes whereas the affective component accounts for changes in emotions. Motivation reflects the trainee's interest, investment, and effort expended in clinical training and practice. Autonomy includes the changes in the degree of independence demonstrated by trainees over time.

The domains of professional activity can be conceptualized in varying degrees of specificity. Stoltenberg and Delworth (1987) offer the following categories: Intervention Skills Competence, Assessment Techniques, Interpersonal Assessment, Client Conceptualization, Individual Differences, Theoretical Orientation, Treatment Goals and Plans, and Professional Ethics. Although each of these could be further reduced to more specific domains, the general categories serve to highlight the fact that one must attend carefully to the focal activity in which the trainee is engaging to adequately assess the developmental level at which the trainee is functioning at any given time. Intervention Skills Competence addresses the trainee's confidence in and ability to carry out therapeutic interventions. Assessment Techniques addresses the trainee's confidence in and ability to conduct psychological assessments. Interpersonal Assessment extends beyond a formal assessment period and includes the "use of self" in conceptualizing a client's interpersonal dynamics. Client Conceptualization incorporates, but is not limited

to, diagnosis. This domain goes beyond an axis diagnosis and involves the therapist's understanding of how the client's characteristics, history, and life circumstances blend to impact adjustment. Individual Differences includes an understanding of ethnic, racial, and cultural influences on individuals as well as the idiosyncrasies that form the person's personality. Theoretical Orientation involves formal theories of psychology as well as eclectic approaches and personal integration. Treatment Plans and Goals addresses how the therapist plans to organize her or his efforts in working with clients in the psychotherapeutic context. Finally, Professional Ethics addresses how professional ethics and standards of practice are intertwined with personal ethics in the development of the therapist.

According to the IDM, the twin processes of assimilation and accommodation induce a counselor trainee's upward movement. Piaget (1970) described assimilation as the process of fitting reality into one's current cognitive organization. Accommodation, however, was defined as significant adjustments in cognitive organization that result from the demands of reality. Piaget considered assimilation and accommodation to be closely interrelated in every cognitive activity (Miller, 1989). Attempts to assimilate involve minor changes in the individual's cognitive structures as these adjust to new ideas, whereas accommodation involves the formation of new constructs through the loosening of old ones.

Level 1 counselors tend to assimilate with their clients, but accommodate with their supervisors. These trainees possess extreme self-focus and difficulties hearing their client's view. Level 2 trainees may demonstrate exceedingly tight assimilations with the supervisor. With clients, however, trainees tend to overaccommodate, losing their ability

to form their own structures. This conflict between overaccommodation and overassimilation may account for the confusion and struggle of Level 2. In Level 3, assimilation and accommodation begin to work in a more reciprocal manner.

The Level 1 trainee demonstrates a self-focus, resulting from apprehension regarding evaluation by the supervisor and the client. In all domains, the Level 1 trainee has skills to learn and needs opportunities to practice them. Stimulated by anxiety, the motivation of the Level 1 trainee is high across all domains and toward the activities associated with becoming a counselor which is characterized by a desire to learn the “right” way of counseling. Due to the lack of skills and confidence, this trainee is portrayed also by dependency on the supervisor across domains. This is a period of assimilation of new knowledge for the trainee.

The self-focus of Level 1 gives way to the Level 2 trainee’s focus on the cognitive and emotional experience of the client even to the extent that the trainee may lose track of self by delving too far into the client’s experience. This change in focus begins the accommodation process of the trainee’s therapeutic constructs. At this level, the disappointment and frustration throughout the experience of trying to become an adept counselor and contrasting periods of success, results in a fluctuation of trainee motivation. The domain of individual differences may be the only one that receives consistent and motivated interest from the trainee. This trainee also experiences a dependency-autonomy conflict. Again the conflict with the supervisor is often played out in the domain of individual differences. The trainee vacillates between a desire to be treated as an independent therapist and maintaining feelings of dependence on the supervisor. Resistance is seen across domains.

Vacillations characteristic of Level 2 trainees begin to diminish as the trainee attains an ability to productively use the dual processes of accommodation and assimilation. This Level 3 trainee is now able to comfortably utilize both self- and other-awareness, focusing personal cognitive and emotional processes relating to the client, as well as the experiences of the client. Trainee motivation is more consistent across domains. This motivation results from knowledge of idiosyncratic strengths and weaknesses, an understanding of the limitations of counseling, and the integration of individual identity with therapeutic style. The resolution of the above dependency-autonomy conflict results in confidence in one's ability to function as an autonomous counselor. Level 3 trainees feel comfortable seeking out qualified advice and evaluating this information in terms of its fit for their personal orientation, personal style, and impressions of the client.

The Level 3 Integrated Counselor has synthesized the knowledge and skills of Level 3 across all domains. This level may take considerable time and experience to be achieved, if at all. This level is different in that it moves away from the clear linearity of movement in the first three levels and reflects horizontal movement and depth. This therapist is *not only consistently motivated, appropriately autonomous, and well focused*, but “is creative, able to learn from self and others and able to evolve strong and appropriate accommodations and assimilations throughout the life cycle” (Stoltenberg & Delworth, 1987, p. 45).

In their expansion of the IDM, Stoltenberg, McNeill, and Delworth (1998) elaborate on cognitive processing and development across domains as well as offer explanations for regression and similarity of behavior across levels. Within the construct

of cognitive processing, an important extension of the model is the notion of schemata. The authors rely on the definition of schemata as the information regarding the function, categories, parts, and so on of something as well as images of the entity that are organized together in memory. For the beginning trainee, it is suggested that initial schemata tend to be overly general and of little use distinguishing among numerous characteristics. This tendency to overgeneralize in schema development is characteristic of novices within a given domain. Discriminations are increasingly refined as one learns more about a particular domain.

Stoltenberg et al. (1998) also stress the importance that in practice, all counselors function at different levels of professional development across domains. This perspective on trainee development complicates the supervisor's task. Not only does a supervisor need to know how to provide optimal supervision for different levels of supervisees, but must also be able to assess level of development across the professional activities in which the trainees are engaged while under supervision. The supervisor must move from supervision appropriate for a particular level of development in one domain, to supervision appropriate for a different level of another domain, even within the same supervision session.

The authors also account for issues such as regression and similarity of behavior across levels. It is suggested Level 2 trainees under stress, in a crisis context or when things are not going well, may become dependent or, on occasion, evasive. This can result in lowered confidence in clinical work and may reflect behavior similar to Level 1 trainees. For Level 3, some of the self-focus seen in Level 1 returns, however the quality is remarkably different. The trainee is much more self-accepting of all professional

strengths and weaknesses. The Level 2 high empathy and understanding remains as the counselor focuses on the client, processes the information provided, and “pulls back” to reflect on her or his own reactions. This reflection can be fairly objective by including a memory search to identify relevant schemata and bring the information into awareness for use in decision-making. Through the self-knowledge that has developed, this counselor is more able to use her/himself in therapy.

Finally, Stoltenberg et al. (1998) point out that trainees who may have had considerable experience in certain domains of clinical activity (for example, other theoretical orientations, other modalities, or related mental health experience) nevertheless will be functioning at Level 1 if these experiences are significantly different from the primary training focus in supervision. For example, it is common for trainees to acquire significant training and experience in individual counseling, but little or no knowledge or experience in another therapeutic modality (for example, marital, family, or group therapy). Similarly, trainees may have engaged in significant training in assessment but little in psychotherapy, or vice versa.

Empirical Evidence of Counselor Development

One of the earliest empirical studies of the development of counselors was conducted by Hill, Charles, and Reed (1981). Through a longitudinal study, the researchers directly investigated the development of counselors as they gained supervised experience. They followed twelve counseling psychology graduate students through their training. Brief counseling work samples were collected at various times, as well as in-depth exit interviews. Results demonstrated improvement in skills over time as evidenced by the use of minimal encouragers and asking fewer questions during sessions.

The exit interviews showed increases in student perception of confidence and abilities to focus on their clients, as opposed to themselves, over the course of their training. In addition, according to student perception, the tendency to become over-invested with clients declined. Students also reported that they had become more relaxed and spontaneous during counseling sessions and were more able to act naturally with their clients. As experience level increased, all trainees reported decreased levels of anxiety in dealing with clients. The trainees' views of their supervisors also changed over time. Trainees' views of their supervisors as experts in an evaluation role changed to a view of supervisors as consultants, with primary responsibility for clients belonging to the trainees.

Miars et al. (1983) also investigated Stoltenberg's (1981) Counselor Complexity Model by asking 37 counseling or clinical psychologists to rate their supervisory behavior with first semester, second semester, advanced practicum and intern level trainees. Supervisors reported that they conducted supervision differently depending on the level of the hypothetical student at that level. The supervisors reported the most variations across supervisee level in dimensions of instruction, directiveness, structure, and degree of collegiality. Less direction, structure, support and teaching were considered necessary for the more experienced counselors. Supervisors' perceived supervisory environments paralleled Stoltenberg's expectations, though supervisors' expectations were less differentiated than Stoltenberg's.

Reising and Daniels (1983) tested constructs within Hogan's (1964) developmental model. Surveys were administered to 141 counselor trainees from 20 universities grouped by experience into premaster-, master-, advanced master-, and PhD

level counselors. Results provided strong support for the construct validity of Hogan's model though not for his supervision recommendations. Trainees in the premaster- and master levels reported higher levels of dependence on their supervisors, more technique orientation, more feelings of anxiety relevant to counseling, as well as less readiness for confrontation in the supervisory relationship than did the advanced master- and Ph.D. level trainees. Increased trainee experience resulted in reports of increased independence in the supervisory relationship.

Heppner and Roehlke (1984) evaluated constructs related to developmental models of supervision through three studies in which they surveyed a total of 145 supervisees. They examined beginning practicum, advanced practicum, and intern counselor trainees. The first study revealed that there were no differences in supervisory experience level for expectations, locus of control, or perceptions of supervisor as expert, attractive, or trustworthy.

In their second study, Heppner and Roehlke (1984) compared the supervision behaviors perceived by supervisees of different levels of experience. Results indicated that beginning practicum counselors were more satisfied with supervisors who fostered a positive relationship with the supervisee. Advanced practicum students were more satisfied with supervisors who facilitated development of additional counseling skills. Interns reported more satisfaction with supervisors who helped them to develop better counseling skills and allowed them to deal with personal issues or defensiveness that affect counseling.

In their third study, Heppner and Roehlke (1984) examined some of the critical incidents in supervision. Critical incidences occurred earlier for interns than they did for

other practicum students. Also, for beginning and advanced trainees', the critical incidences centered around issues of emotional self-awareness, confrontation, competence and support, while the critical incidences of interns centered around personal issues and their own defensiveness in therapy.

Worthington (1984) surveyed 237 counselors from ten counseling centers nationwide. Classifying trainees into first-, second-, third-, fourth-year, and predoctoral interns. He found that supervision differed across levels of experience on independence with direction, preference for infrequently taught skills, and establishing goals. Ratings by trainees in practica 2, 3, and 4 suggested that their supervisors encouraged independent actions while giving support and explicit instruction more frequently than practicum 1 trainees. Practicum 1 trainees report high satisfaction when given literature and reference material. This was not found to be true for trainees at other levels of experience. Practica 3, 4, and internship trainees reported high satisfaction when observed live by their supervisors. This was not found to be true for practica 1 and 2 trainees. Practica 1 and 2 trainees gave high ratings to supervisors who set and later re-negotiated goals. This was not true at higher levels of experience. Generally, supervisors were viewed as behaving in ways which promoted independence in their trainees as they became more experienced counselors.

Yogev and Pion (1984) examined goals, expectations, and procedures as perceived by 31 supervisors with their first-year, second-year and internship-year trainees. Results indicated no differences perceived by supervisors on any of the variables studied across supervisee levels of experience.

Examining constructs from Stoltenberg's (1981) Counselor Complexity Model,

McNeill, Stoltenberg, and Pierce (1985) administered the Supervisee Levels Questionnaire (SLQ) to 91 trainees. Divided, by experience, into groups of beginning, intermediate, and advanced, the SLQ gathered trainee self-perceptions both in counseling and supervision. Level of experience in this study was an aggregate of level of education, counseling and supervision experience. Results demonstrated significant differences for beginning versus intermediate trainees in self-awareness and dependency-autonomy. Results also found differences between intermediate and advanced experience trainees in theory/skills acquisition and dependency-autonomy. Differences were noted between beginning and advanced trainees on dependency-autonomy, self-awareness, and theory/skills acquisition. The researchers discovered increased levels of self-awareness and knowledge of counseling skills, less dependence on the supervisor, and a greater desire for autonomy in counseling and supervision reported as the trainees' levels of experience increased.

Ellis and Dell (1986) examined supervision dyads via the perceptions of 19 supervisors relating to their supervisory roles as derived from Bernard's (1979) model of nine supervisor roles. Although different levels of supervisors and supervisees were included in the study, general reactions or "cognitive maps" to supervisor roles were assessed rather than the perceptions of suitability of these roles across different levels of trainees. Results indicated that neither the experience level of the trainee nor the supervisor alone affected the supervisor's description of the supervision. Nonetheless, results suggested a trend toward an interaction of supervisor and trainee experience levels consistent with Littrell, Lee-Borden, & Lorenz's (1979) model of supervision.

Rabinowitz, Heppner, & Roehlke (1986) examined beginning, advanced

practicum, and internship level trainee perceptions of important issues and supervisor interventions following each weekly supervision session and upon termination of the supervisory relationship. Thus, the researchers examined differences across experience levels and changes throughout the semester long supervisory relationship. Overall, results indicated that the pattern of supervision for all three levels involved establishing a working supervisory relationship "...followed by a movement from dependency toward autonomy" (p. 299). This movement varied in rate, with beginning trainees retaining dependence on structure and support the longest. In the middle stage of the supervisory relationship, personal issues tended to arise and were most significant for the advanced practicum trainees. As the supervisory relationship approached termination, all levels of "...trainees were more likely to make more autonomous interventions and show greater conceptual understanding" (pg. 299). Although the trainees of varying levels of experience possess many similarities, the existing differences were generally supportive of developmental models of supervision both across experience levels and throughout the four-month supervisory relationships.

Wiley and Ray (1986) tested aspects of Stoltenberg's Counselor Complexity Model (1981). They operationalized Stoltenberg's four levels of counselor development by describing each level in terms of phrases that applied to a counselor at that level. Throughout the United States, 71 supervisors rated 107 of their trainees on the list of descriptive phrases. The supervisors also described the environment that they believed they provided for each supervisee on a list of descriptive phrases. The researchers tested three main hypotheses. They found that the level of supervisor-rated development of their supervisees was related to the amount of supervised, not unsupervised, counseling

experience of the counselor. They also found that the supervisors perceived themselves to be providing different levels of supervisory environment with supervisees of different levels of supervised counseling experience but not with supervisees of different levels of unsupervised counseling experience. Last, they found that congruence of supervisee's level of experience and supervision environment was unrelated to either supervisor's or supervisee's satisfaction with supervision. Generally, when supervisors did not match the supervision environment with the level of supervisee development, they differed by providing supervision at a level lower than the supervisee's level of development. There were a few gross mismatches, suggesting that supervisors might intuitively match levels of counselor and supervision environment.

Zucker and Worthington (1986) surveyed 34 psychology interns and 25 post-Ph.D. psychologists being supervised for licensure. Results suggested that interns and post-Ph.D. psychologists were supervised similarly with the exception of evaluation and the amount of time spent in supervision. Interns received supervision that was generally more evaluative than the postdoctoral psychologists.

Stoltenberg, Pierce, & McNeill (1987) studied Stoltenberg's (1981) proposition that counselor trainees' needs change as a function of developmental level. They measured differences according to previous counseling experience, semesters of supervision and education. Based on previous counseling experience, significant differences were found between Levels 1 and 2 for feedback, and between Levels 1 and 3 for structure, feedback, and overall needs. Discrepancies were found between Levels 1 and 3 for feedback, structure and overall needs and between Levels 2 and 3 for structure and overall needs. Finally, based on the number of semesters of previous

supervision, results indicated differences between Levels 1 and 3 for feedback, structure and overall needs and between Levels 2 and 3 for feedback.

Guest and Beutler (1988) investigation of 16 trainees over a three to five year period found that, in general, beginning trainees valued support from their supervisors and increasingly preferred supervisors who held complex and dynamic views of change as they gained experience. For advanced trainees, assessment of personal issues and relationships affecting the psychotherapy process increased in importance.

In a survey of 87 supervisors and 77 trainees from 31 schools, Krause and Allen (1988) studied Stoltenberg's (1981) model. Supervisors classified their trainees and the trainees classified themselves according to Stoltenberg's (1981) model. The researchers developed a new instrument to measure perceptions of supervisory behaviors, feelings of satisfaction, and personal impact of supervision. Results indicated that supervisors perceived themselves as varying their behavior with trainees of different developmental levels in a manner consistent with Stoltenberg's (1981) model. However, trainees, did not perceive differences in their supervisors' behavior. Trainees in congruent dyads reported significantly more satisfaction in supervision than did trainees in noncongruent dyads. Congruency of dyads, however, had no affect on the supervisors' ratings of satisfaction.

Fisher (1989) investigated Hogan's (1964) developmental theory for "systems" oriented supervision using five American Association for Marriage and Family Therapy (AAMFT) approved supervisors and their 16 trainees (at least master's level). The trainees were divided into "beginning" and "advanced" categories according to the AMFT cutoffs of 500 clinical hours and 100 supervision hours. No significant

differences were found between the supervision of “beginning” and “advanced” trainees regarding the focus of supervision or between the types of supervisory relationships.

Tracey, Ellickson, & Sherry (1989) examined the reactions of 40 first-year practicum counselors and 38 advanced practicum counselors to different supervisory environments. The study highlighted the importance of attending to specific domains when choosing supervision environments. Their results indicated that all the participants preferred highly structured supervision (directive teaching) when dealing with a suicidal condition (low experience for all trainees). In response to non-crisis content, the beginning trainees preferred structured supervision in the form of directive teaching, while the more experienced counselors preferred a less structured supervisory environment. Also, advanced trainees who were high in “reactance” demonstrated a preference for supervision with less structure than did advanced trainees with low reactance. These differences highlight the importance of not assuming advanced level of development across domains, but rather reinforces the need to assess specific developmental level for trainees.

In 1992, McNeill, Stoltenberg, and Romans revised the SLQ (SLQ-R) to reflect the three structures (self-other awareness, motivation, and dependency-autonomy) hypothesized by Stoltenberg and Delworth’s IDM (1987) as important determinants of therapist development. The researchers examined 104 trainees in eight training sites across the nation and found significant differences between beginning and advanced trainees and the intermediate and advanced trainees in the expected direction. No differences were found between beginning and intermediate trainees. There was evidence of a lack of ceiling effects on the SLQ-R suggesting a higher possible range of

scores of trainees possessing more experience.

Bear and Kivlighan (1994) used Stoltenberg and Delworth's (1987) IDM for the basis of a single-subject study examining the process of individual supervision. An experienced supervisor worked with both a beginning and an advanced trainee. The researchers taped and transcribed 12 supervision sessions for each dyad. The session transcripts were then rated for supervisor and supervisee interpersonal behaviors and for supervisee depth of information processing. Results, consistent with the IDM, revealed that the supervisor was more structured and directive with the beginning supervisee, who made more dependent responses. On the other hand, the supervisor was more collegial and collaborative with the advanced supervisee, who made more autonomous responses. The directive and structured supervisor interventions produced more deep-elaborative information processing by the beginner whereas this preferred type of processing was stimulated by the collegial or consultative supervisor interventions for the advance trainee.

In a phenomenological investigation of "good" supervision events, Worthen and McNeill (1996) interviewed eight trainees from three APA approved counseling psychology doctoral programs. Results demonstrated that intermediate trainees, or Level 2, experienced a fragile and fluctuating level of confidence and a generalized state of disillusionment and demoralization with the efficacy of providing therapeutic interventions and were anxious and sensitive to supervisor evaluation. Trainees felt that their anxiety level decreased when supervisors helped to "normalize" their struggles as part of their ongoing development. They also characterized the supervisory relationship as one experienced as empathic, nonjudgmental, and validating, with encouragement to

explore and experiment. These conditions appeared to set the stage for nondefensive analysis as their confidence was strengthened. Participants also reported an increased perception of therapeutic complexity, an expanded ability for therapeutic conceptualizing and intervening, a positive anticipation to reengage in previous difficulties and issues they had struggled with, and a strengthening of the supervisory alliance. Finally, Worthen and McNeill (1996) found that intern-level, or Level 3, trainees exhibited a basic sense of confidence and autonomy and that inadequacies were identified as domain specific. As a result of increased levels of insight and self-awareness, Level 3 trainees not only display openness, but also prefer to further acknowledge and confront issues of transference-countertransference, therapy-supervision overlap, and parallel processes in supervisory and client relationships. Interestingly, they also reported previous unrewarding supervision experience, perhaps resulting in an aversion to overt evaluation and a strong desire for more rewarding supervision. In common with lesser experienced trainees, the interns also viewed good supervision as characterized by an empathic, nonjudgmental relationship with encouragement to experiment and explore, and they were pleased when their struggles were normalized. As a result, positive outcomes of good supervision events were similar to those of their less experienced peers. In addition, their confidence was affirmed and they reported an increased impetus for refining a professional identity.

Tryon (1996) examined the self-rated development of 25 Integrated Developmental Model Level 2 supervisees. The SLQ-R was used to assess ratings of self-other awareness, motivation, and dependency-autonomy among 18 clinical and 7 counseling advanced psychotherapy practicum trainees. Supervisees completed the SLQ-

R at five weeks, fifteen weeks, and thirty-one weeks during the advanced practicum experience. Group data indicates significant development in supervisee self-rated autonomy during the year across the three testings. This developmental level signifies a shift from a self-focus to a focus on understanding clients and understanding their treatment relationships with clients.

Statement of the Problem

This study investigated how first and second year students grow and progress within an APA accredited counseling psychology doctoral program. It explored trainee responses to their training by considering not only the supervision received but also the influences of the trainees' current and previous counseling experiences and the academic program itself. Through this exploration we are better able to understand and explain the growth and development unique to counselor trainees and supervision.

Questions related to these issues include the following:

Do changes in supervision as counselors gain experience promote growth and improvement of the trainee, or do they merely satisfy the trainee? How does the trainee make the transition from one level to the next? What can the supervisor do to facilitate movement from one level of counseling to the next? What can the supervisor do to prohibit movement from one level of counseling to the next? What are the trainee's needs at a given level and how do these needs change as the trainee gains experience? What can the supervisor do to contribute to satisfaction with supervision? What can the supervisor do to contribute to the dissatisfaction with supervision? What is the supervision relationship like?

Significance of the Study

Although there is evidence supporting general models of counselor development, the field still lacks clear evidence of the existence of some of the characteristics of level 2 trainees as hypothesized by Stoltenberg and Delworth (1987) and more recently Stoltenberg et al. (1998). The fluctuation in the motivation, the vacillation between autonomy and dependency, the client centered focus of the trainee, and a lack of interest in labeling clientele with a diagnosis, are noteworthy examples of hypothesized differences between level 2 trainees and other trainees.

Building on the knowledge and evidence gained thus far from researchers exploring trainees' supervisory needs as they gain experience, the consistency of trainee and supervisor perceptions with developmental theories, the changes in supervisor behavior as trainees gain experience, and the change in supervision relationship as counselors gain experience (Stoltenberg, McNeill, & Crethar, 1994), this study proposes to contribute to current discussions concerning the relationships among trainee levels, needs, experience, and supervision. Through the Critical Incident Questionnaires, the objective instruments and interviews with trainees and supervisors, researchers may learn much about the knowledge and sources from which trainees benefit as they grow as counselors. Specifically, this study included consideration of the interactions between trainees and supervisors in an APA accredited counseling psychology doctoral program and the influence of supervision on the growth and development of counselors. In addition to informing researchers, findings from this study may also inform those who supervise.

Limitations of the Study

The proposed study was in no way an attempt to explain, define, or delineate all

the variables involved in the complexity of counselor development and supervision. To do so, a researcher would need expansive resources in time, money, equipment, and willing research participants. None of these were currently feasible or available. What this study did do was attempt to accurately portray the growth and development of two first year and two-second year doctoral students within the context of an APA accredited counseling doctoral psychology program.

Since the study involved volunteer participants, their particular characteristics restricted the subject pool and possibly shaped the data (Rosenthal & Rosnow, 1975). Because of the limited number of participants, the study was exploratory, rather than conclusive.

Method

In investigations of supervision and counselor training, researchers have used a variety of methods in study designs including objective tests, interviews and observations. The proposed study considers individuals and their development as counselors within a training program context, thus, the methods for investigation should allow for highly individualized responses. Critical Incident Questionnaires (CIQs; see Appendix C) and interviews will permit participants to give their perceptions of the supervision experience in individual ways without limitations imposed by objective-test items. By focusing on the experiences revealed through the CIQs and referencing information gained through interviews as well as objective instruments, this study can add to current knowledge of counselor development and supervision.

Participants

Four men (two first year and two second year students) of European-American ethnicity were recruited from a Midwest counseling psychology doctoral program accredited by the American Psychological Association. Trainees ranged in age from 23 to 27 years, were in their 2nd to 4th year of graduate education, and had completed 2-6 semesters of supervision. Their supervisors were two men, a 34 year-old Mexican-American at the start of his supervisory experience and a 43 year old European-American with 16 years of supervisory experience. All six participants chosen were men so as to avoid gender interaction within the supervision dyad. Further, trainees were chosen for their match in education, counseling and supervision experience. Criteria for participant selection included willingness to complete the CIQs, the objective instruments and participate in tape-recorded interviews, use of English as primary language, ability to

articulate their supervision experience, and current counseling supervision in the practicum. Participants were volunteers and were not paid for any part of their involvement in the research. All trainees and supervisors who were invited to participate accepted the invitation.

The number of participants is small, so the sample's characteristics should not be considered representative of the program, APA accredited programs in general, or the counseling field. Accordingly, results should not be generalized to a larger population of counseling psychology trainees as a whole. The small sample size was a necessity since I was the sole researcher, and time and resources were limited.

Instruments

Supervisee levels of the trainees were assessed using the Supervisee Level Questionnaire-Revised (SLQ-R; McNeill, Stoltenberg, & Romans, 1992), as well as supervised counseling experience (see Appendix D). The SLQ-R is a 30-item Likert-style instrument constructed to tap characteristics on a continuum of development associated with levels hypothesized by Stoltenberg and Delworth (1987). It has three subscales that are based on the overriding structures of Stoltenberg and Delworth's model: Self and Other Awareness, Motivation, and Dependency-Autonomy, with an emphasis on applications to the domains of intervention skills competence, client conceptualization and interpersonal assessment. Cronbach alpha reliability coefficients calculated for the three subscales resulted in reliability estimates of .83, .74, .64, and .88 for the Self- and Other Awareness, Motivation, Dependency-Autonomy subscales and total scores, respectively. Pearson correlation coefficients were calculated on the above subscales to assess the construct validity of the SLQ-R. The scores indicate that the

subscales were significantly related for Self and Other Awareness and Dependency Autonomy, $r = .53$, $p < .001$; for Self and Other Awareness and Motivation, $r = .58$, $p < .001$; and Motivation and Dependency Autonomy, $r = .43$, $p < .001$. A multivariate analysis of variance (MANOVA) using trainee experience as the independent variable and the SLQ-R subscales as dependent variables was used to initially explore for differences in SLQ-R subscale scores between the groups. Hotelling's test of significance indicated that the beginning, intermediate, and advanced groups differed on a linear combination of SLQ-R subscale scores, $F(6,198) = 2.45$, $p < .001$. An analysis of variance (ANOVA), again using the independent variable of trainee experience, indicated that the total SLQ-R scores of the groups differed, $F(2,102) = .737$, $p < .001$. Finally, McNeill et al. (1992) conducted a series of focused, one-way planned contrasts in the form of one-tailed t-tests to test the hypothesis that subscale and total scores on the SLQ-R would increase as a result of trainee experience. Using an alpha level of .05, they found consistent significant differences in mean subscale and total SLQ-R scores between the beginning and advanced trainee groups as well as the intermediate and advanced trainee groups. Given that the levels in the validation study were set somewhat arbitrarily, the SLQ-R is considered a valid and reliable instrument for delineating a relative measure of trainee development level within Stoltenberg and Delworth's (1987) model.

The trainees' supervisee needs were assessed with the Supervisee Needs Questionnaire (SNQ; Stoltenberg, Pierce, & McNeill, 1987). The SNQ consists of 30 items in a Likert scale format (see Appendix E). The SNQ was designed to assess the needs of trainees within supervision along five conceptual categories: (1) Structure--the

need to have one's supervisor provide the structure in supervision, (2) Instruction--the need to receive specific instruction in areas such as assessment, diagnosis, and therapeutic skills and techniques, (3) Feedback--the need to receive direct feedback in regard to professional strengths and weaknesses, progress as a counselor, etc., (4) Support/Availability--the need of the supervisor's support, counsel, and availability for emergency consultation, (5) Self-Directed--the need to define one's own structure and criteria in supervision. The SNQ was found to be a valid measure of the trainee's self-reported needs in supervision at various levels of professional development (Stoltenberg, Pierce, & McNeill, 1987). One-tailed t-tests based on levels of education indicated differences in the predicted direction between levels 2 and 3 for structure and overall needs, as well as between levels 1 and 3 for structure, feedback, and overall needs. One-tailed t-tests based on semesters of previous counseling experience indicated differences in the predicted direction between levels 1 and 3 for structure, feedback, and overall needs, and between levels 1 and 2 for feedback. Finally, one-tailed t-tests based on number of semesters of previous supervision indicated differences in the predicted direction between levels 1 and 3 for structure, feedback, and overall needs, and between levels 2 and 3 for feedback and overall needs.

The relationship within counselor supervision was assessed with the 23-item Likert-style supervisor and 19-item supervisee Likert-style Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990). The supervisor instrument contains three subscales: Client Focus, Rapport, and Identification, and the supervisee instrument contains Rapport and Client Focus subscales (see Appendix F). Cronbach's alpha reliability coefficients resulted in internal consistency reliability

estimates of .71, .73, and .77 for the Supervisor subscales Client Focus, Rapport, and Identification respectively. Alpha coefficients for the Supervisee were .90 for Rapport and .77 for Client Focus (Efstation et al., 1990. p.325). Item-scale correlations for the Supervisor SWAI ranged from .29 to .54 for the Client Focus scale, from .29 to .56 for the Rapport scale, and from .38 to .57 for the Identification scale. Trainee SWAI item-scale correlation's ranged from .44 to .77 for the Rapport scale and from .37 to .53 for the Client Focus scale.

In addition, the Supervision Attitude Inventory (SAI; Stoltenberg, Ashby, Leach, McNeill, Eichenfield, & Crethar, 1996), a revision of the Therapeutic Reactance Scale (TRS; Dowd, Milne, & Wise, 1991), was used for the purpose of measuring psychological reactance specific to the supervision context (see Appendix G). The SAI is composed of 28 items that are responded to using a 4-point format from *strongly disagree* (1) to *strongly agree* (4). The items are summed to yield a total reactance score and two correlated subscale scores (behavioral reactance and verbal reactance). Cronbach's alpha reliability coefficients resulted in internal consistency reliability estimates of .76, .63, and .76 for Behavioral Reactance, Verbal Reactance, and Total Reactance, respectively. The TRS Cronbach's alpha reliability coefficients resulted in internal consistency reliability estimates of .81, .75, and .84 for Behavioral Reactance, Verbal Reactance, and Total Reactance, respectively. Test-retest reliability for the original sample ranged from .57 to .60 over 3 weeks, while internal consistency reliability ranged from .75 to .84. Lukin, Dowd, Plake, and Kraft (1985) found a 1-week test-retest correlation of .76 on the total scale.

Finally, the Supervision Evaluation Scale (SES; Tracey, Ellickson, & Sherry,

1989) was used to measure the evaluation of supervision by the trainees and the supervisors (see Appendix H). The SES is a scale consisting of 10 items measuring the positive evaluation of and willingness to work with the specific supervisor. Participants are asked to respond to each item using a 7-point scale from *very strongly disagree* (1) to *very strongly agree* (7). The responses of these 10 items are averaged to yield a mean evaluation score, with high scores representing positive evaluation. Internal consistency estimate of .95 was obtained.

The Critical Incident Questionnaire (CIQ; Heppner & Roehlke, 1984) asked trainees and supervisors to describe events related to critical incidents, or major turning points, within the supervision process that resulted in change(s) in the trainee's effectiveness as a counselor. For this instrument, a critical incident was defined as an occurrence that resulted in a significant change; that is an interaction between supervisor and trainee, which is recognizable as a kind of turning point, resulting in change(s) in the trainee's effectiveness as a counselor/psychotherapist. This definition was followed by three questions that asked for information related to the occurrence of any such critical incident in supervision; these were as follows: (a) Please describe any such incident in your supervision this session, (b) What made this a critical incident for you? and (c) What were you wanting to gain from this supervision session? Did you receive it?

Interviews were conducted with each participant across the academic year. According to Bogdan and Biklen (1992), interviews are used predominantly in two ways: as the primary source of data, or in conjunction with other data gathering techniques such as observation or written questionnaires. This second use is most appropriate for the proposed study because the interview can provide insight in analyzing participants' CIQs

and can lead to a better understanding of how supervision and personal aspects influence counselor training/development. Given that vital role in the data collection, it is important to consider some of the issues associated with interviewing and interview data. McCracken (1988) outlined several concerns related to the conducting of interviews. One point made is the importance of questions and their influence on the resulting data. Interviewers can unintentionally skew outcomes by using inappropriate questions (too open or too restricted), not listening carefully, or failing to follow-up with suitable prompts. Researchers should match their questions to the research goal (Bogdan & Biklen, 1992). For exploratory studies, questions may be open-ended while more structured questions provide support for specific research topics. In any case, those conducting interviews must take care to avoid so much control that the respondent "cannot tell his or her story personally in his or her own words" (p. 97).

According to McCracken (1988), questions at the beginning of a longitudinal study could include questions gathering biographical data or small talk in an attempt to locate common ground between the interviewer and respondent (Bogdan & Biklen, 1992). A common approach begins with biographical data before moving on to general questions about attitudes toward the research topic, and then in later interviews, questions about specific details revealed by observations or other data collected. Such a technique of moving from biographical data, to general questions, to specific details might help build the rapport between researcher and participant which is important to this type of data collection method.

The rapport or relationship between researcher and respondent was another concern of McCracken (1988). He commented on the unusual nature of the interview

and its differences from conversation since one person does most of the talking and the other essentially listens and probes with questions. McCracken believed that such a social dynamic requires careful crafting to meet the goals of the research and at the same time protect the rights of the respondent.

Rosenthal (1966) explored other aspects of the researcher-respondent relationship. He found that several factors influence participant behaviors including gender, age, race, cultural background, and volunteer status (Rosenthal & Rosnow, 1975). For instance, female participants tend to be treated more considerately than male participants. Also, volunteers tend to have unique characteristics all their own: are most often first-born, have a high need for approval, and are more sociable than non-volunteers. These few factors and the hundreds of others brought to light by Rosenthal suggest that no matter how neutral and unbiased the researcher wishes to remain; human interactions could influence the data. Such interactions do not mean that conducting interviews is an inappropriate way to gather data. On the contrary, the interactions and relationship between researcher and respondent reveal information otherwise lost or buried. Knowledge of the factors that could influence interview data allows researchers to develop adequate questions, to plan the interview session, to handle unexpected responses, and to analyze the results in the most appropriate way possible.

For the proposed study, careful attention should yield results, which will add to the body of knowledge about supervision and the development of counselors. Interviews will give access to personal, counseling, and supervision experiences, as well as educational backgrounds that guide supervision and affect counselor training.

Procedures

Data collection involved the following procedures. The Critical Incident Questionnaires (CIQ; Heppner & Roehlke, 1984) were completed independently by both trainee and supervisor following every supervision session from September 1996 through May 1997. Objective questionnaires, including copies of the Supervision Evaluation Scale (SES; Tracey et al., 1989), Supervisee Levels Questionnaire-Revised (SLQ-R; McNeil et al., 1992), the Supervisee Needs Questionnaire (SNQ-T, SNQ-S; Stoltenberg et al., 1987), the Supervisory Working Alliance Inventory (SWAI; Efstation et al., 1990), and the Supervision Attitude Inventory (SAI; Stoltenberg et al., 1996) were administered three times, at the start (September 1996) and completion (December 1996) of the fall semester and then at the completion of the spring semester (May 1997).

In addition, audio-taped personal interviews, lasting approximately thirty minutes to one hour each to follow up on responses to the questionnaires, were conducted six times for each subject across the Fall and Spring semesters on the following dates: October 4th - October 11th, 1996; November 15th - November 22nd, 1996; December 16th - December 18th, 1996; February 18th - February 25th, 1997; April 5th - April 11th, 1997; and May 5th - May 9th, 1997. The principal investigator conducted interviews.

Commonalities

The results reported in this paper are based on the analysis of interviews with two first-year and two second-year Counseling Psychology doctoral students and their respective supervisors. Both first-year students had obtained one year of masters practicum prior to this year. The two second-year students had completed masters practicum plus one year of doctoral practicum. In addition to being exposed to the same doctoral academic courses, these trainees conducted treatment in the same psychology clinic, therefore working with the same clientele population. Finally, both first-year students were in the same practicum seminar class. The two second-year students were, also, in the same practicum seminar with one of the supervisors the fall semester and the other supervisor the spring semester.

The author of this report conducted six interviews with each trainee and his respective supervisor at four to five week intervals during the Fall 1996 and Spring 1997 semesters. All interviews focused on the counseling and training experiences remembered and their reaction to and interpretations of these experiences. In the last interview, the researcher asked trainees to review the factors most salient to and those inhibiting their counselor training across the 1996-1997 academic year.

The interviews were recorded and then transcribed for analysis. In the first level of analysis, the Critical Incident Questionnaires (CIQs) and the transcripts for each trainee were read and reread to identify the trainee's relevant counseling and training experiences. In the second stage, the author charted each theme and then wrote a short summary for the main commonalities identified. The experiences were then categorized according to Stoltenberg's et al. (1998) eight domains (Intervention Skills, Assessment

skills, Interpersonal Assessment, Client Conceptualization, Individual Differences, Theoretical Orientation, and Professional Ethics). Finally, the author examined transcripts for evidence concerning trainees' experiences inconsistent with or not predicted by the Integrated Developmental Model.

Sources of influence on the data could come from various presses, such as individual differences (training, experiences, personality, etc.), and different supervisors. Nonetheless, there were also commonalties, such as the trainees were all in the same program, there were constant pressures, and so on. It was the commonalties across the 2 first-year students (see Tables I1, I2, J1, and J2) and across the 2 second-year students (see Tables K1, K2, L1, and L2) throughout this year of research that will be reported in this chapter.

First Year Doctoral Trainees

From this study, across the first-year doctoral trainees a lot of attention was given to Counseling Skills, Theoretical Orientation, and Professional Identity. Each commonality will be reported separately (see Tables I1, I2, J1, and J2).

Counseling Skills

This commonality considers the trainees' confidence in their knowledge and ability to perform a therapeutic intervention adequately and/or time it appropriately. In this study, both first year trainees began the year with a lack of self-efficacy in their ability to carry out therapeutic interventions. Initially, both trainees looked to their supervisors to provide detailed interventions as well as additional readings and information. In addition, both first year trainees presented as very aware, and somewhat anxious, about this initial lack of knowledge and skills. However, as each trainee took

active responsibility for searching and reading relevant literature and as his client caseload increased, a confidence and perceived sense of autonomy with his intervention skills slowly grew.

At the beginning of the year, in interview 1, the first year doctoral trainees discussed their insecurities in implementing therapeutic interventions.

Alan: I would probably structure supervision in the exact same way that it's being done, but with more specific direction in terms of what outside reading I need to be doing and what I need to look for in terms of specific things. I don't feel like I know the counseling process well enough. I feel like I ask questions, and I deal with things with clients and we talk about things, but I don't feel like I am directed . . . I want to be told exactly how do I use this and how do I do this specifically.

Dirk: I was gone and had a leave of absence for a year so that kind of threw me off a little bit. I knew it would but maybe it did more than I expected. My supervisor has been encouraging me to look at things I might not have otherwise looked at and to look up information . . . I'm still feeling kind of shaky about the whole thing and just need get an idea of what I should be doing when. Most of my experience has been with adults, dealing with adjustment issues, depression, anxiety and that sort of thing.

In his week seven Critical Incident Questionnaire (CIQ), Dirk reported, "My supervisor emphasized the importance of research to clinical practice and suggested that I use my down time to read up on therapeutic techniques and theory." By mid-November, Dirk had begun to put together his own professional readings file of different relevant topics related to therapy and clinical issues. As a result, he presented with a perceived sense of autonomy in session with his individual adult clients. However, new to couples counseling, he reported a dependency on his supervisor.

Dirk: I've begun to put together my own professional readings file of articles and other stuff I went and got about different topics related to therapy and clinical issues, so that has been a good thing . . . This is my first couple. My supervisor is suppose to give me some information about couples therapy.

During this same time Alan continued to struggle with a sense of therapeutic ineffectiveness. Alan reported a great deal of dependence on his supervisor in his CIQs at this time.

Alan: I wish there was an instruction book that tells you how to implement these things. I feel like I have the general understanding, but I have no idea of how to use them in a session. I tend to just fire questions continuously without really having a conversation.

Just before the Winter/Christmas break both first year students were still looking to their supervisors to provide readings and specific therapeutic interventions. In his week 11 CIQ, Dirk reported, "My supervisor wrote out a first session outline for me to use in a couples counseling situation." Although Dirk continued to look to his supervisor to provide concrete direction in couples counseling, he worked with a perceived sense of autonomy with his individual, adult clients.

Dirk: My supervisor sat down and kind of wrote down a plan for a first session with them and we haven't gotten through it yet . . . My supervisor also gave me a big ol' chapter on integrated behavioral couples therapy. It's been really helpful, 'cause I've been very much up in the air about that. It's been helpful, I haven't gotten through all of it. It's been good.

Frustrated, Alan summed up, and attempted to account for, the fall semester's lack of progress in therapeutic interventions.

Alan: This semester I really had very few clients and didn't feel like I learned a lot counseling wise. I think my supervisor and I were both frustrated that I didn't have new clients, and we were trying to do stuff and we couldn't really make progress, just cause I didn't have anybody to experiment or try out new things. I had the same client every week and we watched his video tape every week and that's all we'd be doing. I don't feel like I'm improving that much with my counseling skills. I think the majority of that is the limited client load. I don't think any supervisor really has a chance if their trainee isn't seeing any people. And there's always these mystery readings I'm going to get, but I still haven't seen any.

By the end of February 1997, both trainees had reported an increase in client case-

load. Both trainees also reported an increase of enjoyment derived from their counseling sessions with individual clients. However, Dirk reported that he still felt "a little overwhelmed" when he worked with couples. Just as Dirk had begun to put together a professional readings file in November, Alan had now begun to conduct and read his own literature searches relevant to his clients. As a result, like Dirk, Alan reported a perceived sense of autonomy in implementing therapeutic interventions.

Dirk: I feel I enjoy counseling more now than I used to. I would say that, you know, for sure. Typically, I rarely have a session that I come out of like, 'Oh, it sucked,' and it ruins the rest of my day, and things like that. Usually it's more apt to be the opposite route. It seems to be - whether it went particularly well, just the, you know, the whole process, I really enjoy it right now. For one thing, I don't typically sit down and plan out what I'm going to do before I go in where I used to do that, and end up not following it anyway. But I don't do that anymore, and typically I don't feel I need to. With a couple I do sometimes, because I feel a little overwhelmed. It's just one of those things where the more you know, the more you know how little you actually know. I think that sums it up.

Alan: Counseling is a lot more productive now, and it's a lot more enjoyable than it was at any point last semester. Part of it is I finally had more clients and done the reading and the preparation. I don't feel that pressure to need to solve things like I did last semester. And some of that letting go of that frustration stuff made it more fun for me to do the reading and research what's going on and it just made counseling in general more fun. I feel like I now have control over what's going on.

In interview five, April 1997, both trainees continued this level of confidence and perceived sense of autonomy implementing interventions. In addition, both attempted to account for this sense of confidence. *Italics have been added to emphasize main or important points within quotes.*

Dirk: I'm just totally paying attention to what the person is telling me. I feel, I mean, almost invariably something happens in the session that I feel I'm just useful or productive or enlightening or something. Whereas the first year, I was always sitting there thinking, 'Oh gosh, did I remember to put the tape in?' or this, that or the other. And now most of the stuff just I've gotten comfortable with and it's not a problem. And I can get into their

world a little better than I used to. And I feel more confident about things, so it's been real good. Very rarely do I ever find myself lost or not knowing what to say, as soon as I say things that aren't terribly pertinent, I'm usually aware of that when I'm doing it. *I really think more than anything else it's just been experience, more clients that has contributed to the confidence.* When I was with clients, that's always the most stressful part of the week, but it's also the best. At the end of the day, I come out of it feeling pretty good.

Alan: Counseling has continued to be positive. It's continued about the same since that last interview we had. But as far as anything that caused that, I don't know exactly what it was. *Maybe I came in with a better attitude this semester.* Part of it for me was that day I went into supervision, and showed my supervisor that I wasn't just firing questions at people any more. His approach kind of changed after that, I guess. I think both of us kind of let loose the reins a little bit or backed off or eased up or something. I also remember telling you that I was looking for a tone of support from my supervisor and looking for him to direct me and this semester, I haven't looked for that. *I've done the stuff on my own and then just kind of gone and checked in with my supervisor.* The other thing that happened, which I didn't think about, between the end of last semester and the beginning of this semester was that I got new clients. *When I got new clients, I think I got a chance to try some of the stuff out on the people and new clients and start fresh with somebody. So part of it was maybe, I just got new clients and got some more experience.*

At the end of their first year of doctoral training, the trainees maintained a comfortable, steady level of confidence in their therapeutic intervention skills.

Alan: I believe in a model where you always stay at a level and then all of a sudden you improve and then you go back to being level . . . and I guess for me, I just, for whatever reason, I was ready to improve my counseling in January, February and now I'm back level again. I feel like I haven't really made a huge improvement at the end of this semester.

Dirk: Beginning out, my focus at that time was the structure of the thing and ... well, some of it was, "am I sitting right, am I . . . That kind of crap. That doesn't even cross my mind anymore, I don't put a lot of emphasis on whether I'm leaning forward or whatever. I think I know how to appear interested to somebody, everybody does it all the time in conversation, so I think it's silly to put too much emphasis on that. So I don't worry about that kind of stuff so much. Occasionally I'll find myself leaning way back and . . . or looking out the window, I've done that a lot, cause one of my client's is blind, so he doesn't know, so I'm looking out the window the whole time I'm talking to him . . . I've got to stop doing that.

Theoretical Orientation

This commonality includes the trainees' knowledge and application of formal theories of psychology and psychotherapy. In this study, the first year doctoral students reported a discomfort with their lack of detailed and integrated knowledge of any orientation. As a result, both attempted to gather information on formal theories of psychology in order to identify an orientation that worked. Eventually, they both chose a base orientation to work from, but comfortably dealt with their limited knowledge of any given theoretical orientation. Finally, the trainees began to realize that no one approach worked in all cases and began to broaden their knowledge from one chosen orientation in order to learn about and try out different theoretical orientations.

Five weeks into the Fall Semester, October 1996, both trainees reported a discomfort and an uncertainty about their own theoretical orientation.

Dirk: Well, I guess I probably best identify with the cognitive-behavioral because that seems to be the theory of choice of many of my supervisors. It is more comfortable because it is easier, at least it's something you can sink your teeth into. I don't feel like I ever picked up the theories very well the first time around in the one or two classes and that is what everything else is based on.

Alan: I'm uncomfortable with my theoretical viewpoint. I don't feel grounded. I don't know what I'm doing. I know that's where I'm supposed to be, but it's not comfortable. I feel like I ask questions, and I deal with things with clients, but I don't feel like I'm directed in my questions or my questions are all coming from the same theory. I'm thinking about theories as a textbook cookbook, which they're not, and I wish there was a cookbook for this recipe, this is exactly what I have to add and exactly what I need to do and then they are okay. I guess I don't feel comfortable, but, and I know you can't do that with theories, but I feel like I need to do more than I'm doing.

For the remaining of the fall 1996 semester, Dirk reported more comfort with a chosen theoretical orientation. However, Alan continued to struggle to identify a chosen

theoretical orientation.

Dirk: I feel like I'm starting to do better, I've definitely become a lot more comfortable with cognitive type therapy. It seems to kind of fit my style. I kind of cling to the cognitive part because, like I say, that's something I can understand. I just came to the realization that well, I don't know a whole lot about this so I needed to kind of pick something and stick to it. Going from the cognitive approach I picked, from the literature, you know, well, I need to stick to something and then broaden it as I go.

Alan: I wish there was an instruction book that tells you how to implement these things. I feel like I have the general understanding of theory, but I have no idea of how to use them in a session. I really want to be more theoretically based and have what I do rooted in theory and I still hate the interviewing and I guess I'm realizing that theories aren't you put this part together and this part and this part and you've fixed it. And I wish there were. But I'm realizing that there's not. And, I keep looking for this instruction book and it doesn't exist so it's been frustrating. So I wouldn't say that I have a theoretical orientation right now. If anything, I would rely on cognitive-behavioral approach.

Five weeks into the Spring 1997 semester, both trainees identified a theoretical orientation from which they attempted to work. By this time both trainees had begun to read the relevant literature and prepare for supervision. However, both, also, seemed to accept their limited theoretical knowledge at this time.

Dirk: Applying theory on the one hand is getting easier, and on the other hand, I'm kind of thinking, well, my understanding of efficacy studies and that really doesn't matter, so, as far as what theory you use, that, as long as you use it well. I guess I'm not so much thinking what will work, like a doctor thinking of medicine, but what makes it easier for me to conceptualize. What makes more sense kind of theoretically. I think of a more rational approach anyway. Overall, since Christmas break I'm just kind of cruising along on autopilot. I haven't really been doing a whole lot of thinking. I do whatever I'm told. I'm just floating through to Spring Break kind of thing. I'm motivated to keep up, but I'm not threatened about things like I probably should be.

Alan: I'm feeling a lot more comfortable with not being completely sure what to do. I don't feel as much pressure now to have to tie myself to a theoretical orientation. But, I'm also able now where I can take a client's problem and think about it from different perspectives where I couldn't before. But

I've given up the idea that I need to use a manual in session. I can use cognitive-behavioral interventions.

At the end of their first doctoral year both trainees reported a return to uncertainty about a theoretical orientation. However, now, both reported more security with the theoretical knowledge they worked from and expected to augment this knowledge.

Dirk: I don't know, I probably don't have a theoretical orientation, probably as eclectic as anything. And I'm trying, very actively trying, to formulate an eclectic approach, because I just don't see the rationale in picking one thing and sticking to it because you are told to or whatever. But in the sense of trying to learn 2 or 3 different orientations well and within their parameters and pick and choose in terms of. Well, in terms of conceptualization, probably sticking to one, but in terms of procedure, probably taking form all of them. So trying to be truly eclectic, as they say, as opposed to just doing whatever. But definitely lean more towards cognitive type therapy than anything.

Alan: The whole time I've been saying I'm cognitive-behavioral, but I'm not cognitive-behavioral. I have no idea what I am. More client-centered than anything and I really don't like it. I just get so much crap about being client-centered from everybody that it's just not enough that this program supposedly teaches us to be cognitive-behavioral, but I haven't picked it up so far and I wouldn't say that I will . . . But that's still not a question I can answer with a great deal of confidence. But the difference is this semester I'm okay not knowing what my theoretical orientation is. Before I felt like I had to have one before I even stepped in the counseling room and there was something wrong with me that I didn't know what it was. I feel like I do a good job with my clients and that I'm still learning about theory. And I'm learning to use different ones, but I guess before I felt like I had to know what my theoretical orientation was to be confident in counseling.

Professional Identity

This commonality considers the trainees' understanding of and confidence in the efficacy of the counseling profession. In this study, both first year trainees began the year skeptical of, and even pessimistic about, the effectiveness of their chosen profession. Dirk seemed to externalize this process, as evidenced through his stated disappointments by the irrelevance of research to the efficacy of the field and his role as counselor. For

Alan, this process appeared internalized as he became more and more frustrated with his lack of understanding of the counseling process and his ineffectiveness in the counselor role.

Dirk: I feel like I've learned a lot more, learned a lot about counseling, which most of all I learned was quite disheartening. The irrelevance of most of the research being done, the political climate that doesn't allow any relevant research to be done or very much. I know I'm exceedingly pessimistic about this but I don't know, I just call it like I see it and I think there's good research being done in psychology. I just don't think there's much being done in counseling per se. There's good research even being done with counseling psychologists but what I see, even in our program, I don't see them studying counseling very much. I see them studying, you know, individual differences in certain populations and characteristics but I don't see them studying does this kind of therapy work better than this one. There's only a couple of studies that I know of dealing with that. Just the efficacy of the whole thing.

Alan: The past month was better in terms of, I think, I picked up a couple more clients and I've had to do some more stuff, but it still isn't fun to do, it's still frustrating and a pain in the neck. Counseling in general, I'm feeling pretty ineffective . . . I feel really ineffective and don't have the confidence to really help them, or help them change attitude...

Toward the Winter/Christmas break the trainees verbalized their understanding or conceptualization of the counseling process. In his week seven CIQ, Alan reported a walk with his supervisor in which he was asked to define counseling. Alan discussed this same incident in an interview.

Dirk: But, yeah, I probably conceptualize counseling much more as an art now even then I did when I started. All this science-practitioner model be damned is still what I think, but I think, too, you have to look at from a critical standpoint, you know. Um, well, yeah, even in class though we often, we pay a lot of lip service to being data driven and all that but when it gets right down to it, what I really hear people doing is going with their gut instinct a lot of times. I've, you know, had a chance to work through some professional type issues and stuff that's been here.

Alan: One day my supervisor and I just took a walk down the street, but we just took a walk and he asked just fundamentally what I thought counseling was and I never really thought about it like that. I was thrown into the theory, in learning theory, but I never really came in with an idea of what,

away from everything else, I thought counseling was. So it was good to be able to talk about that. And I still don't know if I know the answer to that question but it's been nice to think about.

As the year progressed, the trainee's understanding of their professional role and level of efficacy in the counseling field appeared to grow. Dirk connected this growth to knowledge gained from courses, which focused on efficacy studies. Also, in his week two CIQ for the Spring, Dirk reported that he and his supervisor "discussed the importance of the political BS in our profession and that without politics, unfortunately, nothing gets done." Alan, however, linked his growth to an increase in his client load and his efforts to search out relevant literature.

Dirk: I have a little more of a sense of competence. Kind of more - feeling more comfortable from my end, being some of it. *Maybe little by little seeming to be more convinced of the efficacy of the whole thing. And that -that not so much from experience, but we had to take a couple of classes where we had to read a bunch of outcome studies and things like that.* Which I think, while they might have a little dubious methodology in that, typically, its a pretty consistent theme, and it does help. In fact in some cases it helps quite a bit. And its helpful. At least we feel better about it.

Alan: I feel more confident now. Part of it was - remember we, I don't know if you remember, but I asked tons of questions, and every time I saw a client it would just be one question after another, and I finally have gotten away from that. *And the other part of it is I finally had more clients and done the reading and the preparation so it made supervision go smoother. And some of that letting go of that frustration stuff made it more fun for me to do the reading and research what's going on and it just made counseling in general more fun.* Like a client comes in and you get a hypothesis about it where were supposed to use the scientist practitioner and I don't think I really knew what that meant before this semester; that you go through and you read up on what's possibly going on, and you start to have a hypothesis about what you think and then, I don't think I was doing that before.

At the end of the year both trainees reported their current understanding of and level of efficacy in the counseling process, and ultimately the profession.

Dirk: Just a little more experience and being more confident about things. I just

started feeling like, "yea, there really are people that really do need help and this really is a useful situation." I still, often times, will be sitting there talking to someone and think I have the weirdest job in the world. I've never heard of a job where you sit down and talk to people and they pay you to talk to them. Sometimes I feel like a prostitute. I really do, because it's like the patients pays you to be their friend kind of in a way. I know I have one client that it feels that way almost. But I think it's such a weird job and yet at the same time it's really pretty good. I can live with some weirdness, it's not a problem really. I would say more so, I've struggled less with the relationship with counseling and the usefulness of it and more with just all the rest of it, the politics and that, what's espoused to us, you know, all the science-practitioner stuff.

Alan: Last semester, I just needed to give up those ideas that I need to create change in clients and that counseling is black and white, some of those . . . you come in with certain impressions of counseling, I mean you wait for those answers and you realize that those are the wrong questions to be asking... I think it takes the person to develop to a point, I don't think you can come in and say anything magical that makes that disappear. I think you just have to go through the process yourself, and I think it's a process that everybody has to go through and I don't think there's any magical answers to change that right away. Just getting enough experience with clients and seeing enough people in different situations to . . . it's kind of like when you're a parent, you can tell your kid not to do something, but until they've done it, they don't know what that means. Until you've had the experiences with seeing the clients and screwed up on your own and done some stuff right on your own, then saying it doesn't click, unless the person is ready to hear it, I guess, and I wasn't ready to hear it last semester, and I was ready to hear this semester.

Second Year Doctoral Trainees

From this study, across the second-year doctoral trainees a lot of attention was given to Use of Affect, Theoretical Orientation, and Counseling Skills. Each commonality will be reported separately (see Tables K1, K2, L1, and L2).

Use of Affect

This commonality considers the trainees' awareness of and ability to use affect in session to either elicit responses from the client or use his own emotional reactions to the client as an indication of social skills status or the presence or absence of certain

personality characteristics. In this study, both second year trainees began the year with reports of having their eyes opened or an increased awareness of their own emotional reactions to clients. Initially, the respective supervisors assisted them in developing an awareness of their own reactions to clients. Phil's awareness and increased ability came through his struggle to confront clients with his emotional reactions to them. For David, awareness came through his struggle to move away from the security of working with cognitions to the less secure realm of emotions -- his own and his clients. As the year progressed and both second year trainees increased in awareness of their own emotional reactions within any given session, then they began to report a greater appreciation for what the client actually felt and experienced.

In the fall semester, through CIQs and interviews, both trainees commented on critical incidents within supervision, which produced eye-opening experiences for them.

Phil: One week ago, I talked with my supervisor about how frustrated I was with this particular couple. My supervisor said that it is important that I let them know about my frustrations and tell them. It kind of *opened my eyes to how my frustration was interacting with my therapy.*

David: . . . Um, so, those kind of things and *some in-session dynamics like being aware of how I am feeling about something the client is telling me and using that affect in myself to direct me in intervention.* You know, my supervisor pointed out to me one time where I kind of went after and confronted my client that's the exhibitionist because he was talking in stereotypes about women that I didn't particularly agree with and I, I started going after him on it and, you know, he watched the tape and my supervisor said, you know, what were you feeling right there and I hadn't really stopped and thought about it and forced myself to think about what I was feeling. And I told him, you know, I was kind of pissed off at what he had said and thought it was demeaning toward his wife because, you know, his wife is actually hurt because he's going out and exposing himself to other women that he doesn't even know and he's turning it around and trying to say she's the bad guy and I didn't agree with that. And so I went after him. *And he said that's why it's a good idea to be aware of kind of your barometer and where your affect is because you can*

use that as a tool to know when something's not right and I thought that was insightful.

Toward the end of the fall semester, the trainees reported an awareness of their own reactions and on-going struggle to use affect in session. Phil appeared to have an awareness of his emotional response, but struggled with fears and questions of how to use this in session. At this same time, David expressed, through CIQs and interview, an understanding and appreciation for this new technique of using his own thoughts and feelings in session, but admitted a level of discomfort with the application use of affect.

Phil: Well, I think from supervision for the last couple of weeks has been working really with that couple and my supervisor trying to empower me, I guess that's the term, to confront the couple and tell them that I'm frustrated and angry and upset with them. And it's really frustrating in the session when they bicker back and forth, so my supervisor is trying to get me to the point where I can confront them and really feel comfortable about giving it. *I'm not really comfortable with that because I feel like I may, I mean they're very hostile as it is and I don't know if I say stuff like that how that's going to affect their relationship or affect them down the road.* My supervisor gives me examples of what to say, a little bit of a role-play, but him just kind of saying this is what I would say in this situation.

David: I have more of an appreciation for what the client's experiencing and what they're going through, the emotional side and the soft stuff. Not their right parietal lobe has a lesion and it's causing them to do this or not being able to do that. That they're doing that and experiencing that, but it's also impacting their life in this way and they're depression . . . *But I feel like I need more growth in the affect-based strategies, as far as just feeling comfortable doing it. In supervision, I just want to get more feedback on how I'm working with affect and to grow more in that area because that's what I'm really working on right now.* Uh, you know, and my supervisor made the point you can't fake empathy and I agree with that and I don't have an absence of empathy. *I just don't express it to my clients and that's what I'm working on, being able to get in there with them and really talk about one specific thing and have a feeling about it. That's where I want to grow.*

Further into the Spring, Phil reported growth through finally confronting the couple. David, also, reported a greater investment and understanding of the clients'

world as he continued to work for a level of comfort with the application of affect and use of self in his therapeutic work.

Phil: Yea, that couple, I told them, "you act like a mother, and he acts like a 10 year old. And that was actually the last time I saw them. They failed to continue to show up, so they were terminated. I felt happy and relief. *The confronting the couple was very difficult. I think the accomplishment of feeling more comfortable with confronting and being able to deal with difficult clients that were really pulling me emotionally, was good. I'm not as afraid now to confront, because I know that if they leave, they weren't ready to hear that, or weren't ready to focus on the issues that were really affecting them. Yeah, I felt comfortable after I did it.* When they stopped coming in, it relieved my emotions because I didn't like working with them in the first place. But, I think this showed exactly where they were, and where they didn't want to go. And I've used that same confrontation in another session, and the couple continues to come back

David: *I don't think awareness of my reactions has restricted my ability to focus very much. I mean, I am thinking about it during session, but I'm still able to focus on the client. I don't know that it gets that restrictive. In some sense it might have encouraged me to focus more on what they're going through. I'm getting better, but not where I want to be. I feel like I've made progress in that area, but I catch myself falling back into old habits. Especially with the male client, he's real cognitive and it's real easy to get on that. The mood. And that's where I need it the most, cause him and I both feel that that's what, me and my supervisor both feel that that's what he needs, the client needs, cause he has trouble with affect, so our goal is for me to model that for him. For awhile my supervisor would just kind of talk about it and we would discuss it kind of abstractly, but I've taken the lead with asking for more examples and have him display for me what that would look like in session and so he sort of started kind of modeling what I could do and that's been very helpful. So I can talk about it all the day and be in session and not really know what to do.*

Theoretical Orientation

This commonality includes the trainees' knowledge and application of formal theories of psychology and psychotherapy. In this study, the second year doctoral students identified a base theoretical orientation/approach with which they were most comfortable. As a result, both continued to gather information on their chosen theoretical orientation throughout much of this year. However, toward the end of the year, both

reported turning to the relevant literature to direct their interventions. Thus, they broadened their knowledge and applications of various formal theories and techniques, while maintaining a firm grasp on their already identified base theoretical orientation.

At the start of the academic year, both trainees reported a knowledge and comfort with a chosen approach.

David: I probably lean the most on cognitive-behavioral therapy. We're trained in that pretty heavily in the clinic's study. And I really like it. And I'm not just saying CBT because that's everybody's waving a flag, but we actually were trained in it and I like it.

Phil: Well, I take a really Rogerian, Client Centered approach and I think I develop a really good working relationship with my clients. I think my empathy and my genuineness is very strong.

By February, both trainees identified a strong commitment to and desire to deepen their knowledge of their chosen theoretical orientation, as well as a willingness to broaden their understanding and application of other approaches. For David this meant a goal to learn more about Beck, Cognitive-Behavioral Therapy, and other approaches. As a result of feeling 'attacked' by peers for his Humanistic approach, Phil expressed a confidence in and a justification for his chosen approach, and yet he reported that he had consulted and applied other approaches/techniques as recommended.

David: I want to try to become more versed - I've reached this stage with CBT where I have a basic understanding of it, but if I don't have a depressed patient in front of me, that's producing fairly obvious distortions in thought, I'm not sure how to pull those and work with clients that are less expansive. And I don't have a good feel for how much Beck expected everyone, all kind of clients to have certain patterns of thinking, and whatever. So I want to get more versed and get a deeper understanding of Beck's approach, and I'm working my way through his book, so that's one of my goals. And then just to get a basic, better appreciation of as many approaches as I can. I just think there's more to CBT than I know. I don't think I can defend it very well if somebody attacks it.

Phil: I feel I know what I'm doing. And I feel when I go into session and talk to

my supervisor about what I've done, or what I'm doing, or where I'm going, he doesn't have any comment, he agrees. He says, "Sounds good, sounds like you're doing the right thing." And so I feel very confident in the approach that I take and I don't think - I've never had a client - I mean, this is going to be weird - I've never had a client that after using the approach that I use, you know, humanistic views, I've never had a client just not show up and never come back, you know, that after four sessions left, almost everything - everybody I've had has been, you know, for the long-term or for the duration of counseling. And so I think that gives some credit to my abilities. I'm not really interested in what my peers have to say because I think they're full of dodo when they talk about object relations in there. I'm comfortable with what I'm doing and happy with what I do and I think I do a good job. I'm comfortable with it. I'm confident with it so why change because someone else tells me I should? I do the research on my clients, I know - I have a client now with OCD. I've done the research. I know cognitive behavioral. I'm doing those approaches in there with them. And I feel confident in what I'm doing. And I see only changes in my clients, and my clients have given me praise for, for what I've been able to do.

In April, both trainees reported experiences in which they broadened their knowledge and skills in approaches outside of their chosen theoretical orientation.

David: Actually, looking back at it, the interpersonal intervention eventually opened up the way for the client to make some insights. Cause one of the things is, that the literature pointed was the lack of emotional intimacy and maturing in that area is what leads to a lot of exhibitionism. And talking over with my client about that kind of helped him make big insights. And so far it's kind of changed him. So in that sense doing a lit search actually helped.

Phil: I did a bunch of research on OCD. So, looking at the cognitive-behavioral aspects, the psychodynamic aspects, the interpersonal aspects and cognitive-behavior is pretty much the clinic's study - dysfunctional thoughts tracking them, the strive for perfection, everything the cognitive-behavioral therapy talked about was specifically what he was telling me.

At the end of the academic year, although both trainees reported an unwillingness to change or give up their chosen approach, they did express a willingness to incorporate successful, or literature recommended, approaches and/or techniques. David reflected on how his 'naive loyalty' to one theoretical orientation last fall had broadened to

incorporate other approaches and techniques. Phil defined himself as more Humanistic, but was willing to direct his therapy according to the relevant research.

David: Well last September I was heavily involved in, you know, CBT and learning more about that and the client and also being able to do couple's therapy. And the focus has shifted from a naive loyalty to those approaches to trying to learn more about them, I've sensed they're not always as effective as I would have thought they were. And now I'm trying to learn more about them to see, you know, Beck and Jacobsen, how they address the more difficult cases and what their reasoning is when it doesn't work. Well, just, I'm not really answering the question you asked. But being encouraged to adopt an affective, almost feminist-based therapy, it's almost been implied that I don't use the CBT as much. I don't know if my supervisor intended that or not, but in some ways I reacted against that, because I'm not willing to give up CBT, but I'm willing to incorporate more affective stuff into it. I believe CBT is effective, but you do have problems sometimes with it with some clients.

Phil: Well, at this point I'm definitely more humanistic, but then I did research with the OC client and cognitive-behavioral came out on top with techniques to use, and the other two I had to use cognitive-behavioral approach since that was what was the focus of the study. So I consider usefulness in a combination of both of the two. I think, humanistic, but with cognitive-behavioral tendencies. I can see the reality for the therapeutic ideas involved and once you have the relationship I think you have to take it a little bit deeper. If there's obviously cognitions that are, I mean with OC it was obvious cognitions - it's obvious there's a cognitive dysfunction going on, so you couldn't just bypass that for the sake of the humanistic approach, that's where the research showed to go and that's where he was showing that he needed to work on was cognitions, so. But I wouldn't say that I operate in a solely cognitive-behavioral approach at all.

Counseling Skills

This commonality considers the trainees' confidence in their knowledge and ability to perform a therapeutic intervention adequately and/or time it appropriately. In the first interview both second year students readily offered a clientele population they felt comfortable counseling. Phil reported a comfort with adults overall. However, he reported limited experience with couples and currently struggled treating his couple

client. David explained that he has grown more comfortable working with couples and depressed women as result of his participation in a study utilizing a cognitive-behavioral approach to treat those populations.

Toward the middle of the fall semester, both trainees discussed how they compared their own counseling skills to the counseling skills of others to help define their level of confidence in their therapeutic skills. While David chose to compare himself to his trainees as well as his supervisors, Phil chose to compare himself to his trainees and peers.

David: I'm kind of in that ambivalent stage where you've got the basic skills down and you feel pretty good about those, but yet you know there's so many areas in which you have to grow and so you're kind of regressing. I mean, it's so . . . I guess, it's where you actually regress a little bit in your microskills and your basic skills, because you're going to look, "where the hell am I going with this client, because I'm conceptualizing it like this?" And so, when you're trying to do that, you actually regress as far as your empathy and all that, the basic perfection of those kind of things. Yea, I guess I could go back to that kind of ambivalence stage that I was talking about and that's, you feel like you've got a pretty good grasp on the basics and feeling pretty confident in doing those, and tackling new clients and being able to sort of conceptualize a case and try to push it towards that conceptualization, on skills and techniques that go along with that perspective. But at the same time, you get this feeling that this is usually when you compare yourself to your supervisor or other professionals or professors that you see doing therapy as a licensed psychologist, how they talk about a case, the myriad issues that go along with the case, perspectives you hadn't really considered. And you just realize that you have so much farther to go and you start wondering if you'll ever be that good.

Phil: Well, I think looking back and looking at the master students and the first year doctoral students that I look at how I'm doing and I guess I started, you know, thinking am I doing good. How am I doing with my counseling skills and etc.? And then I listen or I watch some of their tapes and I think, I feel more confident in my abilities then. There has been some big changes made from master's, from first year doc to second year doc work. I think the experience and being comfortable and finally figuring out the style that I enjoy working with. Well, I guess watching what has, you know, in my other supervisees and classmates but they all

ridicule me for Rogerian counseling because they think it's a bunch of baloney and it's, you know, leaning forward, you know, my body posture is always leaning forward into the client and being really in tuned to the client and they all make fun of me for that on a regular basis. So, I guess, on one hand I'm kind of self conscious about it. But, on the other hand, I don't see them making any bigger strides or improvement than I'm making so obviously there can't be much of a difference between the two approaches. And every now and then, I watch some tapes of classmates and think, what the heck are they doing. What is that? But, I wouldn't dare say anything because of the repercussions that would definitely come back to haunt me.

At the end of the fall semester, both trainees reported a sense of growth and comfort in their counseling skills with the clients they had been working with over the past several months.

David: I think it's probably gotten a little bit better because I haven't been so locked up in structure and manuals as I was several weeks ago and a large part of that is the CBT study which has been wonderful but it also was very tempting to get attached to the manual, the treatment and the steps and the techniques to the point where you rely exclusively on that at the exclusion of being flexible in session and processing things that needed to be processed. So, allowing myself to be more flexible and slow down has really allowed to become better.

Phil: Right now I feel really comfortable with where I'm at with my clients, cause I've seen them for awhile. The one divorce client I did see her 12 weeks and she's been back for 6, so I have a really good understanding of who she is and we have a really good relationship and the same with the other lady I've seen for over a year now. I have a really good idea of where to go and I think that she feels comfortable with the direction that we're taking. But if I am assigned a new client, I would hope to get some guidance and I'll probably have a lot of questions about where to go and what to work on.

At the end of the academic year, both trainees commented on applying therapeutic interventions with a variety of clients. Phil reported feeling contented when his work involved motivated clients. However, he identified the difficulty in conducting therapeutic interventions with unmotivated clients as frustrating. On the other hand, David appeared to respond to difficult therapeutic situations as a challenge to conquer

and reported a sense of humbleness. He reported that the sense of humbleness was the result of his struggle to develop his counseling skills beyond the sterile steps of a manualized approach.

Phil: I feel contented, cause I think it's because I know what I'm doing. I thinks it's because these clients I find more interesting . . . that one couple was frustrating and annoying, and this one couple that I'm having trouble with this semester I just find to be really interesting. And I'm really enjoying working with them because it's so interesting, it's so different, you never know what's going to happen. And that makes it somewhat more exciting. Yea, *I think I'm motivated to work with it and it's an interesting case and I'm getting a lot out of my supervision with this couple.* So that matters. And again my OCD client, I enjoy working with him too. *But when it comes to that one couple that's blah, I could . . . don't get excited . . . if they cancel they cancel, they skip till next week. Cause they think they're just here to jump through hoops, they're not really willing to work on the issue at hand, they want to without having any homework or anything else. I think that's how they see it. That's just my motivation to why should I put all this freaking energy into this, when they are not doing anything on their part to get anything else out of it.*

David: I feel humbled, yea, less cocky. Well, I think just growing into your niche causes that. The more counseling experience I've had with clients, different kinds of clients and trouble and the problems you run into with them applying what sounds so nice in a text or a manual. The troubles you run across applying a manualized approach - that's what's humbling, I mean it gets you up to draw on other things and be creative.

The Integrated Developmental Model

In this chapter the trainees' experiences were categorized according to Stoltenberg's et al. (1998) eight domains (Intervention Skills, Assessment Skills, Interpersonal Assessment, Client Conceptualization, Individual Differences, Theoretical Orientation, and Professional Ethics). The first year doctoral trainees' development supportive of the IDM will be presented (see Table I2 and Table J2), followed by a discussion of the second year trainees (see Table K2 and Table L2).

First Year Doctoral Trainees - Level 1

Across domains, the Level 1 therapist is characterized by a predominant self-preoccupation, a strong motivation for learning how to become as proficient as other professionals and a desire to be instructed and nurtured by a more experienced clinician.

Intervention Skills Competence

This rather broad domain in Stoltenberg's et al. (1998) model reflects many different skills associated with numerous types of interventions flowing from various theoretical orientations. The supervisor must consider the specific therapeutic activity of focus when assessing a therapist in this domain. It is important to consider the trainee's level of development for this domain in context and realize that he or she may be quite developed within a given theoretical framework, working with a particular type of client, and from a certain modality, yet be considerably less developed when one or more of these conditions is altered.

During the fall semester in this study, as predicted by Stoltenberg's et al. (1998) IDM, the two first year trainees eagerly looked to their supervisor to supply them with training in some understandable set of skills, preferably within a fairly structured

framework, that provided them with guidelines for working with clients. For example, Alan desperately wished for a step by step “instruction book” as he focused on fundamental listening and conversation skills. Throughout the fall semester, Alan strived to understand how to perform these skills in his sessions and would self-evaluate how effectively they had been implemented. For Dirk, dependency on his supervisor and a cognitive self-focus was evidenced through his desire for training in, and then implementation of a specific set of step by step interventions skills to use in session with his couple client.

Alan: I wish there was an instruction book that tells you how to implement these things. I feel like I have the general understanding, but I have no idea of how to use them in a session. I tend to just fire questions continuously without really having a conversation.

Dirk: My supervisor sat down and kind of wrote down a plan for a first session with them and we haven’t gotten through it yet . . . My supervisor also gave me a big ol’ chapter on integrated behavioral couples therapy. It’s been really helpful, cause I’ve been very much up in the air about that. It’s been helpful, I haven’t gotten through all of it . . . it’s been good.

Both trainees displayed a high level of motivation in their efforts to learn and then remember how to implement a given skill and decide when to use it. Their focus remained primarily on their own internal frame of reference. Consistent with Stoltenberg’s et al. (1998) model, the first year trainees initially experienced a lack of self-efficacy in their ability to perform certain skills adequately and relied on their supervisors to show them how to apply skills learned in class or supervision.

However, in the second semester, after both trainees took active responsibility for searching and reading relevant literature, and as their client caseload increased, a confidence and perceived sense of autonomy with their intervention skills slowly grew. In accordance with Stoltenberg’s et al. (1998) model, this increased confidence in their

ability to understand and implement interventions indicated that the two first year trainees were likely in “transition” to Level 2 in this domain. Although their understanding may have been limited in terms of complexity and breadth, the troublesome anxiety had diminished while their motivation remained good, their self-focus had lessened, and the movement toward some autonomy had begun.

Dirk: I feel I enjoy counseling more now than I used to. I would say that , you know, for sure. Typically, I rarely have a session that I come out of like, ‘Oh, it sucked,’ and it ruins the rest of my day, and things like that. Usually it’s more apt to be the opposite route. It seems to be - whether it went particularly well, just the, you know, the whole process, I really enjoy it right now. Maybe because I have a little more of a sense of competence. Kind of more - feeling more comfortable at my end, being some of it.

Alan: Counseling is a lot more productive now, and it’s a lot more enjoyable than it was at any point last semester. Part of it is I finally had more clients and done the reading and the preparation. I don’t feel that pressure to need to solve things like I did last semester. And some of that letting go of that frustration stuff made it more fun for me to do the reading and research what’s going on and it just made counseling in general more fun. Ya’ know, like a client comes in and you get a hypothesis about it and we’re suppose to use the scientist practitioner and I don’t think I really knew what that meant before this semester; that you go through and you read up on what’s possibly going on, and you start to have a hypothesis about what you think and then , I don’t think I was doing that before. I feel like I now have control over what’s going on.

Theoretical Orientation

Training programs approach teaching theoretical orientations differently. Some are closely identified with a particular orientation, while others are more diverse.

However this training occurs, Stoltenberg et al. (1998) suggest that it is unusual for beginning therapists to have a detailed and integrated knowledge of any orientation when work begins with clients. It is suggested that even in programs that attempt to expose trainees to diverse models, there is a tendency for novice therapists to want to discover

the “best” or most correct orientation.

This tendency was supported in this study. Both first year trainees initially reported a discomfort with their theoretical orientation and high motivation to identify and rely on one theoretical approach. The trainees’ subsequent focus on a single approach did serve to reduce their anxiety and began to provide some cognitive structure for understanding the process.

Dirk: Well, I guess I probably best identify with the cognitive-behavioral because that seems to be the theory of choice of many of my supervisors . . . It is more comfortable because it is easier, at least it’s something you can sink your teeth into. I don’t feel like I ever picked up the theories very well the first time around in the one or two classes and that is what everything else is based on.

Alan: I’m uncomfortable with my theoretical viewpoint . . . I don’t feel grounded, I don’t know what I’m doing. I know that’s where I’m supposed to be, but it’s not comfortable. I feel like I ask questions, and I deal with things with clients, but I don’t feel like I’m directed in my questions or my questions are all coming from the same theory . . . I’m thinking about theories as a textbook cookbook which they’re not, and I wish there was a cookbook for this recipe, this is exactly what I have to add and exactly what I need to do and then they are okay. I guess I don’t feel comfortable, but, and I know you can’t do that with theories, but I feel like I need to do more than I’m doing . . .

Five weeks into the Spring 1997 semester, both trainees had identified a theoretical orientation from which they attempted to work. By this time both trainees had begun to read the relevant literature and prepare for supervision. As the trainees experienced some success with clients and increased in a sense of autonomy, their level of motivation appeared to lower.

Dirk: Applying theory on the one hand is getting easier, and on the other hand, I’m kind of thinking, well, my understanding of efficacy studies and that really doesn’t matter, so, as far as what theory you use, that, as long as you use it well. Overall, since Christmas break I’m just kind of cruising along on autopilot. I haven’t really been doing a whole lot of thinking. I do whatever I’m told. I’m just floating through to Spring Break kind of

thing. I'm motivated to keep up, but I'm not threatened about things like I probably should be.

Alan: I'm feeling a lot more comfortable with not being completely sure what to do. I don't feel as much pressure now to have to tie myself to a theoretical orientation. But, I'm also able now where I can take a client's problem and think about it from different perspectives where I couldn't before. But I've given up the idea that I need to use a manual in session. I can use cognitive-behavioral interventions.

In the spring semester, the reduction in anxiety appeared to allow the trainees to come to realize that no one approach works in all cases. Dirk reported discovering the need to draw from other approaches to work with different clients. At the end of the year he described himself as eclectic and he desired to learn two or three approaches well in order to "pick and choose within their parameters." Alan, too, discovered that a single approach would not work in all cases as his theoretical orientation evolved across the year. At the end of the year, Alan simply stated that he felt comfortable not working from one specific theoretical orientation because he felt he did a "good job with clients while still learning several theories." According to Stoltenberg et al. (1998) this movement away from strict allegiance to a specific theoretical orientation to more experimentation with a wider variety of techniques and strategies suggests "transition" to Level 2 within this domain.

Dirk: I don't know, I probably don't have a theoretical orientation, probably as eclectic as anything. And I'm trying, very actively trying, to formulate an eclectic approach, because I just don't see the rationale in picking one thing and sticking to it because you are told to or whatever. But in the sense of trying to learn 2 or 3 different orientations well and within their parameters and pick and choose in terms of . . . well, in terms of conceptualization probably sticking to one, but in terms of procedure, probably taking form all of them. So trying to be truly eclectic, as they say, as opposed to just doing whatever. But definitely lean more towards cognitive type therapy than anything.

Alan: The whole time I've been saying I'm cognitive-behavioral, but I'm not

cognitive- behavioral. I have no idea what I am. More client-centered than anything. But that's still not a question I can answer with a great deal of confidence. But the difference is this semester I'm okay not knowing what my theoretical orientation is. I feel like I do a good job with my clients and that I'm still learning about theory. And I'm learning to use different ones, but I guess before I felt like I had to know what my theoretical orientation was to be confident in counseling.

Treatment Plans and Goals

This domain addresses how the therapist plans to organize his or her efforts in working with clients in the psychotherapeutic context. Throughout this study, the Intervention Skills Competence, Theoretical Orientation, Treatment Goals & Plans, and Client Conceptualization domains seemed to be very closely linked or even intertwined.

Stoltenberg et al. (1998) predict that the Level 1 trainee's initial focus is often more on keeping the clients coming than of expecting or planning facilitative change. In addition, they suggest that sometimes the trainees have techniques in mind to use, but do not necessarily tie these into goals or they have some goals in mind but no idea how to reach them. Finally, the trainee's approaches are sometimes random or based on a predetermined sequence of interventions as part of a structured program.

The first year trainees' report in this study is consistent with the model's prediction for a Level 1 therapist. In this domain, Dirk reported an initial focus on keeping clients coming and worked with a couple from his supervisor's outline. In addition, he reported a concern that his supervisor assumed that he knew more about treatment planning than he actually knew. Alan's comments in this domain were limited to his desire for an instruction book.

Dirk: My supervisor sat down and kind of wrote down a plan for a first session with them and we haven't gotten through it yet . . . I think my supervisor takes for granted or something that I don't need help to actually plan cases. And, well, I've had that, what I'm beginning to see is a pretty common

feeling that, gosh, I must be the worst counselor because they come once and I never see them again.

Alan: I wish there were cookbooks and for this recipe, this is exactly what I have to add and exactly what I need to do and then they are okay.

Client Conceptualization

This domain can take many forms, often varying according to the theoretical model the therapist uses. Stoltenberg et al. (1998) caution not to limit client conceptualization to simple diagnoses. Further, they suggest that novice therapists tend to focus on specific aspects of the client's history, current situation, or assessment data and exclude consideration of other relevant information.

In this study, Client Conceptualization appeared to be almost dependent on the trainees' knowledge and competence in the Theoretical Orientation domain for the two first year trainees. Both trainees reported their efforts to utilize the theoretical orientation they struggled to understand and apply at any given time as a template to try to conceptualize their clients. In addition, the trainees reported a reliance on their respective supervisors to provide assistance with conceptualizations.

Dirk: I guess I'm more comfortable at the general operations of getting a whole new community of resources, all that stuff is something that comes kind of more naturally now. So I guess now it's more how do I conceptualize this case? How do I get a client to see, uh, to have some insight into their behavior, you know, how do I get their attention. How do you manage this stress level so that they want to keep coming in but yet they still feel like they're getting something out of it, you know, so you know, not too far in either direction. I still need help with conceptualizing cases. I can tell you that much.

Alan: I still want to be more theory driven and use, be able to say, "I'm using this theory and I'm conceptualizing it this way" and do more of that, but that just seems so ambiguous. There's no manual that tells you how to do it. I didn't see enough clients, I don't think, to really meet that goal.

Later in the year, as their confidence in theory application grew, the trainees

reported a motivation to try to conceptualize their cases, along with a reliance on their respective supervisors to provide affirmation and confirmation of the conceptualizations.

Dirk: At first I was really caught up in the whole conceptualization of it, applying theory to conceptualize things. That's, I'm kind of thinking, well, my understanding of efficacy studies and that really doesn't matter, so, as far as what theory you use, that, as long as you use it well, but I don't see anybody evaluating how well they're being used either. I guess I'm not so much thinking what will work, like a doctor thinking of medicine, but what makes it easier for me to conceptualize it. What makes more sense kind of theoretically.

Alan: I want supervision to be a chance for me to be able to check in and to talk about where I'm going and to pick up some things that I'm not seeing but to allow me to do most of the conceptualizing and thinking like that, and have me present it and have supervision say well that's accurate or that's not accurate because of this, this, and this, or you have been doing this a lot and you haven't picked it up. What do you think about that?

Assessment Techniques

Stoltenberg et al. (1998) view early course work in assessment approaches and instruments, along with intake training as the beginning of work in this domain. In this study, the first year trainees selected to participate in the program's assessment clinic. The assessment clinic focused primarily on conducting contract assessments. Consistent with the model, the trainees seemed to be initially more attracted to what they perceived as the more structured and straightforward process of assessment than the less structured process of therapy.

Alan: The assessment clinic is easier for me than counseling, 'cause it's black and white, it's more black and white than. When someone comes in with a problem and I have to assess these different areas and I know what the tests are to assess these different areas and then I know what the results tell me and then I know what that means overall. It's more, I like black and white. I don't like shades of gray. And counseling is more of a shade of gray.

Dirk: I think assessment is actually one of my strengths I would say. I think it's something that really makes a lot of sense to me. I think my head's good

for that kind of thing, maybe more a little more objective and quantifiable than most of what we do, not as much ambiguity. 'Course there's still tons of ambiguity, but not as much, so it's something I could really see myself doing a lot of later on.

It was interesting to note that although both trainees grew in skill and confidence in assessment techniques within the assessment clinic, they did not appear to transfer or integrate these skills into therapy with their clients. It looked as though the trainees compartmentalized the assessment clinic from therapy due to separate supervisors and protocol. Consistent with the view of the IDM, the trainees had not yet developed these skills to the point that they were able to integrate them into their therapy.

Interpersonal Assessment

In this domain the therapist must learn to use himself or herself in the session either to elicit responses from the client that aid the assessment process or use his or her own reactions to the client as an indication of social skill status or the presence or absence of certain personality characteristics.

In this study, consistent with Stoltenberg et al. (1998), the first year trainees' self-focus limited their ability to take the perspective of the client and their ability to monitor their own reactions accurately. As evidenced by the lack of data in this domain throughout most of the academic year, the two first year trainees' self-focus appeared to limit their ability to take the perspective of the client, as well as, their ability to monitor their own reactions accurately. It was not until the last two interviews of the year that the trainees acknowledged the existence of affect in the session. However, at that point both trainees possessed a high level of self-awareness in this new area of learning. Alan reported a belief that he had begun to work to convey his understanding of the client's emotional experience. Dirk also reported a new focus on the client's affect and a hope to

express his own emotional responses effectively.

Alan: Emotions and affective stuff, that's what I wasn't doing before and my supervisor and I really tried to get me to focus on emotions and conveying to the client that I understand the emotions they're talking about. The theme in the beginning was that the thing about me asking tons of questions and the beginning of the semester was getting me just to have conversations with the client. I'm actually doing the just talking and the affective stuff, it's helping me have better relationships in general with clients, so maybe the overall theme was establishing a relationship.

Dirk: . . . I think I'm doing better at paying attention to their affect in session, cause I've always assumed how they must feel, but I think I'm doing better about really finding out even though it's uncomfortable for me to do that. I think I'm doing better at finding out what's really there. Just being more connected, more emotionally available, that kind of thing. That's something I really have a lot of room to grow.

In addition, Alan reported less comfort talking about emotions in session. Dirk, too, reported a desire to maintain an emotional boundary and to develop a coping mechanism to deal with affect.

Alan: I was much more comfortable dealing with the thoughts and cognitions and stuff and not so comfortable talking about the emotions.

Dirk: I don't have any problem feeling empathy for people, but expressing it effectively without getting too, getting out of control with it. And two, being able to deal with another person's emotionality. I haven't had too many clients who were very emotional in session, until recently. More than anything I just feel like I've done better at it, but it has been pointed because it's something I've been paying attention to more in the last few months probably. But maintain emotional boundaries so that you're, very much there and interacting with the person, but yet protecting yourself, because you have to, you know I'm starting to really see that. You really have to. I mean, you must! Not sitting around thinking about stuff, not, about the most I do anymore in terms of personalizing is just saying, "I'm glad I'm not that guy!" or whatever. And I try not to do that too much, cause I think that belittles their problems. I don't intend for it to, but I think maybe it does. But mainly, I'm just saying, not allowing things to bug me, cause I think, maybe I just rationalize it to myself, but I think I'm developing a coping mechanism that is really going to be essential to this field. Not just essential for my own sanity, but, well, that, but, in turn, essential for my effectiveness and longevity. I will not make it if I let

myself get drawn into every person's life that comes along 'cause it's just too much. But with yet, not getting callous to it, that's the trick.

In accordance with Stoltenberg's et al. (1998) model this increased attention to client reactions indicated movement or "transition" to Level 2 in this domain. However, the apparent lack of empathetic understanding and the depth of emotional contact with the clients expected more at Level 2 are still not present.

Individual Differences

This domain includes an understanding of ethnic, racial, and cultural influences on individuals, as well as the idiosyncrasies that form the person's personality.

Stoltenberg et al. (1998) suggest that although it is increasingly likely that Level 1 trainees are being exposed to these issues early in their training experiences, they still often rely too heavily on their own idiosyncratic experiences and perceptions of the world in their attempt to understand their clients.

In this study, it is possible that the first year trainees' own cultural background may have served as the "ground" on which clients were viewed as the "figure." Even with the growing emphasis on multicultural issues, these two trainees appeared to assume that they shared a similar world-view with most of their clients. Through follow-up discussions, it was discovered that the trainees did indeed work with clients tremendously different from themselves. For example, Dirk worked with a male who was blind and living in an extremely low socio-economic status. In fact, at the end of the year Dirk mentioned this client in context of telling about his comfortable and relaxed attitude in working with clients in session.

Dirk: I think I know how to appear interested to somebody, everybody does it all the time in conversation, so I think it's silly to put too much emphasis on that. So I don't worry about that kind of stuff so much. Occasionally I'll

find myself leaning way back and looking out the window. I've done that a lot, 'cause one of my clients is blind, so he doesn't know. So I'm looking out the window the whole time I'm talking to him. I've got to stop doing that.

Consistent with Stoltenberg's et al. model (1998), the scarcity of data in this domain seems to suggest that the trainees were unaware of and did not acknowledge the importance of differences in background, culture, gender, or physical or mental abilities.

Professional Ethics

All mental health service providers are exposed to professional guidelines of ethical behavior and relevant state laws as part of their training programs. Stoltenberg et al. (1998) suggest that initial utilization of these guidelines follows a fairly rigid application of rote memorization, or at least learning to look up specific guidelines for particular situations.

In this study, the two first year trainees did not offer any report in this domain until directly asked in the final interview. At this time, both trainees became quiet, and then reported their commitment to silence in regard to an ethical dilemma they encountered in the Fall and worked with faculty to resolve throughout the Spring semester. Dirk reported that this past year, his practicum class as a whole consulted with each other to decide their liability in regard to a situation that could be career threatening for a colleague/peer in the practicum class. Alan also ambiguously described his experience with this same ethical dilemma. Follow-up discussions indicated that a colleague may have engaged in behavior that had the potential of putting a whole class of clients at risk.

Dirk: Oh yes, definitely, oh absolutely, severely yes. It's not anything I can really talk about, but there has definitely been a major career threatening, not mine, but, career threatening ethical dilemma that I have been

involved in because some of it came to my attention and some other people, so, it was regarding a colleague. So, that's been something we've been dealing with for a couple of months now and that has been a gut wrenching deal, let me tell you. I have talked to my supervisor about it, but it has been very, for the most part, it's like don't talk about it, in fact we've been told not to talk about it. I've talked to my supervisor a couple of times, but it's just been real, like what's the progress with your situation and that kind of thing. It's something that's so clearly an ethical violation that it's not ambiguous at all, so I'm not sitting there saying, "Gosh, what are the ethics of this?" It's clearly that's really serious, so we haven't occasion to talk about it much and really things are just kind of tense right now, so I've just not brought it up. We came to an agreement that, yes, we needed to talk to the faculty, we needed to. It was, as I said, very severe, but then there's still the issue of, well first of all, what's our liability going to be, that was part of it, the potential for us getting in some trouble ourselves, not with a faculty per se, but just maybe even legal trouble potentially, very real potential for that. It was just difficult because it was someone that we work with and we were called upon to do something fairly distasteful.

Alan: Well, with a classmate, stuff has come up, but we dealt with that. This last semester, it's definitely something's that's come up. It was something that was done, myself too, but also my other classmates, all went through it together. It was something that was a part, everyone that was involved with it was in the prac class.

This ethical/legal violation of very grave magnitude affected the whole group of first year trainees, which stretched out across the whole year. This environmental situation may have clouded or impacted the data in this study. The silence by the two trainees across the year was a part of their ethical behavior in this situation. However, it remains unclear if these trainees were aware of and struggled with additional professional ethics throughout the year which were overshadowed by this experience with their colleagues. Another consideration is that the trainees had an awareness of this experience because it was obviously unethical behavior and less evident ethical dilemmas occurred outside of the trainees' knowledge, understanding, or awareness. Finally, it is possible that no other ethical guidelines were compromised throughout this year. Nonetheless, the

lack of data concerning a “personalization” of professional ethics suggests the focus was probably on black and white ethical guidelines.

Second Year Doctoral Trainees

Resolution of Level 1 issues allows the trainee to move into Level 2. Stoltenberg et al. (1998) suggest that this transition can be facilitated, or hindered, by the supervision environment. Further, given that this developmental sequence occurs within domains, we may expect to find differential growth across domains. This differentiation may be a function of more of a focus on some domains rather than others during prior supervision, resulting in greater growth in these domains than others. Additional training opportunities may result in more development in certain domains. Also, the trainee’s personal characteristics may be better suited to particular domains of practice, and there may be more rapid growth in those domains.

At the point of reaching what Stoltenberg et al. (1998) conceptualize as Level 2, trainees are making the transition away from being highly dependent, imitative, and unaware in responding to a highly structured, supportive, and largely instructional supervisory environment. With successful counseling experience comes an increased desire and confidence to make one’s own decisions concerning client cases. An increasing mastery of basic facilitative and attending skills result in less of a self-focus, reduced anxiety, and more of an ability to attend to the client experience. At the same time, however, difficult and unsuccessful cases may cause trainees to question their effectiveness as therapists, affecting their previously high levels of motivation.

The Level 2 therapist is making a transition across the various domains from dependence on the supervisor to a sense of independent functioning, from primarily a

self-focus to a focus on the client experience, and from a previously high and fairly stable level of motivation to fluctuating levels. The assessment of Level 2 functioning can be hindered, however, by decreasing openness by the trainee toward the supervisor, depending on his or her sense of the supervisor's expectations as well as one's own expectations for professional growth. In essence, one may experience and demonstrate a sort of professional adolescence when personal professional goals are not yet realized, but the desire for autonomy and self-direction is growing.

Intervention Skills Competence

Stoltenberg et al. (1998) suggest that the characteristics of the Level 2 therapist are especially apparent in this domain as the trainee is increasingly comfortable with a wide array of intervention skills, although these skills may not be well integrated within an overriding theoretical orientation or conceptual scheme. Further, the model proposes that the Level 2 therapist may become enmeshed and demonstrate a temporary inability to make decisions regarding client welfare or treatment due to the strong cognitive and affective focus on the client's experience. With the intent of establishing the therapeutic alliance, they may also readily express support to clients in appropriate ways.

At the beginning of the academic year, consistent with this suggestion, the second year trainees plainly expressed a confidence in their knowledge and ability to perform basic therapeutic skills adequately. However, this level of comfort appeared contingent on the trainees' previous experience with the given clientele type (i.e., adults, couples, children, and so on). David had gained experience with couples and women dealing with depression. For Phil, his experience, and therefore his confidence in his counseling skills, was initially with adult clients.

A little further into the year David expressed a psychological reactance, or a motivational force which impels individuals to regain or attempt to regain lost or threatened freedoms (Brehm, 1966), against supervision. He also stated some confusion and a sense of regression in his counseling skills while he worked to develop and integrate intervention skills with his use of self in session. David's statement looks to possess a vacillation of all three structures dependent on implementation of the well-known, comfortable basic skills or the newer, use of self intervention skills

David: I'm kind of in that ambivalent stage where you've got the basic skills down and you feel pretty good about those, but yet you know there's so many areas in which you have to grow and so you're kind of regressing. I mean, it's so . . . I guess, it's where you actually regress a little bit in your microskills and your basic skills, because you're going to look, "Where the hell am I going with this client, because I'm conceptualizing it like this?" And so, when you're trying to do that, you actually regress as far as your empathy and all that, the basic perfection of those kind of things. *Well, I mean, just the kind of the common theme that I've been thinking about is just this idea that you reach a certain point in your growth and you're like, "leave me alone, I'm doing fine. I'll grow on my own from now on, just I don't need anymore supervision, thanks. You don't need to supervise my work anymore, cause I'm taking care of it on my own."* But then as you're forced to take more supervision, you realize that's not the case, that while you are growing on your own, you have some responsibility as far as receiving new information, new skills, that it really does help to have someone that's been through that to kind of be monitoring your work, thoughts about it and saying, "well, you've doing good, but have you thought about this? Or, maybe you should consider this or this."

Although Phil did not point out a sense of regression in this domain, he did display some psychological reactance against changing his intervention skills or approach. He, also, reconfirmed his focus to support his clients through building a strong therapeutic relationship.

Phil: The one client that just terminated, the female that was in the study, we were talking, and she was like, "You're the first person who really was concerned about me. As soon as I sat down I knew you were different

from everybody else." So I think in that respect I think my empathy and my genuineness is very strong. I'm comfortable with what I'm doing and happy with what I do and I think I do a good job. I'm comfortable with it. *I'm confident with it so why change because someone else tells me I should?*

Phil may not have experienced a sense of regression because of what appeared to be low motivation and thus avoidance of difficult and unsuccessful cases that may have caused him to question his effectiveness as a therapist.

Phil: I'm not as afraid now to confront, because I know that if they leave, they weren't ready to hear that, or weren't ready to focus on the issues that were really affecting them. Yeah, I felt comfortable after I did it. *When they stopped coming in, it relieved my emotions because I didn't like working with them in the first place.* But, I think this showed exactly where they were, and where they didn't want to go. And I've used that same confrontation in another session, and the couple continues to come back

Theoretical Orientation

According to the IDM, Level 2 therapists initially demonstrate movement away from a strict allegiance to a specific theoretical orientation to more experimentation with a wider variety of techniques and strategies. Further into this level, the therapist works to find a perspective or approach that fits with his or her own view of human behavior and personal counseling style, sometimes at the risk of forcing clients to fit into a particular theoretical model.

This study appeared to join the second year trainees attempting to define and deepen his understanding of an approach which best fit his personal counseling style. As Phil had chosen, and was solidifying his personal counseling style as "Rogerian," David was deepening his knowledge and personal application of a Cognitive-Behavioral Approach.

Phil: Well, I take a really Rogerian, Client-Centered approach and I think I

develop a really good working relationship with my clients. . . I think that I build up a really good rapport and that my clients feel very comfortable around me and that they more than enough I feel, they express emotion and they express difficulties and some of the things that they're having going in their life that may be a little bit more sensitive than others . . .

David: I probably lean the most on Cognitive-Behavioral therapy. . . I want to get more versed and get a deeper understanding of Beck's approach, and I'm working my way through his book, so that's one of my goals. And then just to get a basic, better appreciation of as many approaches as I can. I just think there's more to CBT than I know. I don't think I can defend it very well if somebody attacks it.

Despite this rigid adherence to learning and applying a single theoretical orientation, the two trainees began a return to experimentation with a wider variety of techniques and strategies. Given a stronger focus on the client's responses, the trainees began to value and enjoy exposure to other orientations in which they evaluated the general advantages and disadvantages for their given client against a growing understanding of their chosen therapeutic orientation. Finally, without abandoning this favored orientation, the trainees chose to add theoretical constructs from empirical research to his working knowledge of therapy.

David: Actually, looking back at it, the interpersonal intervention eventually opened up the way for the client to make some insights. 'Cause one of the things is, that the literature pointed was the lack of emotional intimacy and maturing in that area is what leads to a lot of exhibitionism. And talking over with my client about that kind of helped him make big insights. And so far it's kind of changed him. So in that sense doing a lit search actually helped. But being encouraged to adopt an affective, almost feminist-based therapy, it's almost been implied that I don't use the CBT as much. I don't know if my supervisor intended that or not, but in some ways I reacted against that, because I'm not willing to give up CBT, but I'm willing to incorporate more affective stuff into it, because I believe CBT is effective, but you do have problems sometimes with it with some clients.

Phil: Well, at this point I'm definitely more humanistic, but then I did research with the OC client and cognitive-behavioral came out on top with techniques to use, and the other two I had to use cognitive-behavioral approach since that was what was the focus of the study. So I consider

usefulness in a combination of both of the two. I think, humanistic, but with cognitive-behavioral tendencies. I can see the reality for the therapeutic ideas involved and once you have the relationship I think you have to take it a little bit deeper. If there's obviously cognitions that are, I mean with OC it was obvious cognitions, it's obvious there's a cognitive dysfunction going on, so you couldn't just bypass that for the sake of the humanistic approach, that's where the research showed to go and that's where he was showing that he needed to work on was cognitions, so. But I wouldn't say that I operate in a solely cognitive-behavioral approach at all.

Assessment Techniques

In this domain, Level 2 therapists demonstrate an increased knowledge of diagnostic classifications and assessment instruments. However, with the increased focus on the client's perspective, the IDM suggests that the trainees may have difficulty integrating information from assessments and interviews that may be inconsistent or discrepant with their view of the client. Further, assessment may remain a separate activity and still not be integrated into other domains. Consequently, the perceived need for more assessment may not appear strong in many cases. As the trainee transitions to Level 3, he or she develops a solid sense of the role of assessment, the strengths and limitations of various strategies and instruments, and a personal understanding of how to use this information to advance knowledge of the client. In addition, observations and impressions of client behavior during the assessment period are used to validate or modify information provided by the devices themselves. Assessment conclusions, diagnostic classifications, and so on are influenced by the assessment setting and the client's environment.

In this study, both trainees started the year with a reported well-developed confidence in their assessment skills. Phil reported completion of all assessment courses offered, assessment experience, and served as a teacher's assistant in all assessment

courses. David, also, reported that he had completed all assessment courses and had worked graduate assistantships that emphasized assessment and neuropsychological testing. In addition, David went on to point out an increased awareness and focus on client symptomatology and history.

David: Well, one that comes to mind is just to be aware of where your clients are symptomatically as far as their clinical picture, you know, symptoms, cores, frequency, how those tend to wax and wane and especially with my depressed clients, to always be kind of aware of where your depressed client is and the idea of suicide and potential for that, and to just routinely assess that when needed. Because there's been times where I didn't really, like I'd be working with a couple where there's a depressed woman and who had had some suicidal ideation in the past during a particular stressful week where she was crying and stuff in session and things had been really bad in their relationship, you know, my supervisor asked me, "Did you kind of see where she's at, you know, before y'all left the session?" and I said, "no." And, you know, he's just pushing me to be aware of those kind of things. And, you know, just that heightened awareness kind of thing and in forcing me as a clinician to be more aware of what all is going with my clients, not just seeing them once a week and forgetting about them. I mean, not really forgetting about them but just not really worrying about them.

With the exception of David's focus on client symptomatology and thorough history, both trainees discussed assessment techniques only in the context of their experience in the assessment clinic or graduate assistantship. Similar to the two first year trainees, the second year trainees did not appear to transfer or integrate formal assessment techniques into therapy with their clients. Again, perhaps the trainees compartmentalized the assessment clinic and graduate assistantships from therapy due to separate supervisors and protocol. Given David's developed focus on client history and symptomatology, another consideration is that the trainees had just begun to develop these skills to the point that they were now able to integrate them into their therapy.

Client Conceptualization

This domain includes, but is not limited to, diagnosis. It goes beyond an axis or V-code diagnosis and includes the therapist's understanding of how the client's characteristics, history, and life circumstances blend to affect adjustment. The nature of this conceptualization varies depending on the therapist's worldview or theoretical orientation.

Stoltenberg et al. (1998) suggest that while the Level 2 therapist's conceptualizations of therapeutic dynamics and processes are based on a more complete understanding of the client's perspective, they may also be largely based on the client's viewpoint, without integration of other sources of information (i.e., objective or projective psychological testing). Also, obvious discrepancies or inconsistencies in information gathered are often ignored or overlooked. As the therapist transitions to Level 3, the tendency to focus on discrete pieces of information or overaccommodating to the client has given way to an understanding of how diverse client variables interact to yield a complex conceptualization of the whole person.

In this study, while both second year trainees reported a comfort and flexibility with assessment skills and conceptualization of their clients from various approaches, especially their personal orientation, they relied solely on the client's report without integration of other sources of information. Consistent with the IDM Level 2 therapist, David, initially, looked as though he struggled with the overaccommodation demonstrated by the Level 2 therapist and got lost in the client's perspective.

David: I mean, it's so . . . I guess, it's where you actually regress a little bit in your microskills and your basic skills, because you're going to look, "Where the hell am I going with this client, because I'm conceptualizing it like this?"

However, given David's developed focus on client history and symptomatology,

he then began to develop these skills to the point that he was now able to integrate them into his conceptualization and therapy.

David: Well, one that comes to mind is just to be aware of where your clients are symptomatically as far as their clinical picture, you know, symptoms, cores, frequency, how those tend to wax and wane and especially with my depressed clients, to always be kind of aware of where your depressed client is and the idea of suicide and potential for that, and to just routinely assess that when needed.

On the other hand, Phil's new experiences and difficulty with couples was more suggestive of a Level 1 novice therapists, with this new client type, who tends to focus on specific aspects of the client's history, current situation, or assessment data and exclude consideration of other relevant information. Phil reported his efforts to utilize Integrated Behavioral Couples Therapy and struggle to apply this approach as a template to try to conceptualize his couples. Phil, also, reported a reliance on his supervisor to provide assistance with conceptualization with his couples.

Phil: Finally I just got annoyed with it and my supervisor told me to confront them and say, "You're like a mother, and you're like an adolescent, like a teen-ager, if not younger. You're thirty-something, but you're actually only twelve." And they didn't like that because it was their pattern that they were existing in. *And now when I view other couples, I can see that pattern, I mean, it just sticks out. The mother-child pattern in the relationship. The woman is always the mother, and the husband is the kid. It's amazing. I never noticed that before, but after my supervisor - we talked about that, I confronted that behavior - gosh, it's in every single session I see that.*

At the end of this quote, Phil's overgeneralization with couples is a solid indicator of the Level 1 therapist's tendency to take a given conceptualization, or set of skills, to the limit indiscriminately before investing themselves in learning new or more comprehensive conceptualizations.

Treatment Plans and Goals

Stoltenberg et al. (1998) suggest that the overaccommodation demonstrated by the Level 2 therapist may result in anxiety or despair concerning the difficulty of providing effective treatment or discouragement when initial treatment plans fail. Further the Level 2 therapists may lose sight of the necessity and practicality of jointly formulating treatment plans with clients by attempting to experiment with alternative treatment strategies and theoretical orientations. For the Level 3 therapist, there is finally an articulate connection between assessment and conceptualizations, which leads to a comprehensive and effective treatment plan.

Despite a dearth of data in this domain, the trainees treatment planning and goals seemed to be influenced and/or directed by their personalized theoretical orientation or experimentation with new approaches. Consistent with the Level 1 therapist, Phil appeared to depend on his supervisor and deal with anxiety and frustration concerning the difficulty of understanding and providing effective treatment for couples and difficult/unmotivated clients.

Phil: I just got annoyed with it and my supervisor told me to confront them and say, "You're like a mother, and you're like an adolescent, like a teen-ager, if not younger. You're thirty-something, but you're actually only twelve."

Initially, David's anxiety or despair concerning the difficulty of providing effective treatment characterized the overaccommodation of the Level 2 therapist.

David: I'm kind of in that ambivalent stage where you've got the basic skills down and you feel pretty good about those, but yet you know there's so many areas in which you have to grow and so you're kind of regressing. I mean, it's so, I guess, it's where you actually regress a little bit in your microskills and your basic skills, because you're going to look, "Where the hell am I going with this client, because I'm conceptualizing it like this?"

However, toward the end of the year, David displayed movement through Level 2

and seemed to be approaching “transition” to Level 3 as he developed an awareness of and began to articulate a connection between the need for a good history, assessment, and conceptualizations.

David: Well, one that comes to mind is just to be aware of where your clients are symptomatically as far as their clinical picture, you know, symptoms, cores, frequency, how those tend to wax and wane and especially with my depressed clients, to always be kind of aware of where your depressed client is and the idea of suicide and potential for that, and to just routinely assess that when needed. And, you know, just that heightened awareness kind of thing and in forcing me as a clinician to be more aware of what all is going with my clients, not just seeing them once a week and forgetting about them. I mean, not really forgetting about them but just not really worrying about them.

Interpersonal Assessment

This domain considers the trainees’ awareness of and ability to use one’s self in session to either elicit responses from the client or use his own emotional reactions to the client as an indication of social skills status or the presence or absence of certain personality characteristics. According to the IDM, the Level 2 therapist may be overaccommodating to the client’s world-view. Thus, the therapist may find it difficult to separate responses to clients based on accurate perceptions of the client’s interpersonal interactions versus countertransference reactions outside of immediate awareness. It is not unusual that increased awareness in this domain is met with confusion by trainees.

Consistent with the IDM’s Level 1 therapist in transition to Level 2, in this study, both second year trainees began the year with a lack of insight regarding this process and reported having their eyes opened or an increased awareness of their own emotional reactions to clients. Initially, the respective supervisors assisted trainees in developing an awareness of their own reactions to clients. Phil’s awareness and increased ability came through his struggle to confront clients with his emotional reactions to them. For David,

awareness came through his struggle to move away from the security of working with cognitions to the less secure realm of emotions -- his own and his clients'.

Phil: One week ago, I talked with my supervisor about how frustrated I was with this particular couple. My supervisor said that it is important that I let them know about my frustrations and tell them. It kind of *opened my eyes to how my frustration was interacting with my therapy.*

David: . . . Um, so, those kind of things and some in-session dynamics like being aware of how I am feeling about something the client is telling me and using that affect in myself to direct me in intervention.

Toward the end of the fall semester, the trainees reported awareness that they have their own reactions and ongoing struggle to use affect in session. For Phil, he appeared to have an awareness of his emotional response, but struggled with motivation, fears, and questions of how to use this in session. At this same time, David expressed an understanding and appreciation for this new technique of using his own thoughts and feelings in session, but admitted a level of discomfort with the application of use of affect.

Phil: *Well, I think from supervision for the last couple of weeks has been working really with that couple and my supervisor trying to empower me, I guess that's the term, to confront the couple and tell them that I'm frustrated and angry and upset with them and you're acting like a child. I'm not really comfortable with that because I feel like I may, I mean they're very hostile as it is and I don't know if I say stuff like that how that's going to affect their relationship or affect them down the road. My supervisor gives me examples of what to say, a little bit of a role-play, but him just kind of saying this is what I would say in this situation. Kind of questioning me and confronting me on is it fair for you to have these feelings and not be doing productive work with these people and not tell them that's the issue at hand. And, uh, that's, I think, really important because it does hinder what I'm doing there and I don't think we do anything with that couple because, at this point, I almost have an I don't care attitude what happens. If they show up, if they don't show up, it doesn't matter to me. And, so my supervisor is trying to get me to a point of being able to say, you know, I don't think we're doing anything and when I come in here. I don't really care what goes on because you guys don't want to work so why should I put the energy into doing it myself.*

David: I don't think awareness of my reactions has restricted my ability to focus very much. I mean, I am thinking about it during session, but I'm still able to focus on the client. I don't know that it gets that restrictive. In some sense it might have encouraged me to focus more on what they're going through. I'm getting better, but not where I want to be. For awhile my supervisor would just kind of talk about it and we would discuss it kind of abstractly, but I've taken the lead with asking for more examples and have him display for me what that would look like in session and so he sort of started kind of modeling what I could do and that's been very helpful. So I can talk about it all the day and be in session and not really know what to do.

As the year progressed, David increased in awareness of his own emotional reactions within any given session, as well as began to report a greater appreciation for what the client actually felt and experienced.

David: I have more of an appreciation for what the client's experiencing and what they're going through, the emotional side and the soft stuff. Not their right parietal lobe has a lesion and it's causing them to do this or not being able to do that. That they're doing that and experiencing that, but it's also impacting their life in this way and they're depression. Uh, you know, and my supervisor made the point you can't fake empathy and I agree with that and I don't have an absence of empathy. I just don't express it to my clients and that's what I'm working on, being able to get in there with them and really talk about one specific thing and have a feeling about it.

Further into the Spring, Phil reported growth in this domain due to finally confronting a couple client he had been reacting to for sometime.

Phil: Yea, that couple, I told them, "You act like a mother, and he acts like a 10 year old. And that was actually the last time I saw them. They failed to continue to show up, so they were terminated. I felt happy and relief. The confronting the couple was very difficult. I think the accomplishment of feeling more comfortable with confronting and being able to deal with difficult clients that were really pulling me emotionally, was good. I'm not as afraid now to confront, because I know that if they leave, they weren't ready to hear that, or weren't ready to focus on the issues that were really affecting them. Yeah, I felt comfortable after I did it.

However, Phil appeared to avoid difficult and unsuccessful cases that may have caused him to question his effectiveness as a therapist. His motivation and effort in

developing his interpersonal assessment skills seemed to be quite low as reflected by his reported “relief” and desire to escape from therapy situations, such as this, that caused confusion or frustration.

Phil: When they stopped coming in, it relieved my emotions because I didn't like working with them in the first place. But, I think this showed exactly where they were, and where they didn't want to go. And I've used that same confrontation in another session, and the couple continues to come back

On the other hand, David reported a greater investment and understanding of the clients' world as he continued to work for a level of comfort with the application of affect and use of self in his therapeutic work.

David: I don't think awareness of my reactions has restricted my ability to focus very much. I mean, I am thinking about it during session, but I'm still able to focus on the client. I don't know that it gets that restrictive. In some sense it might have encouraged me to focus more on what they're going through. I'm getting better, but not where I want to be. I feel like I've made progress in that area, but I catch myself falling back into old habits. For awhile my supervisor would just kind of talk about it and we would discuss it kind of abstractly, but I've taken the lead with asking for more examples and have him display for me what that would look like in session and so he sort of started kind of modeling what I could do and that's been very helpful. So I can talk about it all the day and be in session and not really know what to do.

David's previous comment, made during the last interview of the year, is indicative of the beginning of “transition” from Level 2 to Level 3 in this domain. His stated ability to focus on the client and the ability to reflect on personal reaction to the client enabled him to use the interpersonal nature of therapy to generate an in-depth understanding of the client's interpersonal world. However, despite the fact that he had the awareness and developed these interpersonal skills, David still struggled with confusion in application of these skills. Also, there was not solid evidence that David's empathic and understanding skills have yet developed to the point of being able to fully

appreciate, let alone utilize, this perspective.

Phil was a bit more difficult to categorize in this domain. Toward the end of the academic year during an interview this is how he responded to the question, “How do you deal with affect?”

Phil: Yea, if you’re talking about that incident I mentioned one time in one of my case notes, she was crying and my supervisor was telling me, “Well what do those tears mean?” I didn’t ask her that. So now I do that a little bit more, usually I would just sit back and let them cry. *But my supervisor was like, “This is the time to ask, ‘What do those tears mean? What are you crying for?’” So he’s giving me those other ways to kind of deal with it and really use it therapeutically, rather than using it as a chance to take a break.* That may have been where you were getting at, but I had not seen that as a pervasive theme. But I’ve used that again with her when she was crying the other day why she was crying. I usually would have sat back and let them cry or let them get angry, but now it seems more concrete now that my supervisor just gave me that one phrase to use and kind of talked about it. So now I realize that and have that. In regard to my on affect, I think I’m generally aware, but I don’t voice it. And that’s why I was getting so frustrated, because I wanted to just tell them then, “Why are you doing this? *I can’t do anything for you, if you’re still going to stay in this relationship!*” So I think talking that over with my supervisor . . . and *I always knew that it was OK to open up and express some of that cause it makes you seem more genuine if you can express that, “Hey, I don’t understand why . . .”* but I think just hearing my supervisor say, “No, that’s fine to do, you can voice that.” Cause I was getting so angry and upset when I was in session with her. Hearing all these stories about her being hit just made me really angry. Angry, not necessarily at the situation, but at her.

Although Phil reported growth in this domain, his growth may not have been purely that of a Level 2 therapist working through issues in “transition” to Level 3. Rather, the growth he experienced may have actually been that of an Advanced Level 1 therapist to a Level 2 therapist. Stoltenberg et al. (1998) describe a “Pseudo Level 3 therapist” as an individual who is able to talk a good game and perhaps write convincing reports. However, closer examination of in-session behavior of this type of therapist indicates that he or she has avoided actually dealing with the necessary development of

an intensive focus of the client. Insufficient understanding of the client's world and a lack of true empathy keep this therapist functioning more at an advanced Level 1 than either Level 2 or 3.

Phil's strong cognitive and affective reactions to various clients may have been the result of the Level 2 therapist's inability to separate responses to the client based on accurate perceptions of the client's interpersonal interactions versus countertransference reactions outside of immediate awareness. Another consideration could be that sprinkled throughout the data were suggestions that Phil's overwhelming frustration and emotional reactions to various clients may have been the result of low motivation or insufficient effort to understand the client's world and thus not developing true empathy with them. It seemed that some of his clients confused and frustrated him, yet, he may have never really understood them. Phil's dislike for working with the couple he confronted and his resultant relieved emotions when they discontinued treatment reflected his avoidance of actually dealing with the necessary development of an intensive focus of the client, as well as a desire to escape from therapy situations that are confusing or frustrating.

Individual Differences

In terms of awareness of issues surrounding lifestyle, gender, and culture or ethnicity, Level 2 trainees are more willing to acknowledge the influence of sociocultural and environmental variables on behavior and the limitations of conventional counseling modalities for working with diverse clientele. However, according to the IDM, they may still vacillate between general culture-specific characteristics they believe apply to all individual members of various groups and the idea that every client is so unique that defining cultural values, attitudes, and behaviors may be ignored. Although the therapist

may be confused or vacillating, he or she simultaneously has greater openness and interest in learning about other groups and exhibits a genuine attempt to understand the varieties of human experience and the effects on the counseling process.

Although the trainees' comments in regard to this domain were not direct, the data suggest that the trainees did possess a vacillating awareness and motivation to learn about clients whose lifestyle, gender, culture or ethnicity differed from their own. An example of awareness and high motivation in this domain is that both trainees were descriptive about their clients and they sought out more information to further educate themselves on the differences.

David: Two of my clients are women with major depression. I have been focusing more on doing more affect based counseling and reading or learning more about feminist therapy or interpersonal therapy to work with these women.

Phil: I'm also having a conference with the 26 year-old woman who has been abused, and that's turning out to be a whole different story when we talked to the male last week and from his account he was the one being abused.

However, the trainees also demonstrated limited other-awareness and low motivation. For example, Phil's frustration with the female client who would not leave her relationship is indicative of his insufficient understanding and/or appreciation for her predicament.

Phil: I wanted to just tell her then, "Why are you doing this? I can't do anything for you, if you're still going to stay in this relationship!"

Professional Ethics

Level 2 therapists generally better understand the implications and ramifications of formal professional ethical guidelines. However, at this level, trainees may place more emphasis on client welfare in situations where both client welfare and counselor welfare

may be at stake. They may sometimes view ethical standards as imposed limitations on practice that may be violated and justified by exceptions to the rule. The ethical behavior of the Level 3 therapist comes from a detailed knowledge of ethical guidelines.

Guidelines are no longer viewed as imposed limitations on practice; rather, they are seen as examples or implications of a broader perspective on the rights of individuals and the responsibility of the profession.

Throughout this academic year, these trainees reported only a couple of ethical issues. During the whole Spring semester, Phil discussed the impending termination or transfer to other clinicians for each of his clients. David, to a lesser extent, discussed his ethical responsibility to his clients given his upcoming departure from the program's clinic. In addition David reported his deliberations in response to a gift given him by a client.

Phil: Yea, yea. I just don't know, during the summer they are going to have to be transferred so they are one of those couples that is going to have to be seen, they can't be put off until August 'cause they won't be back. So they really need to be seen on an individual basis by someone who is going to be here through May and through August. They don't have the finances to go to another facility. And make sure that it's OK with my supervisor that they continue now as a couple and . . . and their DAS, they both did the Dyadic Adjustment Scale, and they both said that they want their relationship to work out and they think it's just out of having no idea where else there is to go. So we'll take what we can get. The OCD, I will see him through, because he was already transferred from another therapist to me, and I don't want to transfer him again to for another two months. So I figure I can stay with him until August, and in August, he should be . . . I'll start preparing him now that end of July will probably be the last time we'll work on issues, just kind of prepare him that the end of July will be his last session here and if he needs to come back, he can, but that he would have to start with someone else, which I think would be really terrifying for him.

David: There was a gift given to me by one of my clients for my baby girl when she was born, made by the client's spouse. And that just caused to pause momentarily and kind of wonder about the situation. But I accepted it and

thought that that was appropriate. But that's about as close as I've come to dealing with ...

The IDM Strengths, Inadequacies, and Implications for Further Research

This study was an attempt to explore Stoltenberg's et al. (1998) Integrated Developmental Model by following two first-year and two second-year counseling psychology doctoral students across an academic year of experience. It is important to note that initially, the interviews were "trainee centered," guided by trainees' CIQs and remembered experiences across time. However, toward the latter part of the year, the interviewer actively directed the trainees to speak to all domains of the IDM. Though obviously limited by the single program studied and the small sample size, this study suggests that some of Stoltenberg's et al. (1998) domains were more effective than others in predicting change in these counselor trainees. Results clearly indicate that Stoltenberg's et al. (1998) Intervention Skills Competence, Interpersonal Assessment, and Theoretical Orientation domains were most effective in predicting development across the structures.

Strengths

Intervention Skills Competence

Within the Intervention Skills Competence domain the trainees plainly followed the IDM progression from therapists highly motivated to acquire skills, dependent on supervisor for step-by-step direction, and with limited self-awareness/focus on self to therapists whose motivation fluctuated, who dealt with conflict of dependency-autonomy, and who began to focus more on the client. Throughout the first semester, Alan's counseling experience with individual adults characterized the Level I therapist across all three structures by his high motivation, dependence on his supervisor, primary focus on himself, and his anxiety due to lack of skills and knowledge.

Alan: I don't feel like I know the counseling process well enough. I feel like I ask questions, and I deal with things with clients and we talk about things, but I don't feel like I am directed . . . I want to be told exactly how do I use this and how do I do this specifically. I wish there was an instruction book that tells you how to implement these things.

Into the spring semester both first year trainees appeared to progress through the IDM Level I across the structures. The trainees reported that as their level of experience and efforts to seek out literature relevant to clients increased, their anxiety decreased and as a result both appeared to desire more autonomy than was warranted. Also, by the end of the year they had begun to switch some of their focus more to the client and away from their own thoughts or performance in session. While Alan experienced this growth in his work with individual adults, Dirk's development occurred in his work with couples.

Alan: Counseling is a lot more productive now, and it's a lot more enjoyable than it was at any point last semester. Part of it is I finally had more clients and done the reading and the preparation. I don't feel that pressure to need to solve things like I did last semester. And some of that letting go of that frustration stuff made it more fun for me to do the reading and research what's going on and it just made counseling in general more fun. I feel like I now have control over what's going on.

Dirk: And now most of the stuff, just I've gotten comfortable with and it's not a problem. And I can get into their world a little better than I used to. And I feel more confident about things, so it's been real good. I really think more than anything else it's just been experience, more clients that has contributed to the confidence.

According to the IDM the next steps in development should be fluctuating motivation, dependency-autonomy conflict, and more focus on the client. This fluctuation, or in this case drop, of motivation was captured in the last interview with Dirk as he was discussing his comfort and confidence in his intervention skills.

Dirk: Occasionally I'll find myself leaning way back and ... or looking out the window. I've done that a lot, cause one of my client's is blind, so he doesn't know. So I'm looking out the window the whole time I'm talking to him. I've got to stop doing that.

This transition issue of motivation fluctuation in Dirk was expanded to include the Level 2 reactance within the dependency-autonomy conflict and more focus on the client by David in his first semester of his second year of doctoral work.

David: I'm kind of in that ambivalent stage where you've got the basic skills down and you feel pretty good about those, but yet you know there's so many areas in which you have to grow and so you're kind of regressing. I mean, it's so. . . I guess, it's where you actually regress a little bit in your microskills and your basic skills, because you're going to look, "Where the hell am I going with this client, because I'm conceptualizing it like this?" And so, when you're trying to do that, you actually regress as far as your empathy and all that, the basic perfection of those kind of things. *Well, I mean, just the kind of the common theme that I've been thinking about is just this idea that you reach a certain point in your growth and you're like, "leave me alone, I'm doing fine. I'll grow on my own from now on, just I don't need anymore supervision, thanks. You don't need to supervise my work anymore, cause I'm taking care of it on my own."* But then as you're forced to take more supervision, you realize that's not the case, that while you are growing on your own, you have some responsibility as far as receiving new information, new skills, that it really does help to have someone that's been through that to kind of be monitoring your work, thoughts about it and saying, "well, you're doing good, but have you thought about this? Or, maybe you should consider this or this."

Congruent with the IDM, at this stage the primary conflict for the trainee is a vacillation between autonomy and dependency. On the one hand, trainees are developing their own ideas and gaining knowledge through experience, individual and group supervision, and course work regarding effective interventions with clients. Thus, they have the tendency to move away from imitating the supervisor. Trainees become more confident, and sometimes reactive, in asserting their independence in intervening with clients. At the same time, however, they remain dependent on their supervisor for advice and direction in various cases where they lack experience or confidence, or both.

According to the IDM, this dependency-autonomy struggle also affects the

motivation of Level 2 therapists. They desire to function independently, but when they are exposed to more difficult client types and problems and methods of intervention they may not be effective with some clients. They may start questioning their skills, and the experience may shake their level of confidence and sense of therapeutic efficacy. For some therapists, this confusion manifests itself in high levels of motivation to seek additional guidance and support. Others wallow in frustration, which can reduce motivation to learn and engage in difficult clinical activities. Phil displayed a reduction of motivation in dealing with the confusion and frustration. He was comfortable and confident in his work with low maintenance clients and he reported an intent to turn to his supervisor given a new clinical situation. However, he appeared to have a reduced motivation and avoided difficult clinical activities

Phil: Right now I feel really comfortable with where I'm at with my clients, cause I've seen them for awhile. But if I am assigned a new client, I would hope to get some guidance and I'll probably have a lot of questions about where to go and what to work on.

Phil: But when it comes to that one couple that's blah, I could ...don't get excited... if they cancel they cancel, they skip till next week. Cause they think they're just here to jump through hoops, they're not really willing to work on the issue at hand, they want to without having any homework or anything else. I think that's how they see it. *That's just my motivation to why should I put all this freaking energy into this, when they are not doing anything on their part to get anything else out of it.*

Interpersonal Assessment

Within the Interpersonal Assessment domain the trainees, again, closely followed the IDM progression from highly motivated, self-aware therapists who rely on their supervisor for step-by-step direction to therapists with fluctuating motivation, who deal with dependency-autonomy conflicts, and who focus more on the client, understand client world views, and empathize with affect.

The IDM's clearest prediction for the Level 1 therapist is a self-focus which limits his or her ability to take the perspective of the client and their ability to monitor his or her own reactions accurately. The motivation to learn to assess clients is high, but the supervisor plays a crucial role in serving to redirect, interpret information, or offer alternative conceptualizations for the trainee. Throughout most of the academic year, the two first year trainees' self-focus appeared to limit their ability to take the perspective of the client, as well as, their ability to monitor their own reactions accurately. It was not until the last two interviews of the year that the trainees identified an awareness of client worldview and affect in the session. Consistent with the IDM's Self and Other Awareness structure, at this point both trainees possessed a high level of self-awareness in this new area of learning. Alan reported a belief that he had begun to work to convey his understanding of the client's emotional experience. Dirk also reported a new focus on the client's affect and a hope to express his own emotional responses effectively. Dirk's comment also reflected his previous Level 1 tendency in this domain to ignore, or not even notice, the client's worldview and affect that were occurring in therapy.

Alan: Emotions and affective stuff, that's what I wasn't doing before and my supervisor and I really tried to get me to focus on emotions and conveying to the client that I understand the emotions they're talking about.

Dirk: ... I think I'm doing better at paying attention to their affect in session, cause I've always assumed how they must feel, but I think I'm doing better about really finding out even though it's uncomfortable for me to do that. I think I'm doing better at finding out what's really there. Just being more connected, more emotionally available, that kind of thing. That's something I really have a lot of room to grow.

In accordance with the IDM this increased attention to client reactions indicated movement or "transition" to Level 2 in this domain. However, the apparent lack of empathetic understanding and the depth of emotional contact with the clients expected

more at Level 2 are still not present. Nonetheless, according to the IDM, the Level 2 therapist may overaccommodate to the client's worldview. Thus, the therapist may find it difficult to separate responses to clients based on accurate perceptions of the client's interpersonal interactions versus countertransference reactions outside of immediate awareness. It is not unusual that increased awareness in this domain is met with confusion by trainees. At the end of the academic year, Dirk demonstrated his initial awareness and his concern, or confusion regarding how to handle and "protect" himself from client affect.

Dirk: But maintain emotional boundaries so that you're, very much there and interacting with the person, but yet protecting yourself, because you have to, you know I'm starting to really see that. You really have to. I mean, you must! Not sitting around thinking about stuff, not, about the most I do anymore in terms of personalizing is just saying, "I'm glad I'm not that guy!" or whatever. And I try not to do that too much, cause I think that belittles their problems. I don't intend for it to, but I think maybe it does. But mainly, I'm just saying, not allowing things to bug me, cause I think, maybe I just rationalize it to myself, but I think I'm developing a coping mechanism that is really going to be essential to this field. Not just essential for my own sanity, but well, that, but, in turn, essential for my effectiveness and longevity. I will not make it if I let myself get drawn into every person's life that comes along 'cause it's just too much. But with yet, not getting callous to it, that's the trick.

Consistent with the IDM's Level 1 therapist in transition to Level 2, in this study, both second year trainees began the year with an awareness of client affect but reported having their eyes opened or an increased awareness of their own emotional reactions to clients. As suggested by the IDM, initially, the respective supervisors assisted trainees in developing an awareness of their own reactions to clients.

Phil: One week ago, I talked with my supervisor about how frustrated I was with this particular couple. My supervisor said that it is important that I let them know about my frustrations and tell them. It kind of *opened my eyes to how my frustration was interacting with my therapy.*

David: . . . Um, so, those kind of things and some in-session dynamics like being aware of how I am feeling about something the client is telling me and using that affect in myself to direct me in intervention.

As the year progressed it was interesting to note how the two second year trainees appeared to develop differently. Consistent with the IDM's prediction of Level 2 development, David experienced a fluctuation of motivation and confidence while gaining experience with more complexity. He, also, increased in awareness of his own emotional reactions within any given session, as well as began to report a greater appreciation for what the client actually felt and experienced. Throughout this process, he vacillated between independent functioning and less assertive, dependent situations.

David: I have more of an appreciation for what the client's experiencing and what they're going through, the emotional side and the soft stuff. Not their right parietal lobe has a lesion and it's causing them to do this or not being able to do that. That they're doing that and experiencing that, but it's also impacting their life in this way and they're depression. Uh, you know, and my supervisor made the point you can't fake empathy and I agree with that and I don't have an absence of empathy. I just don't express it to my clients and that's what I'm working on, being able to get in there with them and really talk about one specific thing and have a feeling about it.

As a result, David reported a greater investment and understanding of the client's world as he continued to work for a level of comfort with the application of affect and use of self in his therapeutic work.

David: I don't think awareness of my reactions has restricted my ability to focus very much. I mean, I am thinking about it during session, but I'm still able to focus on the client. I don't know that it gets that restrictive. In some sense it might have encouraged me to focus more on what they're going through. I'm getting better, but not where I want to be. I feel like I've made progress in that area, but I catch myself falling back into old habits. For awhile my supervisor would just kind of talk about it and we would discuss it kind of abstractly, but I've taken the lead with asking for more examples and have him display for me what that would look like in session and so he sort of started kind of modeling what I could do and that's been very helpful. So I can talk about it all the day and be in session and not really know what to do.

David's previous comment, made during the last interview of the year, is indicative of the beginning of the IDM's "transition" from Level 2 to Level 3 in this domain. His stated ability to focus on the client and the ability to reflect on personal reaction to the client enabled him to use the interpersonal nature of therapy to generate an in-depth understanding of the client's interpersonal world. However, despite the fact that he had the awareness and developed these interpersonal skills, David still struggled with confusion in application of these skills. Also, there was not solid evidence that David's empathic and understanding skills had developed to the point of being able to fully appreciate, let alone utilize, this perspective.

On the other hand, Phil appeared to avoid difficult and unsuccessful cases that may have caused him to question his effectiveness as a therapist. His motivation and effort in developing his interpersonal assessment skills seemed to be quite low as reflected by his reported "relief" and desire to escape from therapy situations, such as this, that caused confusion or frustration.

Phil: If they show up, if they don't show up, it doesn't matter to me . . . When they stopped coming in, it relieved my emotions because I didn't like working with them in the first place.

The IDM describes a "Pseudo Level 3 therapist" as an individual who is able to talk a good game and perhaps write convincing reports. However, closer examination of in-session behavior of this type of therapist indicates that he or she has avoided actually dealing with the necessary development of an intensive focus of the client. Insufficient understanding of the client's world and a lack of true empathy keep this therapist functioning more at an advanced Level 1 than either Level 2 or 3.

Phil's strong cognitive and affective reactions to various clients may have been

the result of the Level 2 therapist's inability to separate responses to the client based on accurate perceptions of the client's interpersonal interactions versus countertransference reactions outside of immediate awareness. Another consideration could be that sprinkled throughout the data were suggestions that Phil's overwhelming frustration and emotional reactions to various clients may have been the result of low motivation or insufficient effort to understand the client's world and thus not developing true empathy with them. It seemed that some of his clients confused and frustrated him, yet, he may have never really understood them. Phil's dislike for working with the couple he confronted and his resultant relieved emotions when they discontinued treatment reflected his avoidance of actually dealing with the necessary development of an intensive focus of the client, as well as a desire to escape from therapy situations that are confusing or frustrating.

Theoretical Orientation

The Theoretical Orientation domain development was also accurately predicted by the IDM. Highly motivated in his search for the "best" orientation for himself, Dirk displayed his dependence on his supervisors when he reported in the initial interview, "Well, I guess I probably best identify with the cognitive-behavioral because that seems to be the theory of choice of many of my supervisors." This focus on a single approach did serve to reduce anxiety, as predicted by the IDM, and began to provide some cognitive structure for understanding the process. Although not clearly predicted by the IDM, as the trainees experienced some success with clients and increased in a sense of autonomy, they appeared to experience a temporary period of lowered motivation in this domain.

Dirk: Applying theory on the one hand is getting easier, and on the other hand, I'm kind of thinking, well, my understanding of efficacy studies and that

really doesn't matter, so, as far as what theory you use, that, as long as you use it well. Overall, since Christmas break I'm just kind of cruising along on autopilot. I haven't really been doing a whole lot of thinking. I do whatever I'm told. I'm just floating through to Spring Break kind of thing. I'm motivated to keep up, but I'm not threatened about things like I probably should be.

Alan: I'm feeling a lot more comfortable with not being completely sure what to do. I don't feel as much pressure now to have to tie myself to a theoretical orientation. But, I'm also able now where I can take a client's problem and think about it from different perspectives where I couldn't before. But I've given up the idea that I need to use a manual in session.

Perhaps what appeared to be a fluctuation of motivation for these Level 1 therapists was actually a representation of Stoltenberg's et al. (1998) "disheartened" trainee as the trainees came to realize that no one approach would work in all cases and that specific guidance was lacking as to the superior approach across many situations. Nonetheless, at the end of the year, the trainees reported a high level of motivation to move away from their strict allegiance to one specific theoretical orientation to more experimentation with a wider variety of techniques and strategies.

Dirk: I'm trying, very actively trying, to formulate an eclectic approach, because I just don't see the rationale in picking one thing and sticking to it because you are told to or whatever. But in the sense of trying to learn 2 or 3 different orientations well and within their parameters and pick and choose

Alan: But the difference is this semester I'm okay not knowing what my theoretical orientation is. I feel like I do a good job with my clients and that I'm still learning about theory. And I'm learning to use different ones, but I guess before I felt like I had to know what my theoretical orientation was to be confident in counseling.

According to the IDM, after this movement away from a strict allegiance to a specific theoretical orientation identified with the program, faculty member, or supervisor one would expect the next step to be more experimentation with a wider variety of techniques and strategies. This study appeared to join the second year trainees defining

and building upon a personal approach. However, as the year progressed, the two trainees developed the Level 2 therapist's stronger focus on the client's responses and they began to value and enjoy exposure to other orientations in which they evaluated the general advantages and disadvantages for their given client against a growing understanding of their chosen therapeutic orientation. Finally, without abandoning this preferred orientation, the trainees chose to add theoretical constructs from empirical research to his working knowledge of therapy. David's comment specifically demonstrated the IDM's Level 2 therapist's reactance, which is a common result of the dependency-autonomy conflict.

David: Actually, looking back at it, the interpersonal intervention eventually opened up the way for the client to make some insights. But being encouraged to adopt an affective, almost feminist-based therapy, it's almost been implied that I don't use the CBT as much. I don't know if my supervisor intended that or not, but in some ways I reacted against that, because I'm not willing to give up CBT. But I'm willing to incorporate more affective stuff into it, because I believe CBT is effective, but you do have problems sometimes with it with some clients.

Phil: Well, at this point I'm definitely more humanistic, but then I did research with the OC client and cognitive-behavioral came out on top with techniques to use, and the other two I had to use cognitive-behavioral approach since that was what was the focus of the study. So I consider usefulness in a combination of both of the two. I think, humanistic, but with cognitive-behavioral tendencies.

Assessment Techniques

The IDM purports that early course work in assessment approaches and instruments, along with intake training, marks the beginning of work in this domain. Further, it states that some trainees may pursue an early preference for "interview data" as the primary source of information for assessment, while others may become intrigued with objective, norm-based assessment. This latter preference was supported by the first

year trainees in this study. In fact the IDM states that some seem to be initially more attracted to what they perceive as the more structured and straightforward process of therapy. Nonetheless, according to the IDM, motivation is usually high and the supervisor is expected to be there to help decide on the assessment strategy, train in administration and scoring, and interpret results.

Consistent with the IDM's prediction, both first year trainees chose to participate in the program's assessment clinic. Further, the trainees demonstrated and reported, across the year, an inclination toward the more structured, straightforward process of assessment over the less structured process of therapy.

Alan: The assessment clinic is easier for me than counseling, 'cause it's black and white, it's more black and white than. When someone comes in with a problem and I have to assess these different areas and I know what the tests are to assess these different areas and then I know what the results tell me and then I know what that means overall. It's more; I like black and white. I don't like shades of gray. And counseling is more of a shade of gray.

Dirk: I think assessment is actually one of my strengths I would say. I think my head's good for that kind of thing, maybe more a little more objective and quantifiable than most of what we do, not as much ambiguity. 'Course there's still tons of ambiguity, but not as much, so it's something I could really see myself doing a lot of later on.

Consistent with the view of the IDM, although the trainees grew in skill and confidence in assessment techniques within the assessment clinic, they had not developed these skills to the point that they were able to integrate these skills into therapy with their clients. The next step of development in this domain would be a demonstration of increased knowledge of diagnostic classifications and assessment instruments. Further, assessment may remain a separate activity and still not be integrated into other domains. Consequently, the perceived need for more assessment may not appear strong in many

cases.

The second year trainees had completed all assessment courses and had gained assessment experience through participation in the assessment clinic and/or graduate assistantships. Thus, both reported a well-developed confidence in their assessment skills. Nonetheless, with the exception of David's reported focus on client symptomatology and thorough history, the second year trainees did not appear to transfer or integrate formal assessment techniques into therapy with their clients.

David: Well, one that comes to mind is just to be aware of where your clients are symptomatically as far as their clinical picture, you know, symptoms, cores, frequency, how those tend to wax and wane and especially with my depressed clients, to always be kind of aware of where your depressed client is and the idea of suicide and potential for that, and to just routinely assess that when needed.

Client Conceptualization

The IDM states that this domain can take many forms, often varying according to the theoretical model the therapist uses. Consistent with the Level 1 therapist in the Dependency-Autonomy structure, the trainees reported a reliance on their respective supervisor to provide assistance with conceptualizations.

Dirk: So I guess now it's more how do I conceptualize this case? How do I get a client to see, uh, to have some insight into their behavior, you know, how do I get their attention. How do you manage this stress level so that they want to keep coming in but yet they still feel like they're getting something out of it, you know, so you know, not too far in either direction. I still need help with conceptualizing cases. I can tell you that much.

Although Phil was more comfortable and autonomous conceptualizing his individual adult clients, his new experiences and difficulty with couples was demonstrative of the Level 1 novice therapist, who tends to take a given conceptualization, or set of skills, to the limit indiscriminately before investing

themselves in learning new or more comprehensive conceptualizations. Phil reported his efforts to utilize Integrated Behavioral Couples Therapy and struggle to apply this approach as a template to try to conceptualize his couples. Phil, also, reported a reliance on his supervisor to provide assistance with conceptualization with his couples. Phil's overgeneralization with couples is a solid indicator of a Level 1 therapist in this domain.

Phil: And now when I view other couples, I can see that pattern, I mean, it just sticks out. The mother-child pattern in the relationship. The woman is always the mother, and the husband is the kid. It's amazing. I never noticed that before, but after my supervisor - we talked about that, I confronted that behavior - gosh, it's in every single session I see that.

Client Conceptualization goes beyond an axis or V-code diagnosis and includes the therapist's understanding of how the client's characteristics, history, and life circumstances blend to affect adjustment. The IDM does agree that the nature of this conceptualization varies depending on the therapist's worldview or theoretical orientation. The next steps in development would suggest that while the Level 2 therapist's conceptualizations of therapeutic dynamics and processes are based on a more complete understanding of the client's perspective, they may also be largely based on the client's viewpoint, without integration of other sources of information (i.e., objective or projective psychological testing). David's initial struggle with getting lost in the client's perspective is a solid demonstration of the Level 2 therapist's overaccommodation to the client.

David: I mean, it's so . . . I guess, it's where you actually regress a little bit in your microskills and your basic skills, because you're going to look, "Where the hell am I going with this client, because I'm conceptualizing it like this?"

According to the IDM, as the therapist transitions to Level 3, the tendency to focus on discrete pieces of information or overaccommodating to the client has given

way to an understanding of how diverse client variables interact to yield a complex conceptualization of the whole person. For example, throughout the year David developed a focus on client history and symptomatology. Toward the end of the year, he appeared to develop these skills to the point that he was able to integrate them into his conceptualization and therapy.

David: Well, one that comes to mind is just to be aware of where your clients are symptomatically as far as their clinical picture, you know, symptoms, cores, frequency, how those tend to wax and wane and especially with my depressed clients, to always be kind of aware of where your depressed client is and the idea of suicide and potential for that, and to just routinely assess that when needed.

Treatment Plans and Goals

The IDM predicts that the Level 1 trainee's initial focus is often more on keeping the clients coming than of expecting or planning facilitative change. In addition, it suggests that sometimes the trainees have techniques in mind to use, but do not necessarily tie these into goals or they have some goals in mind but no idea how to reach them. Finally, the trainee's approaches are sometimes random or based on a predetermined sequence of interventions as part of a structured program.

Although the data within this domain was very limited, the first year trainees' report in this study supports some of the model's prediction for a Level 1 therapist. For example, Dirk reported an initial focus on keeping clients coming, as well as, worked with a couple from his supervisor's outline. In addition, he reported an anxiety that his supervisor assumed that he knew more about treatment planning than he actually knew.

Dirk: My supervisor sat down and kind of wrote down a plan for a first session with them and we haven't gotten through it yet . . . I think my supervisor takes for granted or something that I don't need help to actually plan cases. And, well, I've had that, what I'm beginning to see is a pretty common

feeling that, gosh, I must be the worst counselor because they come once and I never see them again.

Phil's dependence on his supervisor, as well as his anxiety with the difficulty of understanding and providing effective treatment for couples is another solid indicator of the Level 1 therapist's self-focus and dependence on the supervisor for this client type in this domain.

Phil: I just got annoyed with it and my supervisor told me to confront them and say, "You're like a mother, and you're like an adolescent, like a teen-ager, if not younger. You're thirty-something, but you're actually only twelve."

Individual Differences

The IDM (1998) suggests that although it is increasingly likely that Level 1 trainees are being exposed to these issues early in their training experiences, they still often rely too heavily on their own idiosyncratic experiences and perceptions of the world in their attempt to understand their clients. This self-focus seemed to be captured by Dirk's unreported acknowledgment of the cultural differences between himself and a male client who was blind and living in extremely low socio-economic status. The only mention Dirk gave regarding this client was in context of telling about his comfortable and relaxed attitude in working with clients in session.

Dirk: I think I know how to appear interested to somebody, everybody does it all the time in conversation, so I think it's silly to put too much emphasis on that. So I don't worry about that kind of stuff so much. Occasionally I'll find myself leaning way back and looking out the window. I've done that a lot, 'cause one of my clients is blind, so he doesn't know. So I'm looking out the window the whole time I'm talking to him. I've got to stop doing that.

Consistent with Stoltenberg's et al. (1998) model, the scarcity of data in this domain seems to suggest that the first year, Level 1 trainees were unaware of and did not acknowledge the importance of differences in background, culture, gender, or physical or

mental abilities.

The IDM's prediction for progress to Level 2 across the structures in this domain is an ability to acknowledge the influence of sociocultural and environmental variables on behavior and the limitations of conventional counseling modalities for working with diverse clientele. However, according to the IDM, they may still vacillate between general culture-specific characteristics they believe apply to all individual members of various groups and the idea that every client is so unique that defining cultural values, attitudes, and behaviors may be ignored. Although the therapist may be confused or vacillating, he or she simultaneously has greater openness and interest in learning about other groups and exhibits a genuine attempt to understand the varieties of human experience and the effects on the counseling process. This vacillation in awareness and motivation was seen in the two second year trainees. For example, David demonstrated cultural awareness and high motivation as he sought out more information on women with depression.

David: Two of my clients are women with major depression. I have been focusing more on doing more affect based counseling and reading or learning more about feminist therapy or interpersonal therapy to work with these women.

On the other hand, Phil's experience with a female client who would not leave an "abusive" relationship was indicative of limited other-awareness and low motivation to thoroughly understand and/or appreciate her predicament.

Phil: I wanted to just tell her then, "Why are you doing this? I can't do anything for you, if you're still going to stay in this relationship!"

Professional Ethics

The IDM suggests that the Level 1 therapist is one high in motivation, self-

focused, and dependent on his or her supervisor. In the Professional Ethics domain, trainees are learning the guidelines for particular situations and fairly rigid in their application. Although the data was limited in this domain for the first years due to their oath of silence, the comment made by Dirk characterizes the rigid thinking and self-focus of a Level 1 therapist.

Dirk: It's something that's so clearly an ethical violation that it's not ambiguous at all, so I'm not sitting there saying, "Gosh, what are the ethics of this?" It's clearly that's really serious, so we haven't occasion to talk about it much and really things are just kind of tense right now, so I've just not brought it up. We came to an agreement that, yes, we needed to talk to the faculty, we needed to. It was, as I said, very severe, but then there's still the issue of, well first of all, *what's our liability going to be, that was part of it, the potential for us getting in some trouble ourselves*, not with a faculty per se, but just maybe even legal trouble potentially, very real potential for that. It was just difficult because it was someone that we work with and we were called upon to do something fairly distasteful.

The IDM proposes that transition into Level 2 includes a better understanding of the implications and ramifications of formal professional ethical guidelines. Further, at this level, trainees place more emphasis on client welfare. Phil's discussions during the Spring semester regarding the impending termination or transfer to other clinicians for each of his clients captured this client focus.

Phil: During the summer they are going to have to be transferred so they are one of those couples that is going to have to be seen, they can't be put off until August 'cause they won't be back. So they really need to be seen on an individual basis by someone who is going to be here through May and through August. They don't have the finances to go to another facility. And make sure that it's OK with my supervisor that they continue now as a couple and ... and their DAS, they both did the Dyadic Adjustment Scale, and they both said that they want their relationship to work out and they think it's just out of having no idea where else there is to go. So we'll take what we can get. The OCD. I will see him through, because he was already transferred from another therapist to me, and I don't want to transfer him again to for another two months. So I figure I can stay with him until August, and in August, he should be ... I'll start preparing him now that end of July will probably be the last time we'll work on issues,

just kind of prepare him that the end of July will be his last session here and if he needs to come back, he can, but that he would have to start with someone else, which I think would be really terrifying for him.

Inadequacies

Equally useful is to define the shortcomings of the IDM. In retrospect, areas of the model not specifically questioned in the interviews made it difficult, but not impossible for these to emerge. The researcher is left to draw some inferences based on the absence of data. Were the areas/domains with a dearth of data irrelevant to the trainees or were they indeed relevant, but untapped. The author leaves it to the reader and future researcher to determine if these inadequacies are due to weaknesses in the model or failure of this researcher to explore. The following are some of these areas.

Assessment Techniques

Although both second year trainees reported a well-developed confidence in their assessment skills, they provided limited discussions of assessment techniques and only in the context of their experience in the assessment clinic or their graduate assistantship. Nonetheless, given an increased focus on the client's perspective, the IDM's Self and Other Awareness structure suggests that the trainees may have difficulty integrating information from assessments and interviews that may be inconsistent or discrepant with their view of the client. This study provided no evidence of this difficulty in the second year trainees who appeared to meet the criteria for a Level 2 therapist. The CIQs and the interview reports by the trainees did not manifest a "siding" with the client or difficult or skewed interpretations of assessment results. Further, supervisors in this study offered no evidence of trainee difficulties integrating assessment information due to increased focus on the client's perspective.

Client Conceptualization

The IDM states that this domain can take many forms, often varying according to the theoretical model the therapist uses. Although the IDM does not account for the possibility that one domain may be contingent on development in another domain, in this study, Client Conceptualization appeared to be dependent on the trainees' knowledge and competence in the Theoretical Orientation domain for the two first year trainees. Both trainees reported their efforts to utilize the theoretical orientation they struggled to understand and apply at any given time as a template to try to conceptualize their clients.

Also, not clearly supported by the IDM, rather than a focus on specific aspects of the client's history, current situation, or assessment data at the exclusion of other relevant information, these Level I therapists, initially, appeared unable to focus on any aspect to gather relevant information.

Dirk: I guess I'm more comfortable at the general operations of getting a whole new community of resources, all that stuff is something that comes kind of more naturally now. So I guess now it's more how do I conceptualize this case? How do I get a client to see, uh, to have some insight into their behavior, you know, how do I get their attention. How do you manage this stress level so that they want to keep coming in but yet they still feel like they're getting something out of it, you know, so you know, not too far in either direction. I still need help with conceptualizing cases. I can tell you that much.

Alan: I still want to be more theory driven and use, be able to say, "I'm using this theory and I'm conceptualizing it this way" and do more of that, but that just seems so ambiguous. There's no manual that tells you how to do it. I didn't see enough clients, I don't think, to really meet that goal.

Later in the year, as their confidence in theory application grew, the trainees' skills in this domain appeared to remain dependent on their knowledge and understanding of theory and on their respective supervisor's direction.

Dirk: At first I was really caught up in the whole conceptualization of it, applying theory to conceptualize things. That's, I'm kind of thinking, well, my understanding of efficacy studies and that really doesn't matter,

so, as far as what theory you use, that, as long as you use it well, but I don't see anybody evaluating how well they're being used either. I guess I'm not so much thinking what will work, like a doctor thinking of medicine, but what makes it easier for me to conceptualize it. What makes more sense kind of theoretically.

Alan: I want supervision to be a chance for me to be able to check in and to talk about where I'm going and to pick up some things that I'm not seeing but to allow me to do most of the conceptualizing and thinking like that, and have me present it and have supervision say well that's accurate or that's not accurate because of this, this, and this, or you have been doing this a lot and you haven't picked it up. What do you think about that?

Treatment Plans and Goals

Setting basic treatment goals and plans seems functional and concrete for the Level 1 trainee and serves to reduce anxiety. However, the IDM's Self and Other Awareness structure suggests that the overaccommodation demonstrated by the Level 2 therapist may result in anxiety or despair concerning the difficulty of providing effective treatment or discouragement when initial treatment plans fail. Further, in the act of overaccommodating to the client's perspective, treatment goals may simply reflect the client's initial reasons for seeking counseling, ignoring the relevance of therapist assessment and conceptualization in the goal-setting process. These criteria did not manifest themselves clearly throughout this study. In fact little evidence to support this Level 2 prediction was provided by either trainee or supervisor interviews or written reports.

Professional Ethics

The IDM's Self and Other Awareness structure purports that the Level 2 therapist may place more emphasis on client welfare in situations where both client welfare and counselor welfare may be at stake. They may also sometimes view ethical standards as imposed limitations on practice that may be violated and justified by exceptions to the

rule. This character of change did not become evident throughout this study.

Implications for Further Research

This study was in no way an attempt to explain, define, or delineate all the variables involved in the complexity of counselor development and supervision. To do so, a researcher would need expansive resources in time, money, equipment, and willing research participants. None of these were currently feasible or available.

Since the study involved volunteer participants, their particular characteristics restricted the subject pool and possibly shaped the data (Rosenthal & Rosnow, 1975). Because of the limited number of participants, the study was exploratory, rather than conclusive. Obviously limited by the single program studied and the small sample size, repeated samples of different training models are recommended.

Also, it is interesting to note that the trainees consistently relinquished power in deference to their supervisor. Given that all participants in this study are male, this evidence contradicts Nelson and Holloway (1996) findings that female trainees relinquish power in deference to more powerful authority figure more often than male trainees. It is recommended that future repeated samples consider this gender, power, and supervision relationship in order obtain additional evidence supportive or discrepant of Nelson and Holloway's (1996) findings.

Second, both first year and second year trainees appeared not to transfer or integrate formal assessment techniques into therapy with their clients. This would be expected in the first-year trainees. For the second-year trainees perhaps they compartmentalized the assessment clinic and graduate assistantships from therapy due to separate supervisors and protocol. Given David's developed focus on client history and

symptomatology, another consideration is that the trainees had just begun to develop these skills to the point that they were now able to integrate them into their therapy.

It is uncertain if this program's use of an assessment clinic actually facilitated the compartmentalization of assessment techniques, and therefore possibly delayed the development of the trainee's skill to integrate this activity into other domains.

Nonetheless, throughout this study, trainees did not cognizantly include this domain as part of their reported clinical experience. Therefore, it is recommended that future research directly pursue trainee discussion on this domain despite the possible belief that it is a separate, and maybe less relevant, activity in the study.

Third, for the first-year trainees in this study, Client Conceptualization appeared to be dependent on their knowledge and competence in the Theoretical Orientation domain. Both trainees reported their efforts to utilize the theoretical orientation they struggled to understand and apply at any given time as a template to try to conceptualize their clients. Perhaps further research could determine if this contingency is a result of these two specific trainees, the dearth of data obtained in this domain, or an actual pattern in therapist development.

Fourth, the IDM's Self and Other Awareness structure suggests that overaccommodation demonstrated by the Level 2 therapist may result in anxiety or despair concerning the difficulty of providing effective treatment or discouragement when initial treatment plans fail. Further, in the act of overaccommodating to the client's perspective, treatment goals may simply reflect the client's initial reasons for seeking counseling, ignoring the relevance of therapist assessment and conceptualization in the goal-setting process. These criteria did not manifest themselves clearly throughout this study. In fact

little evidence to support this Level 2 prediction was provided by either trainee or supervisor interviews or written reports. Given the lack of data in this domain, it is recommended that future research utilize a more directive method of exploration in order to obtain additional evidence supportive or discrepant of the IDM's prediction of the Level 2 therapist.

Finally, the character of change the IDM's Self and Other Awareness structure purports that the Level 2 therapist may manifest in the Professional Ethics domain did not become evident throughout this study. It is recommended that future research utilize a more directive method of exploration in order obtain additional evidence supportive or discrepant of the Level 2 therapist in this domain.

References

- American Psychological Association. (1980). Criteria for accreditation of doctoral training programs and internships in professional psychology. Washington, DC: American Psychological Association.
- Ard, B.N. (1973). Providing clinical supervision for marriage counselors: A model for supervisor and supervisee. The Family Coordinator, 22, 91-97.
- Baker, E.E. (1978). Psychotherapy supervision: Introductory remarks. Symposium presented at the annual meeting of the American Psychological Association, Toronto.
- Bartlett, W. E., Goodyear, R. K., & Bradley, F. O. (Eds.). (1983). Special issue: Supervision in counseling II. The Counseling Psychologist, 11(1), 7-79.
- Bear, T.M., & Kivlighan, D.M., Jr. (1994). Single-subject examination of the process of supervision of beginning and advanced supervisees. Professional Psychology: Research and Practice, 25, 450-457.
- Bernard, J. M. (1979). Supervisory training: A discrimination model. Counselor Education and Supervision, 19, 60-68.
- Blount, C.M. (1982). A developmental mode of supervision: Implications for practice and research. Paper presented at the annual meeting of the American Psychological Association, Washington, DC.
- Bogdan, R.C., & Biklen, S.K. (1992). Qualitative research for education: An introduction to theory and methods. Boston: Allyn & Bacon.
- Brehm, J. W. (1966). A theory of psychological reactance. New York: Academic Press

- Chickering, A. W. (1969). Education and Identity. San Francisco: Jossey-Bass.
- Dowd, T., Milne, C., & Wise, S. (1984). The Therapeutic Reactance Scale: Development and reliability. Paper presented at the annual meeting of the American Psychological Association, Toronto, Ontario, Canada.
- Efstation, J.F., Patton, M.J., & Kardash, C.M. (1990). Measuring the working alliance in counselor supervision. Journal of Counseling Psychology, 37, 322-329.
- Ellis, M. V., & Dell, D. M. (1986). Dimensionality of supervisor roles: Supervisors' perceptions of supervision. Journal of Counseling Psychology, 33(3), 282-291.
- Erikson, E. H. (1968). Identity, youth, and crisis. New York: Norton.
- Fisher, B. L. (1989). Differences between supervision of beginning and advanced therapists: Hogan's Hypothesis empirically revisited. The Clinical Supervisor, 7(1), 57-74.
- Fitzgerald, L.F., & Osipow, S.H. (1986). An occupational analysis of counseling psychology: How special is the specialty? American Psychologist, 41, 535-544.
- Fleming, J. (1953). The role of supervision in psychiatric training. Bulletin of the Menninger Clinic, 17, 157-159.
- Friedlander, S.R., Dye, N.W., Costello, R.M., & Kobos, J.C. (1984). A developmental model for teaching and learning in psychotherapy supervision. Psychotherapy, 21, 198-196.
- Gaoni, B. & Neumann, M. (1974). Supervision from the point of view of the supervisee. American Journal of Psychotherapy, 24, 108-114.
- Garfield, S. L., & Kurtz, R. (1976). Clinical psychologists in the 1970s.

American Psychologist, 31, 1-9.

Grotjahn, M. (1955). Problems and techniques of supervision. Psychiatry, 18, 9-15.

Guest, P. D., & Beutler, L. E. (1988). Impact of psychotherapy supervision on therapist orientation and values. Journal of Consulting and Clinical Psychology, 56(5), 653-658.

Hart, G.M. (1982). The process of clinical supervision. Baltimore: University Park Press.

Harvey, O. J., Hunt, D. E., & Schroder, H. M. (1961). Conceptual systems and personality organization. New York: Wiley.

Heppner, P. P., & Roehlke, H. J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. Journal of Counseling Psychology, 31, 76-90.

Hess, A.K. (1986). Growth in supervision: Stages of supervisee and supervisor development. The Clinical Supervisor, 4, 51-67.

Hess, A. K., & Hess, K. A. (1983). Psychotherapy supervision: A survey of internship practices. Professional Psychology: Research and Practice, 14, 504-513.

Hill, C.E., Charles, D., & Reed, K.G. (1981). A longitudinal analysis of changes in counseling skills during doctoral training in counseling psychology. Journal of Counseling Psychology, 28, 428-436.

Hogan, R. A. (1964). Issues and approaches in supervision. Psychotherapy: Theory, Research, and Practice, 1, 139-141.

Hunt, D. E. (1971). Matching models in education: The coordination of teaching

methods with student characteristics. Toronto: Ontario Institute for Studies in Education.

Krause, A. A., & Allen, G. J. (1988). Perceptions of counselor supervision: An examination of Stoltenberg's Model from the perspectives of supervisor and supervisee. Journal of Counseling Psychology, 35(1), 77-80.

Leddick, G.R., & Bernard, J.M. (1980). The history of supervision: A critical review. Counselor Education and Supervision, 19, 186-196.

Littrel, J. M., Lee-Borden, N., Lorenz, J. (1979). A developmental framework for counseling supervision. Counselor Education and Supervision, 19, 129-136.

Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. The Counseling Psychologist, 10(1), 3-42.

Lukin, M., Dowd, E.T., Plake, B.S., & Kraft, R.G. (1985). Comparing computerized vs. traditional psychological assessment in a counseling setting. Computers in Human Behavior, 1, 49-58.

Mahler, M. S. (1979). Separation-individuation. The selected papers of Margaret S. Mahler, M.D., (Vol. II). New York: Wiley.

Matarazzo, R.G., & Patterson, D.R. (1986). Research on the teaching and learning of therapeutic skills. In S.L. Garfield & A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed., pp. 821-843). New York: Wiley.

McColley, S. H., & Baker, E. L. (1982). Training activities and styles of beginning supervisors: A survey. Professional Psychology: Research and Practice, 13, 283-292.

McCracken, G. (1988). The long interview. Newbury Park: Sage.

McNeill, B. W., Stoltenberg, C. D., & Pierce, R. A. (1985). Supervisees' perceptions of their development: A test of the counselor complexity model. Journal of Counseling Psychology, 32(4), 630-633.

McNeill, B. W., Stoltenberg, C. D., & Romans, J. S. (1992). The integrated developmental model of supervision: Scale development and validation procedures. Professional Psychology: Research and Practice, 23(6), 504-508.

Miars, R. D., Tracey, T. J., Ray, P. B., Cornfeld, J. L., O'Farrell, M., & Gelso, C. J. (1983). Variation in supervision process across trainee experience levels. Journal of Counseling Psychology, 30, 403-412.

Miller, P. H. (1989). Theories of developmental psychology. (2nd Ed.). New York: W. H. Freeman and Company.

Miller, R. (1982). Supervision: A conceptual model. The Counseling Psychologist, 10(1), 47-48.

Nelson, M. L. and Holloway, E. L. (1996). Relation of gender to power and involvement in supervision. The Journal of Counseling Psychology, 4(4), 473-481.

Norcross, J. C., Prochaska, J. O., & Gallagher, K. M. (1989). Clinical psychologists in the 1980s: Theory, research, and practice. The Clinical Psychologist, 42(3), 45-53.

Piaget, J. (1970). Structuralism. New York: Basic Books.

Piaget, J. (1971). Biology and knowledge: An essay on the relations between organic regulations and cognitive processes. Chicago: University of Chicago Press.

Rabinowitz, F. E., Heppner, P. P., & Roehlke, H. J. (1986). Descriptive study of process outcome variables of supervision over time. Journal of Counseling Psychology,

33(3), 292-300.

Reising, G. N., & Daniels, M. H. (1983). A study of Hogan's model of counselor development and supervision. Journal of Counseling Psychology, 30, 235-244.

Robiner, W. N., & Schofield, W. (1990). References on supervision in clinical and counseling psychology. Professional Psychology: Research and Practice, 21(4), 297-312.

Rosenthal, R. (1966). Experimenter effects in behavioral research. NY: Appleton-Century-Crofts.

Rosenthal, R., & Rosnow, R.L. (1975). The volunteer subject. NY: John Wiley & Sons.

Sansbury, D.L. (1982). Developmental supervision from a skills perspective. The Counseling Psychologist, 10(1), 53-57.

Stoltenberg, C. D. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. Journal of Counseling Psychology, 28(1), 59-65.

Stoltenberg, C.D., Ashby, R.H., Leach, M., McNeill, B.W., Eichenfield, G., & Crethar, H.C. (1996). Effects of supervisee reactance on the supervision relationship and satisfaction. Poster presented at the annual meeting of the American Psychological Association, Toronto, Ontario, Canada.

Stoltenberg, C. D., & Delworth, U. (1987). Supervising counselors and therapists. San Francisco: Jossey-Bass.

Stoltenberg, C. D., McNeill, B. W., & Crethar, H. C. (1994). Changes in supervision as counselors and therapists gain experience: A review. Professional

Psychology: Research and Practice, 25(4), 416-449.

Stoltenberg, C.D., McNeill, B.W., & Delworth, U. (1997). IDM: The Integrated Developmental Model of Supervision. San Francisco: Jossey-Bass.

Stoltenberg, C. D., Pierce, R. A., & McNeill, B. W. (1987). Effects of experience on counselor trainee's needs. The Clinical Supervisor, 5(1), 23-32.

Tracey, T. J., Ellickson, J. L., & Sherry, P. (1989). Reactance in relation to different supervisory environments and counselor development. Journal of Counseling Psychology, 36(3), 336-344.

Tryon, G.S. (1996). Supervisee development during the practicum year. Counselor Education and Supervision, 35, 287-294.

Wiley, M. O., & Ray, P. B. (1986). Counseling supervision by developmental level. Journal of Counseling Psychology, 33(4), 439-445.

Wiley, M.O. (1982). Developmental counseling supervision: Person-environment congruency, satisfaction, and learning. Paper presented at the annual meeting of the American Psychological Association, Washington, DC.

Worthen, V., & McNeill, B.W. (1996). A phenomenological investigation of "good" supervision events. Journal of Counseling Psychology, 43, 25-34.

Worthington, E. L., Jr. (1984). Empirical investigation of supervision of counselors as they gain experience. Journal of Counseling Psychology, 31(1), 63-75.

Worthington, E. L., Jr. (1987). Changes in supervision as counselors and supervisors gain experience. Professional Psychology: Research and Practice, 18(3), 189-208.

Yogev, S. (1982). An eclectic model of supervision: A developmental sequence

for beginning psychotherapy students. Professional Psychology, 13, 236-243.

Yogev, S., & Pion, G. M. (1984). Do supervisors modify psychotherapy supervision according to supervisees' level of experience? Psychotherapy, 21(2), 206-208.

Zucker, P. J., & Worthington, E. L., Jr. (1986). Supervision of interns and postdoctoral applicants for licensure in university counseling centers. Journal of Counseling Psychology, 33, 87-89.

Appendix A

COUNSELOR DEVELOPMENT AND SUPERVISION:
AN EXPLORATORY STUDY OF
THE INTEGRATED DEVELOPMENTAL MODEL OF SUPERVISION
Dissertation Prospectus
Approved for the University of Oklahoma
Department of Educational Psychology

Introduction

Loganbill, Hardy, and Delworth (1982, p. 3) have defined clinical supervision as “. . . an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person.” Supervision is a key aspect of practice for clinical and counseling psychologists, as well as for applications of psychology within schools, industry, and organizations. Until the mid-1970s, there was limited literature on supervision within psychology journals (Baker, 1978). In 1980, the American Psychological Association established the educational requirement that clinical, counseling and school psychology trainees needed to receive supervised practicum and internship experiences as part of their education toward a doctoral degree (American Psychological Association, 1980). This emphasized the importance of supervision in the development of a counselor. In recent years, there has been a proliferation of articles, books, and entire journals addressing supervision and related issues of professional development. The greater interest in supervision has resulted in *Psychological Abstracts* adding professional supervision as a category.

Although supervision is within the top five activities on which psychologists spend the most professional time (Garfield & Kurtz, 1976; Norcross et al., 1989) and more than two thirds of counseling psychologists provide clinical supervision (Fitzgerald & Osipow, 1986), few supervisors (less than 10 to 15 percent) have actually attended formal courses in supervision (Hess & Hess, 1983; McColley & Baker, 1982), and most lack training in supervision (Leddick & Bernard, 1980). Little is known about how supervisors assume the supervisory role (Loganbill, Hardy, & Delworth, 1982) and standardized rating scales for assessing supervisees' and supervisors' skills are wanting

(Hess & Hess, 1983; Matarazzo & Patterson, 1986). These data argue for the need for more research and a greater focus on issues relevant to the supervision of developing counselors.

The approach of the supervisor, what is taught, how fast it is taught, and what is assumed to be known by the trainee differs in accordance with the supervisor's assumptions about the trainees level of experience (Worthington, 1987). The manner in which supervision changes as counselors gain experience depends on the supervisor's beliefs regarding counseling and supervision (Bartlett, Goodyear, & Bradley, 1983). One of the most prominent explanations regarding supervision relies on developmental theory. The developmental perspective asserts that counselors and therapists change in abilities and needs as they gain counseling experience. Supervisors' interventions vary in accordance with perceptions of their trainee's developmental stage of counseling, rather than being based primarily on the content of the trainee's theoretical approach. Although counselors may not develop cleanly along precise developmental lines, it can be very helpful to a supervisor to be aware of expected developmental changes in organizing her or his supervisory approach.

Review of the Literature

Historical Perspective of Supervision and the Developing Counselor

The types of training that counselors with different levels of experience receive have changed over time (Leddick & Bernard, 1980). Early in the history of supervision, psychoanalysis dominated the field and supervisees underwent training analysis, presumably learning psychotherapy skills through experiencing the role of the client and through observing the training analyst at work. Later, it was thought that teaching the

theories of therapy and personality development occurred in the classroom, whereas training in counseling occurred at practicum sites or counseling agencies. As Carl Rogers, Robert Carkhuff, Charles Truax, Allen Ivey, and others developed technologies of training, “skills training” began to occur earlier in programs that trained therapists. Currently, counselors are expected to enter their first counseling practicum already knowledgeable of beginning counseling skills (Robiner & Schofield, 1990).

Much of the recent training and research on how supervision changes with time has been done by developmental theorists who have described supervision apart from the supervisor’s theory of counseling. Generally, in these theories an implicit stage theory of counselor development is assumed and supervisory behaviors that are thought to be consistent with the hypothesized level of development of the counselor are specified (Worthington, 1987; Stoltenberg, McNeill, & Crethar, 1994). Focus on counselor change over time serves as the critical difference between developmental theories and other theories of supervision. Major tasks of any developmental theory include: (1) describing changes within one or more areas of behavior over time, (2) describing changes in the relationships among areas of behavior; and, (3) explaining the course that the development has taken (Miller, 1989). A developmental theory that clearly describes and explains a path of development should not only provide organization and meaning to facts but also guide further research.

Stoltenberg and Delworth (1987) believe a theory of development must be able to “...describe behavior changes across time and across individuals and must then go on to explain why these changes occur in the order in which they are observed” (p. 2). They go on to state that a theory should also define an environment for encouraging the process of

development that the theory describes. Finally, such a theory should predict changes in both the counselor and the supervisory environment through the counselor's development.

History of Developmental Models of Counseling Supervision

Publication of theoretical articles in the 1950's by Fleming (1953) and Grotjahn (1955) serve as the roots to the history of a developmental perspective of counseling. Fleming's (1953) stages of development include: a) imitative learning, b) corrective learning, and c) creative learning. In the imitative learning stage, supervisors demonstrate methods of counseling and offer suggestions to the trainee. Anxious trainees, due to the novelty of the therapeutic experience, learn through imitating their supervisors. In the corrective learning stage less support is necessary because trainee self-confidence is relatively high. The supervisor primarily corrects inaccurate techniques and interpretations. The creative learning stage of trainee development is the most autonomous stage. In this stage, the supervisor permits the trainee optimal room to develop a therapeutic style while investigating personal reactions to the client and how these reactions affect counseling.

Grotjahn's (1955) developmental theory also describes three stages: a) period of preparation, b) period of elaboration on the therapist's knowledge of the client, and c) period of working through. Throughout the period of trainee preparation, the supervisor provides support, technical help, respect, and encouragement to the trainee. In the second phase, the supervisor focuses on the personality dynamics and psychopathology of the client. The working through phase of counselor development promotes a supervisory focus on the trainee's affect and conflicts in relation to the therapeutic process.

Hogan's (1964) two-page outline of a supervision process serves as the next influential theory of counselor development. Hogan's model proposed a progression through four stages of trainee development for psychotherapists and operationalized supervision behaviors ideal for each stage. The purpose of supervision in this model is to foster the growth of the trainee toward more independent functioning based on acquired skills and insight into the client and the trainee's own person. The roles of the trainee and the supervisor change over time as development occurs.

Hogan's first stage, characterized by trainee dependence on the supervisor, describes this novice counselor as neurosis bound, insecure, and un insightful, although highly motivated. When working with this Level 1 trainee, Hogan assumes trainee imitation of the supervisor, thus teaching, support, interpretation, and self-awareness training are recommended.

Hogan's Level 2 trainee is characterized by a dependency-autonomy conflict regarding the supervisory relationship. The trainee, while experiencing a fluctuation in motivation, vacillates between feelings of confusion and overconfidence. Clarification of these feelings of ambivalence was added to the list of appropriate supervisory behaviors recommended for working with the Level 2 trainee.

The Level 3 trainee demonstrates increased professional self-confidence and only conditional dependency on the supervisor. The trainee possesses increased ability to be insightful and evidences more stable motivation. At Level 3, supervision progresses to a more collegial relationship, with the supervisor displaying a blend of sharing, example, and personal confrontation.

Hogan's Level 4 trainee is considered a master psychologist characterized by

security in self, autonomy from the supervisor, insightfulness with awareness of the limitations of insight, stabilized motivation. A master psychologist also possesses an awareness of the need to confront and focus on both personal and professional problems. The supervisory relationship, if one exists, is collegial, emphasizing what Hogan refers to as the peer supervisor model, which is comprised of sharing, confrontation, and mutual consultation.

Ard (1973) described a five-stage model. In the first stage, Perceptorship, the trainee has the need of orientation. Thus the supervisor orients this beginning student. Stage two, Apprenticeship, consists of the supervisor responding to the trainee's requests for specific instruction. During the Mentorship or stage three, the trainee demonstrates work and struggles with personal issues. Here the supervisor critiques the work of the student and facilitates trainee self-examination. By stage four, Sponsorship, the trainee is largely competent and the supervisor simply instills more confidence. Finally, in stage five, Peership, the trainee has emerged from training to full professional status. The supervisor establishes a coequal relationship after termination of formal supervision.

In 1974, Gaoni and Neumann proposed a four-stage model without complementary recommended supervisor behaviors for each stage. The stages were defined as follows: a) Teacher-student stage, b) Apprenticeship, c) Developing the therapeutic personality, and d) Mutual consultation among equals.

Littrel, Lee-Borden, and Lorenz's (1979) model emerged from the integration of four existing models of training for counselors: teaching, counseling/therapeutic, consulting, and self-supervision. These four models were seen as useful for various tasks that trainees must master to become competent professionals. The models were

combined into a sequence that offered a four-stage model of supervision based on the integration of models of counselor training designed to encourage counselor competency.

In Stage 1, the supervisor's goals include building a supportive and non-judgmental supervision relationship, exploring and setting goals, and developing a learning contract defining criteria for counselor competency. During Stage 2 the supervisor teaches specific skills in counseling and conceptualization while focusing on the actions, feelings, and thoughts of the trainee with the goal of overcoming therapeutic blocks. In Stage 3, supervision is characterized by consultation, in which the goals are set by the trainee and self-evaluation is encouraged. Stage 4 of this model is distinguished by self-supervision.

Based on Hogan's (1964) outline, Stoltenberg (1981) proposed the Counselor Complexity Model (CCM). Constructs from Hunt's (1971) Conceptual Systems Theory and the earlier work of Harvey, Hunt, and Schroeder (1961) which emphasized matching trainee development to particular environments were adapted. Hogan's stages were retained, but descriptions of optimum supervision environments were enhanced. The CCM asserts that the counselor trainee becomes more cognitively complex and therapeutically capable as the trainee develops.

Stoltenberg (1981) described supervisory methods to create growth-producing environments for the trainees as they develop through four levels of complexity. In level 1, the novice trainee imitates the supervisor, is lacking in both self- and other-awareness, and thinks categorically about the various elements of counseling. This dependency on the supervisor is appropriately addressed by encouraging autonomy through instruction, interpretation, support, awareness training and exemplification in a very structured

environment.

A conflict between dependency and autonomy from the supervisor characterizes level 2. Striving for greater independence, the trainee becomes more self-assertive and less imitative while increasing in self-awareness and experiencing fluctuating motivation. The supervisor for this level should provide a less structured and more autonomous environment. Supervisory methods include ambivalence clarification, support, exemplification, and less instruction to encourage trainee development in this level.

Level 3 is depicted as a period of conditional dependency. The trainee develops a personal counselor identity with increased insight, more consistent motivation, increased empathy, and more differentiated interpersonal orientation. At this level, the supervisor should treat the trainee more like a peer, relying on structure provided by the trainee. Sharing, mutual exemplification, and confrontation are recommended supervisory behaviors at this level.

In the final level, master counselor, supervision becomes collegial, if utilized at all. A counselor who attains this level of development has adequate self- and other-awareness in therapy, is insightful of her or his own therapeutic strengths and weaknesses, has been able to integrate personal identity with high professional standards, and is able to maintain willful interdependence with the supervisor.

In 1982, Hart, Yogev, Blount and Wiley all proposed developmental supervision models. Wiley (1982) expanded on Stoltenberg's model of counselor complexity but identified five critical issues that are behaviorally defined for each of Stoltenberg's four stages. Hart (1982) offered three stages of recommended supervisor behaviors:

a) Didactic instruction, b) Feedback on trainee work and personal awareness, and

c) Integration of skill development with personal awareness. Yogeve (1982) presented a three stage developmental model, limited to first-year graduate trainees, with endorsed supervisor behaviors. The first stage, Role definition, is portrayed by the trainee's acknowledged commitment to becoming a therapist, demystification of therapy, and feelings of inadequacy, anxiety, but recognition of some strengths. The supervisor at this level helps the trainee with role definition, clarifying expectations in supervision and evaluation of the trainee. The trainee learns the skills of counseling in stage two, Skill acquisition. Here the supervisor observes the trainee and possibly engages in co-therapy with the trainee. Finally, the supervisor uses both emotional aspects and didactic and skill-practice aspects to facilitate stage three, Solidification and evaluations of practice. Blount's (1982) four-stage model also included advocated supervisor behaviors. During the first stage, Adequacy versus Inadequacy, the supervisor should create a supportive relationship in which awareness training, modeling, and didactic skills instruction may occur. According to Blount, the Independence versus Dependence struggle of stage two is best supervised by exemplification and integration of dynamics and advanced skill development. In stage three, Conditional dependency versus Individuation, the supervisor allows greater autonomy, offers appropriate confrontation, and encourages a peer relationship. The fourth stage, Professional integrity versus personal autonomy, is characterized by collegial consultation, self-supervision, supervision of others, and mentoring.

Loganbill, Hardy, and Delworth's (1982) model of supervision was based on Chickering (1969), Erikson (1968), and Mahler's (1979) developmental models. Their model identified three stages of counselor development: stagnation, confusion, and

integration. These stages are similar to stages identified by Hill et al. (1981) as well as by Hogan (1964) and Stoltenberg (1981). However, Loganbill's et al. (1982) added twist was that trainees need to resolve eight critical issues before becoming master counselors: competence, emotional awareness, autonomy, theoretical identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics. The trainee is thought to resolve the issues independently of each other. Thus the trainee could be in any of the three stages (stagnation, confusion, or integration) with any issue. They go on to posit that trainees will recycle through the three stages for these eight issues in ever deepening levels.

The first stage, stagnation, is characterized by a naive unawareness for the neophyte counselor, or "stuckness" for a more experienced counselor with little experience in the given area of content. The second stage, confusion, includes disorganization, conflict, and confusion and fluctuations in motivation. During this phase, the trainee seeks equilibrium while experiencing ambivalence. The third stage, integration, is made possible by the unfreezing of emotions, behaviors, and attitudes. At this time there is an integration of learning, reorganization of understanding, flexibility, and feelings of security based on awareness of areas of insecurity. In this stage, the counselor assimilates the intense emotional factors that were experienced in the second stage and integrates them with a cognitive conceptual learning.

The year 1982 concluded with models submitted by Miller and Sansbury. Miller (1982) describes a model with five stages: a) Quiescence, b) Early exploration, c) Imitation, d) Partial autonomy, and e) Autonomy. The supervisor's interventions across the stages are represented along three continua: a) intrusive -reflective, b) oppositional-

supportive, and c) prescriptive-elicitive. Sansbury's (1982) three-stage model begins with the Prepracticum stage. This stage consists of developing basic listening skills and assimilations of the counselor role. The supervisor facilitates with evaluative feedback, needs assessment, modeling good counseling skills, as well as, reinforcing and supporting the trainee. In stage two, Practicum, the trainee develops new therapeutic techniques, improves conceptualization, refines personal theory, develops competence, and establishes limits of responsibility for self and client. The supervisor analyzes cases, helps resolve counselor-client impasses, promotes counselor understanding through confrontation, role reversals, interpretation and feedback, as well as teaches the trainee to ask for help in supervision. During the final stage, Internship, the trainee broadens and refines understanding of clients, learns types of clients that are best helped, examines personal issues, and learns reliance of self. The Internship supervisor confronts the trainee on differences in talk and behavior, supports increased risk taking, helps the trainee with personal issues and assists trainee in self-evaluation. It is interesting to note that Sansbury's stages were defined by years of practicum experience and not individual development.

Friedlander, Dye, Costello and Kobos (1984) offered a three stage developmental model. In the first stage, the trainee possesses ambiguity. The supervisor helps the trainee deal with the demands for wide-ranging tolerance of ambiguity and emphasizes learning to learn. During stage two the trainee recognizes the limits of therapeutic conditions. The supervisor aids the trainee to see differences in theory and practice, and to accept mistakes and unanticipated client responses, and helps to deal with guilt over failures. The discovery of therapy as deep communication is introduced in stage three.

Here the supervisor helps to take the focus off techniques and onto human relationships. Finally, in stage four, the trainee uses eclecticism in light of client needs. The supervisor facilitates the development of a repertoire of interventions.

Hess's (1986) developmental model also included four stages: a) Inception, b) Skill development, c) Consolidation, and d) Mutuality. The Inception stage is characterized by confusion, anxiety, identity formation, unanchored experience, and adequacy versus inadequacy. Hess believes the supervisor should help to identify experience with cognitive maps for handling experience, as well as encourage, support and build trust. Working through the dependence versus independence conflict and choosing a theory make up the Skills development stage. The supervisor induces trainees to try out techniques, rehearses techniques with them, and gives corrective feedback. Throughout the Consolidation stage, skills become "owned," new skills develop, and the trainee may actually supervise less experienced colleagues. Here the supervisor simply encourages and facilitates the learning of new skills. Mutuality offers conditional dependency versus individualism and the establishment of a professional identity. Supervision takes the form of mentoring or collegial supervision and focuses on how the therapist's personality affects the case.

Stoltenberg and Delworth (1987) introduced the most comprehensive and detailed model of counselor development and supervision to date, the Integrated Developmental Model (IDM). The primary basis for this model includes the work of Hogan (1964), Stoltenberg (1981), Loganbill, Hardy, and Delworth (1982), Piaget (1970, 1971) as well as several empirical studies of counselor development conducted prior to 1987. The IDM uses three overriding structures to monitor trainee development through four levels across

various domains of clinical training and practice, thus integrating mechanistic and organismic models and providing markers to assess development across domains.

The three structures are Self and Other Awareness (Cognitive and Affective), Motivation, and Autonomy. The Self and Other Awareness structure indicates where the individual is in terms of self-preoccupation, awareness of the client's world, and enlightened self-awareness. The cognitive component includes the content of the thought processes whereas the affective component accounts for changes in emotions. Motivation reflects the trainee's interest, investment, and effort expended in clinical training and practice. Autonomy includes the changes in the degree of independence demonstrated by trainees over time.

The domains of professional activity can be conceptualized in varying degrees of specificity. Stoltenberg and Delworth (1987) offer the following categories: Intervention Skills Competence, Assessment Techniques, Interpersonal Assessment, Client Conceptualization, Individual Differences, Theoretical Orientation, Treatment Goals and Plans, and Professional Ethics. Although each of these could be further reduced to more specific domains, the general categories serve to highlight the fact that one must attend carefully to the focal activity in which the trainee is engaging to adequately assess the developmental level at which the trainee is functioning at any given time. Intervention Skills Competence addresses the trainee's confidence in and ability to carry out therapeutic interventions. Assessment Techniques addresses the trainee's confidence in and ability to conduct psychological assessments. Interpersonal Assessment extends beyond a formal assessment period and includes the "use of self" in conceptualizing a client's interpersonal dynamics. Client Conceptualization incorporates, but is not limited

to, diagnosis. This domain goes beyond an axis diagnosis and involves the therapist's understanding of how the client's characteristics, history, and life circumstances blend to impact adjustment. Individual Differences includes an understanding of ethnic, racial, and cultural influences on individuals as well as the idiosyncrasies that form the person's personality. Theoretical Orientation involves formal theories of psychology as well as eclectic approaches and personal integration. Treatment Plans and Goals addresses how the therapist plans to organize her or his efforts in working with clients in the psychotherapeutic context. Finally, Professional Ethics addresses how professional ethics and standards of practice are intertwined with personal ethics in the development of the therapist.

According to the IDM, the twin processes of assimilation and accommodation induce a counselor trainee's upward movement. Piaget (1970) described assimilation as the process of fitting reality into one's current cognitive organization. Accommodation, however, was defined as significant adjustments in cognitive organization that result from the demands of reality. Piaget considered assimilation and accommodation to be closely interrelated in every cognitive activity (Miller, 1989). Attempts to assimilate involve minor changes in the individual's cognitive structures as these adjust to new ideas, whereas accommodation involves the formation of new constructs through the loosening of old ones.

Level 1 counselors tend to assimilate with their clients, but accommodate with their supervisors. These trainees possess extreme self-focus and difficulties hearing their client's view. Level 2 trainees may demonstrate exceedingly tight assimilations with the supervisor. With clients, however, trainees tend to overaccommodate, losing their ability

to form their own structures. This conflict between overaccommodation and overassimilation may account for the confusion and struggle of Level 2. In Level 3, assimilation and accommodation begin to work in a more reciprocal manner.

The Level 1 trainee demonstrates a self-focus, resulting from apprehension regarding evaluation by the supervisor and the client. In all domains, the Level 1 trainee has skills to learn and needs opportunities to practice them. Stimulated by anxiety, the motivation of the Level 1 trainee is high across all domains and toward the activities associated with becoming a counselor which is characterized by a desire to learn the “right” way of counseling. Due to the lack of skills and confidence, this trainee is portrayed also by dependency on the supervisor across domains. This is a period of assimilation of new knowledge for the trainee.

The self-focus of Level 1 gives way to the Level 2 trainee’s focus on the cognitive and emotional experience of the client even to the extent that the trainee may lose track of self by delving too far into the client’s experience. This change in focus begins the accommodation process of the trainee’s therapeutic constructs. At this level, the disappointment and frustration throughout the experience of trying to become an adept counselor and contrasting periods of success, results in a fluctuation of trainee motivation. The domain of individual differences may be the only one that receives consistent and motivated interest from the trainee. This trainee also experiences a dependency-autonomy conflict. Again the conflict with the supervisor is often played out in the domain of individual differences. The trainee vacillates between a desire to be treated as an independent therapist and maintaining feelings of dependence on the supervisor. Resistance is seen across domains.

Vacillations characteristic of Level 2 trainees begin to diminish as the trainee attains an ability to productively use the dual processes of accommodation and assimilation. This Level 3 trainee is now able to comfortably utilize both self- and other-awareness, focusing personal cognitive and emotional processes relating to the client, as well as the experiences of the client. Trainee motivation is more consistent across domains. This motivation results from knowledge of idiosyncratic strengths and weaknesses, an understanding of the limitations of counseling, and the integration of individual identity with therapeutic style. The resolution of the above dependency-autonomy conflict results in confidence in one's ability to function as an autonomous counselor. Level 3 trainees feel comfortable seeking out qualified advice and evaluating this information in terms of its fit for their personal orientation, personal style, and impressions of the client.

The Level 3 Integrated Counselor has synthesized the knowledge and skills of Level 3 across all domains. This level may take considerable time and experience to be achieved, if at all. This level is different in that it moves away from the clear linearity of movement in the first three levels and reflects horizontal movement and depth. This therapist is consistently motivated, appropriately autonomous, and well focused, as well as "creative, able to learn from self and others and able to evolve strong and appropriate accommodations and assimilations throughout the life cycle" (Stoltenberg & Delworth, 1987, p. 45).

In their expansion of the IDM, Stoltenberg, McNeill, and Delworth (1997) elaborate on cognitive processing and development across domains as well as offer explanations for regression and similarity of behavior across levels. Within the construct

of cognitive processing, an important extension of the model is the notion of schemata. The authors rely on the definition of schemata as the information regarding the function, categories, parts, and so on of something as well as images of the entity that are organized together in memory. For the beginning trainee, it is suggested that initial schemata tend to be overly general and of little use distinguishing among numerous characteristics. This tendency to overgeneralize in schema development is characteristic of novices within a given domain. Discriminations are increasingly refined as one learns more about a particular domain.

Stoltenberg et al. (1997) also stress the importance that in practice, all counselors function at different levels of professional development across domains. This perspective on trainee development complicates the supervisor's task. Not only does a supervisor need to know how to provide optimal supervision for different levels of supervisees, but must also be able to assess level of development across the professional activities in which the trainees are engaged while under supervision. The supervisor must move from supervision appropriate for a particular level of development in one domain, to supervision appropriate for a different level of another domain, even within the same supervision session.

The authors also account for issues such as regression and similarity of behavior across levels. It is suggested Level 2 trainees under stress, in a crisis context or when things are not going well, may become dependent or, on occasion, evasive. This can result in lowered confidence in clinical work and may reflect behavior similar to Level 1 trainees. For Level 3, some of the self-focus seen in Level 1 returns, however the quality is remarkably different. The trainee is much more self-accepting of all professional

strengths and weaknesses. The Level 2 high empathy and understanding remains as the counselor focuses on the client, processes the information provided, and “pulls back” to reflect on her or his own reactions. This reflection can be fairly objective by including a memory search to identify relevant schemata and bring the information into awareness for use in decision-making. Through the self-knowledge that has developed, this counselor is more able to use her/himself in therapy.

Empirical Evidence of Counselor Development

One of the earliest empirical studies of the development of counselors was conducted by Hill, Charles, and Reed (1981). Through a longitudinal study, the researchers directly investigated the development of counselors as they gained supervised experience. They followed twelve counseling psychology graduate students through their training. Brief counseling work samples were collected at various times, as well as in-depth exit interviews. Results demonstrated improvement in skills over time as evidenced by the use of minimal encouragers and asking fewer questions during sessions. The exit interviews showed increases in student perception of confidence and abilities to focus on their clients, as opposed to themselves, over the course of their training. In addition, according to student perception, the tendency to become over-invested with clients declined. Students also reported that they had become more relaxed and spontaneous during counseling sessions and were more able to act naturally with their clients. As experience level increased, all trainees reported decreased levels of anxiety in dealing with clients. The trainees' views of their supervisors also changed over time. Trainees' views of their supervisors as experts in an evaluation role changed to a view of supervisors as consultants, with primary responsibility for clients belonging to the

trainees.

Miars et al. (1983) also investigated Stoltenberg's (1981) Counselor Complexity Model by asking 37 counseling or clinical psychologists to rate their supervisory behavior with first semester, second semester, advanced practicum and intern level trainees. Supervisors reported that they conducted supervision differently depending on the level of the hypothetical student at that level. The supervisors reported the most variations across supervisee level in dimensions of instruction, directiveness, structure, and degree of collegiality. Less direction, structure, support and teaching were considered necessary for the more experienced counselors. Supervisors' perceived supervisory environments paralleled Stoltenberg's expectations, though supervisors' expectations were less differentiated than Stoltenberg's.

Reising and Daniels (1983) tested constructs within Hogan's (1964) developmental model. Surveys were administered to 141 counselor trainees from 20 universities grouped by experience into premaster-, master-, advanced master-, and Ph.D. level counselors. Results provided strong support for the construct validity of Hogan's model though not for his supervision recommendations. Trainees in the premaster- and master levels reported higher levels of dependence on their supervisors, more technique orientation, more feelings of anxiety relevant to counseling, as well as less readiness for confrontation in the supervisory relationship than did the advanced master- and Ph.D. level trainees. Increased trainee experience resulted in reports of increased independence in the supervisory relationship.

Heppner and Roehlke (1984) evaluated constructs related to developmental models of supervision through three studies in which they surveyed a total of 145

supervisees. They examined beginning practicum, advanced practicum, and intern counselor trainees. The first study revealed that there were no differences in supervisory experience level for expectations, locus of control, or perceptions of supervisor as expert, attractive, or trustworthy.

In their second study, Heppner and Roehlke (1984) compared the supervision behaviors perceived by supervisees of different levels of experience. Results indicated that beginning practicum counselors were more satisfied with supervisors who fostered a positive relationship with the supervisee. Advanced practicum students were more satisfied with supervisors who facilitated development of additional counseling skills. Interns reported more satisfaction with supervisors who helped them to develop better counseling skills and allowed them to deal with personal issues or defensiveness that affect counseling.

In their third study, Heppner and Roehlke (1984) examined some of the critical incidents in supervision. Critical incidences occurred earlier for interns than they did for other practicum students. Also, for beginning and advanced trainees', the critical incidences centered around issues of emotional self-awareness, confrontation, competence and support, while the critical incidences of interns centered around personal issues and their own defensiveness in therapy.

Worthington (1984) surveyed 237 counselors from ten counseling centers nationwide. Classifying trainees into first-, second-, third-, fourth-year, and pre-doctoral interns. He found that supervision differed across levels of experience on independence with direction, preference for infrequently taught skills, and establishing goals. Ratings by trainees in practica 2, 3, and 4 suggested that their supervisors encouraged

independent actions while giving support and explicit instruction more frequently than practicum 1 trainees. Practicum 1 trainees report high satisfaction when given literature and reference material. This was not found to be true for trainees at other levels of experience. Practica 3, 4, and internship trainees reported high satisfaction when observed live by their supervisors. This was not found to be true for practica 1 and 2 trainees. Practica 1 and 2 trainees gave high ratings to supervisors who set and later re-negotiated goals. This was not true at higher levels of experience. Generally, supervisors were viewed as behaving in ways, which promoted independence in their trainees as they became more experienced counselors.

Yogev and Pion (1984) examined goals, expectations, and procedures as perceived by 31 supervisors with their first-year, second-year and internship-year trainees. Results indicated no differences perceived by supervisors on any of the variables studied across supervisee levels of experience.

Examining constructs from Stoltenberg's (1981) Counselor Complexity Model, McNeill, Stoltenberg, and Pierce (1985) administered the Supervisee Levels Questionnaire (SLQ) to 91 trainees. Divided, by experience, into groups of beginning, intermediate, and advanced, the SLQ gathered trainee self-perceptions both in counseling and supervision. Level of experience in this study was an aggregate of level of education, counseling and supervision experience. Results demonstrated significant differences for beginning versus intermediate trainees in self-awareness and dependency-autonomy. Results also found differences between intermediate and advanced experience trainees in theory/skills acquisition and dependency-autonomy. Differences were noted between beginning and advanced trainees on dependency-autonomy, self-awareness, and

theory/skills acquisition. The researchers discovered increased levels of self-awareness and knowledge of counseling skills, less dependence on the supervisor, and a greater desire for autonomy in counseling and supervision reported as the trainees' levels of experience increased.

Ellis and Dell (1986) examined supervision dyads via the perceptions of 19 supervisors relating to their supervisory roles as derived from Bernard's (1979) model of nine supervisor roles. Although different levels of supervisors and supervisees were included in the study, general reactions or "cognitive maps" to supervisor roles were assessed rather than the perceptions of suitability of these roles across different levels of trainees. Results indicated that neither the experience level of the trainee nor the supervisor alone affected the supervisor's description of the supervision. Nonetheless, results suggested a trend toward an interaction of supervisor and trainee experience levels consistent with Littrell, Lee-Borden, & Lorenz's (1979) model of supervision.

Rabinowitz, Heppner, & Roehlke (1986) examined beginning, advanced practicum, and internship level trainee perceptions of important issues and supervisor interventions following each weekly supervision session and upon termination of the supervisory relationship. Thus, the researchers examined differences across experience levels and changes throughout the semester long supervisory relationship. Overall, results indicated that the pattern of supervision for all three levels involved establishing a working supervisory relationship "...followed by a movement from dependency toward autonomy" (p. 299). This movement varied in rate, with beginning trainees retaining dependence on structure and support the longest. In the middle stage of the supervisory relationship, personal issues tended to arise and were most significant for the advanced

practicum trainees. As the supervisory relationship approached termination, all levels of "...trainees were more likely to make more autonomous interventions and show greater conceptual understanding" (pg. 299). Although the trainees of varying levels of experience possess many similarities, the existing differences were generally supportive of developmental models of supervision both across experience levels and throughout the four-month supervisory relationships.

Wiley and Ray (1986) tested aspects of Stoltenberg's Counselor Complexity Model (1981). They operationalized Stoltenberg's four levels of counselor development by describing each level in terms of phrases that applied to a counselor at that level. Throughout the United States, 71 supervisors rated 107 of their trainees on the list of descriptive phrases. The supervisors also described the environment that they believed they provided for each supervisee on a list of descriptive phrases. The researchers tested three main hypotheses. They found that the level of supervisor-rated development of their supervisees was related to the amount of supervised, not unsupervised, counseling experience of the counselor. They also found that the supervisors perceived themselves to be providing different levels of supervisory environment with supervisees of different levels of supervised counseling experience but not with supervisees of different levels of unsupervised counseling experience. Last, they found that congruence of supervisee's level of experience and supervision environment was unrelated to either supervisor's or supervisee's satisfaction with supervision. Generally, when supervisors did not match the supervision environment with the level of supervisee development, they differed by providing supervision at a level lower than the supervisee's level of development. There were a few gross mismatches, suggesting that supervisors might intuitively match levels

of counselor and supervision environment.

Zucker and Worthington (1986) surveyed 34 psychology interns and 25 post-Ph.D. psychologists being supervised for licensure. Results suggested that interns and post-Ph.D. psychologists were supervised similarly with the exception of evaluation and the amount of time spent in supervision. Interns received supervision that was generally more evaluative than the postdoctoral psychologists.

Stoltenberg, Pierce, & McNeill (1987) studied Stoltenberg's (1981) proposition that counselor trainees' needs change as a function of developmental level. They measured differences according to previous counseling experience, semesters of supervision and education. Based on previous counseling experience, significant differences were found between Levels 1 and 2 for feedback, and between Levels 1 and 3 for structure, feedback, and overall needs. Discrepancies were found between Levels 1 and 3 for feedback, structure and overall needs and between Levels 2 and 3 for structure and overall needs. Finally, based on the number of semesters of previous supervision, results indicated differences between Levels 1 and 3 for feedback, structure and overall needs and between Levels 2 and 3 for feedback.

Guest and Beutler (1988) investigation of 16 trainees over a three to five year period found that, in general, beginning trainees valued support from their supervisors and increasingly preferred supervisors who held complex and dynamic views of change as they gained experience. For advanced trainees, assessment of personal issues and relationships affecting the psychotherapy process increased in importance.

In a survey of 87 supervisors and 77 trainees from 31 schools, Krause and Allen (1988) studied Stoltenberg's (1981) model. Supervisors classified their trainees and the

trainees classified themselves according to Stoltenberg's (1981) model. The researchers developed a new instrument to measure perceptions of supervisory behaviors, feelings of satisfaction, and personal impact of supervision. Results indicated that supervisors perceived themselves as varying their behavior with trainees of different developmental levels in a manner consistent with Stoltenberg's (1981) model. However, trainees, did not perceive differences in their supervisors' behavior. Trainees in congruent dyads reported significantly more satisfaction in supervision than did trainees in noncongruent dyads. Congruency of dyads, however, had no affect on the supervisors' ratings of satisfaction.

Fisher (1989) investigated Hogan's (1964) developmental theory for "systems" oriented supervision using five American Association for Marriage and Family Therapy (AAMFT) approved supervisors and their 16 trainees (at least master's level). The trainees were divided into "beginning" and "advanced" categories according to the AAMFT cutoffs of 500 clinical hours and 100 supervision hours. No significant differences were found between the supervision of "beginning" and "advanced" trainees regarding the focus of supervision or between the types of supervisory relationships.

Tracey, Ellickson, & Sherry (1989) examined the reactions of 40 first-year practicum counselors and 38 advanced practicum counselors to different supervisory environments. The study highlighted the importance of attending to specific domains when choosing supervision environments. Their results indicated that all the participants preferred highly structured supervision (directive teaching) when dealing with a suicidal condition (low experience for all trainees). In response to non-crisis content, the beginning trainees preferred structured supervision in the form of directive teaching,

while the more experienced counselors preferred a less structured supervisory environment. Also, advanced trainees who were high in "reactance" demonstrated a preference for supervision with less structure than did advanced trainees with low reactance. These differences highlight the importance of not assuming advanced level of development across domains, but rather reinforces the need to assess specific developmental level for trainees.

In 1992, McNeill, Stoltenberg, and Romans revised the SLQ (SLQ-R) to reflect the three structures (self-other awareness, motivation, and dependency-autonomy) hypothesized by Stoltenberg and Delworth's IDM (1987) as important determinants of therapist development. The researchers examined 104 trainees in eight training sites across the nation and found significant differences between beginning and advanced trainees and the intermediate and advanced trainees in the expected direction. No differences were found between beginning and intermediate trainees. There was evidence of a lack of ceiling effects on the SLQ-R suggesting a higher possible range of scores of trainees possessing more experience.

Bear and Kivlighan (1994) used Stoltenberg and Delworth's (1987) IDM for the basis of a single-subject study examining the process of individual supervision. An experienced supervisor worked with both a beginning and an advanced trainee. The researchers taped and transcribed 12 supervision sessions for each dyad. The session transcripts were then rated for supervisor and supervisee interpersonal behaviors and for supervisee depth of information processing. Results, consistent with the IDM, revealed that the supervisor was more structured and directive with the beginning supervisee, who made more dependent responses. On the other hand, the supervisor was more collegial

and collaborative with the advanced supervisee, who made more autonomous responses. The directive and structured supervisor interventions produced more deep-elaborative information processing by the beginner whereas this preferred type of processing was stimulated by the collegial or consultative supervisor interventions for the advance trainee.

In a phenomenological investigation of “good” supervision events, Worthen and McNeill (1996) interviewed eight trainees from three APA approved counseling psychology doctoral programs. Results demonstrated that intermediate trainees, or Level 2, experienced a fragile and fluctuating level of confidence and a generalized state of disillusionment and demoralization with the efficacy of providing therapeutic interventions and were anxious and sensitive to supervisor evaluation. Trainees felt that their anxiety level decreased when supervisors helped to “normalize” their struggles as part of their ongoing development. They also characterized the supervisory relationship as one experienced as empathic, nonjudgmental, and validating, with encouragement to explore and experiment. These conditions appeared to set the stage for nondefensive analysis as their confidence was strengthened. Participants also reported an increased perception of therapeutic complexity, an expanded ability for therapeutic conceptualizing and intervening, a positive anticipation to reengage in previous difficulties and issues they had struggled with, and a strengthening of the supervisory alliance. Finally, Worthen and McNeill (1996) found that intern-level, or Level 3, trainees exhibited a basic sense of confidence and autonomy and inadequacies were identified as domain specific. As a result of increased levels of insight and self-awareness, Level 3 trainees not only display openness, but also prefer to further acknowledge and confront issues of

transference-countertransference, therapy-supervision overlap, and parallel processes in supervisory and client relationships. Interestingly, they also reported previous unrewarding supervision experience, perhaps resulting in an aversion to overt evaluation and a strong desire for more rewarding supervision. In common with lesser-experienced trainees, the interns also viewed good supervision as characterized by an empathic, nonjudgmental relationship with encouragement to experiment and explore, and they were pleased when their struggles were normalized. As a result, positive outcomes of good supervision events were similar to those of their less experienced peers. In addition, their confidence was affirmed and they reported an increased impetus for refining a professional identity.

Tryon (1996) examined the self-rated development of 25 Integrated Developmental Model Level 2 supervisees. The SLQ-R was used to assess ratings of self-other awareness, motivation, and dependency-autonomy among 18 clinical and 7 counseling advanced psychotherapy practicum trainees. Supervisees completed the SLQ-R at five weeks, fifteen weeks, and thirty-one weeks during the advanced practicum experience. Group data indicates significant development in supervisee self-rated autonomy during the year across the three testings. This developmental level signifies a shift from a self-focus to a focus on understanding clients and understanding their treatment relationships with clients.

Statement of the Problem

This study will investigate how first and second year students grow and progress within an APA accredited counseling psychology doctoral program. It will explore trainee responses to their training by considering not only the supervision received but

also the influences of the trainees' current and previous counseling experiences and the academic program itself. Through this exploration we might better understand and explain the growth and development unique to counselor trainees and supervision.

Questions related to these issues include the following:

Do changes in supervision as counselors gain experience promote growth and improvement of the trainee, or do they merely satisfy the trainee? How does the trainee make the transition from one level to the next? What can the supervisor do to facilitate movement from one level of counseling to the next? What can the supervisor do to prohibit movement from one level of counseling to the next? What are the trainee's needs at a given level and how do these needs change as the trainee gains experience? What can the supervisor do to contribute to satisfaction with supervision? What can the supervisor do to contribute to the dissatisfaction with supervision? What is the supervision relationship like?

Significance of the Study

Although there is evidence supporting general models of counselor development, the field still lacks clear evidence of the existence of some of the characteristics of level 2 trainees as hypothesized by Stoltenberg and Delworth (1987) and more recently Stoltenberg et al. (1997). The fluctuation in the motivation, the vacillation between autonomy and dependency, the client centered focus of the trainee, and a lack of interest in labeling clientele with a diagnosis, are noteworthy examples of hypothesized differences between level 2 trainees and other trainees.

Building on the knowledge and evidence gained thus far from researchers exploring trainees' supervisory needs as they gain experience, the consistency of trainee

and supervisor perceptions with developmental theories, the changes in supervisor behavior as trainees gain experience, and the change in supervision relationship as counselors gain experience (Stoltenberg, McNeill, & Crethar, 1994), this study proposes to contribute to current discussions concerning the relationships among trainee levels, needs, experience, and supervision. Through the Critical Incident Questionnaires, the objective instruments and interviews with trainees and supervisors, researchers may learn much about the knowledge and sources from which trainees benefit as they grow as counselors. Specifically, this study will include consideration of the interactions between trainees and supervisors in an APA accredited counseling psychology doctoral program and the influence of supervision on the growth and development of counselors. In addition to informing researchers, findings from this study could also inform those who supervise.

Limitations of the Study

The proposed study is in no way an attempt to explain, define, or delineate all the variables involved in the complexity of counselor development and supervision. To do so, a researcher would need expansive resources in time, money, equipment, and willing research participants. None of these is currently feasible or available. What this study can do is attempt to accurately portray the growth and development of two first year and two second year doctoral students within the context of an APA accredited counseling doctoral psychology program.

Since the study involves volunteer participants, their particular characteristics will restrict the subject pool and possibly shape the data (Rosenthal & Rosnow, 1975). Because of the limited number of participants, the study will be exploratory, rather than

conclusive.

Method

In investigations of supervision and counselor training, researchers have used a variety of methods in study designs including objective tests, interviews and observations. The proposed study considers individuals and their development as counselors within a training program context, thus, the methods for investigation should allow for highly individualized responses. Critical Incident Questionnaires (CIQs; see Appendix C) and interviews will permit participants to give their perceptions of the supervision experience in individual ways without limitations imposed by objective-test items. By focusing on the experiences revealed through the CIQs and referencing information gained through interviews as well as objective instruments, this study can add to current knowledge of counselor development and supervision.

Participants

Four men (two first year and two second year students) of European-American ethnicity were recruited from a Midwest counseling psychology doctoral program accredited by the American Psychological Association. Trainees ranged in age from 23 to 27 years, were in their 2nd to 4th year of graduate education, and had completed 2-6 semesters of supervision. Their supervisors were two men, a 34 year-old Mexican-American at the start of his supervisory experience and a 43 year old European-American with 16 years of supervisory experience. All six participants chosen were men so as to avoid gender interaction within the supervision dyad. Further, trainees were chosen for their match in education, counseling and supervision experience. Criteria for participant selection included willingness to complete the CIQs, the objective instruments and participate in tape-recorded interviews, use of English as primary language, ability to

articulate their supervision experience, and current counseling supervision in the practicum. Participants were volunteers and were not paid for any part of their involvement in the research. All trainees and supervisors who were invited to participate accepted the invitation.

The number of participants is small, so the sample's characteristics should not be considered representative of the program, APA accredited programs in general, or the counseling field. Accordingly, results should not be generalized to a larger population of counseling psychology trainees as a whole. The small sample size is a necessity since I am the sole researcher, and time and resources are limited.

Instruments

Supervisee levels of the trainees were assessed using the Supervisee Level Questionnaire-Revised (SLQ-R; McNeill, Stoltenberg, & Romans, 1992), as well as supervised counseling experience (see Appendix D). The SLQ-R is a 30-item Likert-style instrument constructed to tap characteristics on a continuum of development associated with levels hypothesized by Stoltenberg and Delworth (1987). It has three subscales that are based on the overriding structures of Stoltenberg and Delworth's model: Self and Other Awareness, Motivation, and Dependency-Autonomy, with an emphasis on applications to the domains of intervention competence, client conceptualization and interpersonal assessment. Cronbach alpha reliability coefficients calculated for the three subscales resulted in reliability estimates of .83, .74, .64, and .88 for the Self- and Other Awareness, Motivation, Dependency-Autonomy subscales and total scores, respectively. Pearson correlation coefficients were calculated on the above subscales to assess the construct validity of the SLQ-R. The scores indicate that the

subscales were significantly related for Self and Other Awareness and Dependency Autonomy, $r = .53$, $p < .001$; for Self and Other Awareness and Motivation, $r = .58$, $p < .001$; and Motivation and Dependency Autonomy, $r = .43$, $p < .001$. A multivariate analysis of variance (MANOVA) using trainee experience as the independent variable and the SLQ-R subscales as dependent variables was used to initially explore for differences in SLQ-R subscale scores between the groups. Hotelling's test of significance indicated that the beginning, intermediate, and advanced groups differed on a linear combination of SLQ-R subscale scores, $F(6,198) = 2.45$, $p < .001$. An analysis of variance (ANOVA), again using the independent variable of trainee experience, indicated that the total SLQ-R scores of the groups differed, $F(2,102) = .737$, $p < .001$. Finally, McNeill et al. (1992) conducted a series of focused, one-way planned contrasts in the form of one-tailed t-tests to test the hypothesis that subscale and total scores on the SLQ-R would increase as a result of trainee experience. Using an alpha level of .05, they found consistent significant differences in mean subscale and total SLQ-R scores between the beginning and advanced trainee groups as well as the intermediate and advanced trainee groups. Given that the levels in the validation study were set somewhat arbitrarily, the SLQ-R is considered a valid and reliable instrument for delineating a relative measure of trainee development level within Stoltenberg and Delworth's (1987) model.

The trainees' supervisee needs were assessed with the Supervisee Needs Questionnaire (SNQ; Stoltenberg, Pierce, & McNeill, 1987). The SNQ consists of 30 items in a Likert scale format (see Appendix E). The SNQ was designed to assess the needs of trainees within supervision along five conceptual categories: (1) Structure--the

need to have one's supervisor provide the structure in supervision, (2) Instruction--the need to receive specific instruction in areas such as assessment, diagnosis, and therapeutic skills and techniques, (3) Feedback--the need to receive direct feedback in regard to professional strengths and weaknesses, progress as a counselor, etc., (4) Support/Availability--the need of the supervisor's support, counsel, and availability for emergency consultation, (5) Self-Directed--the need to define one's own structure and criteria in supervision. The SNQ was found to be a valid measure of the trainee's self-reported needs in supervision at various levels of professional development (Stoltenberg, Pierce, & McNeill, 1987). One-tailed t-tests based on levels of education indicated differences in the predicted direction between levels 2 and 3 for structure and overall needs, as well as between levels 1 and 3 for structure, feedback, and overall needs. One-tailed t-tests based on semesters of previous counseling experience indicated differences in the predicted direction between levels 1 and 3 for structure, feedback, and overall needs, and between levels 1 and 2 for feedback. Finally, one-tailed t-tests based on number of semesters of previous supervision indicated differences in the predicted direction between levels 1 and 3 for structure, feedback, and overall needs, and between levels 2 and 3 for feedback and overall needs.

The relationship within counselor supervision was assessed with the 23-item Likert-style supervisor and 19-item supervisee Likert-style Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990). The supervisor instrument contains three subscales: Client Focus, Rapport, and Identification, and the supervisee instrument contains Rapport and Client Focus subscales (see Appendix F). Cronbach's alpha reliability coefficients resulted in internal consistency reliability

estimates of .71, .73, and .77 for the Supervisor subscales Client Focus, Rapport, and Identification respectively. Alpha coefficients for the Supervisee were .90 for Rapport and .77 for Client Focus (Efstation et al., 1990. p.325). Item-scale correlations for the Supervisor SWAI ranged from .29 to .54 for the Client Focus scale, from .29 to .56 for the Rapport scale, and from .38 to .57 for the Identification scale. Trainee SWAI item-scale correlation's ranged from .44 to .77 for the Rapport scale and from .37 to .53 for the Client Focus scale.

In addition, the Supervision Attitude Inventory (SAI; Stoltenberg, Ashby, Leach, McNeill, Eichenfield, & Crethar, 1996), a revision of the Therapeutic Reactance Scale (TRS; Dowd, Milne, & Wise, 1991), was used for the purpose of measuring psychological reactance specific to the supervision context (see Appendix G). The SAI is composed of 28 items that are responded to using a 4-point format from *strongly disagree* (1) to *strongly agree* (4). The items are summed to yield a total reactance score and two correlated subscale scores (behavioral reactance and verbal reactance). Cronbach's alpha reliability coefficients resulted in internal consistency reliability estimates of .76, .63, and .76 for Behavioral Reactance, Verbal Reactance, and Total Reactance, respectively. The TRS Cronbach's alpha reliability coefficients resulted in internal consistency reliability estimates of .81, .75, and .84 for Behavioral Reactance, Verbal Reactance, and Total Reactance, respectively. Test-retest reliability for the original sample ranged from .57 to .60 over 3 weeks, while internal consistency reliability ranged from .75 to .84. Lukin, Dowd, Plake, and Kraft (1985) found a 1-week test-retest correlation of .76 on the total scale.

Finally, the Supervision Evaluation Scale (SES; Tracey, Ellickson, & Sherry,

1989) was used to measure the evaluation of supervision by the trainees and the supervisors (see Appendix H). The SES is a scale consisting of 10 items measuring the positive evaluation of and willingness to work with the specific supervisor. Participants are asked to respond to each item using a 7-point scale from *very strongly disagree* (1) to *very strongly agree* (7). The responses of these 10 items are averaged to yield a mean evaluation score, with high scores representing positive evaluation. Internal consistency estimate of .95 was obtained.

The Critical Incident Questionnaire (CIQ; Heppner & Roehlke, 1984) asked trainees and supervisors to describe events related to critical incidents, or major turning points, within the supervision process that resulted in change(s) in the trainee's effectiveness as a counselor. For this instrument, a critical incident was defined as an occurrence that resulted in a significant change; that is an interaction between supervisor and trainee, which is recognizable as a kind of turning point, resulting in change(s) in the trainee's effectiveness as a counselor/psychotherapist. This definition was followed by three questions that asked for information related to the occurrence of any such critical incident in supervision; these were as follows: (a) Please describe any such incident in your supervision this session, (b) What made this a critical incident for you? and (c) What were you wanting to gain from this supervision session? Did you receive it?

Interviews were conducted with each participant across the academic year. According to Bogdan and Biklen (1992), interviews are used predominantly in two ways: as the primary source of data, or in conjunction with other data gathering techniques such as observation or written questionnaires. This second use is most appropriate for the proposed study because the interview can provide insight in analyzing participants' CIQs

and can lead to a better understanding of how supervision and personal aspects influence counselor training/development. Given that vital role in the data collection, it is important to consider some of the issues associated with interviewing and interview data. McCracken (1988) outlined several concerns related to the conducting of interviews. One point made is the importance of questions and their influence on the resulting data. Interviewers can unintentionally skew outcomes by using inappropriate questions (too open or too restricted), not listening carefully, or failing to follow-up with suitable prompts. Researchers should match their questions to the research goal (Bogdan & Biklen, 1992). For exploratory studies, questions may be open-ended while more structured questions provide support for specific research topics. In any case, those conducting interviews must take care to avoid so much control that the respondent "cannot tell his or her story personally in his or her own words" (p. 97).

According to McCracken (1988), questions at the beginning of a longitudinal study could include questions gathering biographical data or small-talk in an attempt to locate common ground between the interviewer and respondent (Bogdan & Biklen, 1992). A common approach begins with biographical data before moving on to general questions about attitudes toward the research topic, and then in later interviews, questions about specific details revealed by observations or other data collected. Such a technique of moving from biographical data, to general questions, to specific details might help build the rapport between researcher and participant which is important to this type of data collection method.

The rapport or relationship between researcher and respondent was another concern of McCracken (1988). He commented on the unusual nature of the interview

and its differences from conversation since one person does most of the talking and the other essentially listens and probes with questions. McCracken believed that such a social dynamic requires careful crafting to meet the goals of the research and at the same time protect the rights of the respondent.

Other aspects of the researcher/respondent relationship were explored by Rosenthal (1966). He found that several factors influence participant behaviors including gender, age, race, cultural background, and volunteer status (Rosenthal & Rosnow, 1975). For instance, female participants tend to be treated more considerately than male participants. Also, volunteers tend to have unique characteristics all their own: are most often first-born, have a high need for approval, and are more sociable than non-volunteers. These few factors and the hundreds of others brought to light by Rosenthal suggest that no matter how neutral and unbiased the researcher wishes to remain; human interactions could influence the data. Such interactions do not mean that conducting interviews is an inappropriate way to gather data. On the contrary, the interactions and relationship between researcher and respondent reveal information otherwise lost or buried. Knowledge of the factors that could influence interview data allows researchers to develop adequate questions, to plan the interview session, to handle unexpected responses, and to analyze the results in the most appropriate way possible.

For the proposed study, careful attention should yield results, which will add to the body of knowledge about supervision and the development of counselors. Interviews will give access to personal, counseling, and supervision experiences, as well as educational backgrounds that guide supervision and affect counselor training.

Procedures

Data collection involved the following procedures. The Critical Incident Questionnaires (CIQ; Heppner & Roehlke, 1984) were completed independently by both trainee and supervisor following every supervision session from September 1996 through May 1997. Objective questionnaires, including copies of the Supervision Evaluation Scale (SES; Tracey, Ellickson & Sherry, 1989), Supervisee Levels Questionnaire-Revised (SLQ-R; McNeill, Stoltenberg & Romans, 1992), the Supervisee Needs Questionnaire (SNQ-T, SNQ-S; Stoltenberg, Pierce, & McNeill, 1987), the Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990), and the Supervision Attitude Inventory (SAI; Stoltenberg et al., 1996) were administered three times, at the start (September 1996) and completion (December 1996) of the fall semester and then at the completion of the spring semester (May 1997).

In addition, audio-taped personal interviews, lasting approximately thirty minutes to one hour each to follow up on responses to the questionnaires, were conducted six times for each subject across the Fall and Spring semesters on the following dates: October 4th - October 11th, 1996; November 15th - November 22nd, 1996; December 16th - December 18th, 1996; February 18th - February 25th, 1997; April 5th - April 11th, 1997; and May 5th - May 9th, 1997. Interviews were conducted by the principal investigator.

References

- American Psychological Association. (1980). Criteria for accreditation of doctoral training programs and internships in professional psychology. Washington, DC: American Psychological Association.
- Ard, B.N. (1973). Providing clinical supervision for marriage counselors: A model for supervisor and supervisee. The Family Coordinator, 22, 91-97.
- Baker, E.E. (1978). Psychotherapy supervision: Introductory remarks. Symposium presented at the annual meeting of the American Psychological Association, Toronto.
- Bartlett, W. E., Goodyear, R. K., & Bradley, F. O. (Eds.). (1983). Special issue: Supervision in counseling II. The Counseling Psychologist, 11(1), 7-79.
- Bear, T.M., & Kivlighan, D.M., Jr. (1994). Single-subject examination of the process of supervision of beginning and advanced supervisees. Professional Psychology: Research and Practice, 25, 450-457.
- Bernard, J. M. (1979). Supervisory training: A discrimination model. Counselor Education and Supervision, 19, 60-68.
- Blount, C.M. (1982). A developmental mode of supervision: Implications for practice and research. Paper presented at the annual meeting of the American Psychological Association, Washington, DC.
- Bogdan, R.C., & Biklen, S.K. (1992). Qualitative research for education: An introduction to theory and methods. Boston: Allyn & Bacon.
- Chickering, A. W. (1969). Education and Identity. San Francisco: Jossey-Bass.
- Dowd, T., Milne, C., & Wise, S. (1984). The Therapeutic Reactance Scale:

Development and reliability. Paper presented at the annual meeting of the American Psychological Association, Toronto, Ontario, Canada.

Efstation, J.F., Patton, M.J., & Kardash, C.M. (1990). Measuring the working alliance in counselor supervision. Journal of Counseling Psychology, 37, 322-329.

Ellis, M. V., & Dell, D. M. (1986). Dimensionality of supervisor roles: Supervisors' perceptions of supervision. Journal of Counseling Psychology, 33(3), 282-291.

Erikson, E. H. (1968). Identity, youth, and crisis. New York: Norton.

Fisher, B. L. (1989). Differences between supervision of beginning and advanced therapists: Hogan's Hypothesis empirically revisited. The Clinical Supervisor, 7(1), 57-74.

Fitzgerald, L.F., & Osipow, S.H. (1986). An occupational analysis of counseling psychology: How special is the specialty? American Psychologist, 41, 535-544.

Fleming, J. (1953). The role of supervision in psychiatric training. Bulletin of the Menninger Clinic, 17, 157-159.

Friedlander, S.R., Dye, N.W., Costello, R.M., & Kobos, J.C. (1984). A developmental model for teaching and learning in psychotherapy supervision. Psychotherapy, 21, 198-196.

Gaoni, B. & Neumann, M. (1974). Supervision from the point of view of the supervisee. American Journal of Psychotherapy, 24, 108-114.

Garfield, S. L., & Kurtz, R. (1976). Clinical psychologists in the 1970s. American Psychologist, 31, 1-9.

Grotjahn, M. (1955). Problems and techniques of supervision. Psychiatry, 18, 9-

15.

Guest, P. D., & Beutler, L. E. (1988). Impact of psychotherapy supervision on therapist orientation and values. Journal of Consulting and Clinical Psychology, 56(5), 653-658.

Hart, G.M. (1982). The process of clinical supervision. Baltimore: University Park Press.

Harvey, O. J., Hunt, D. E., & Schroder, H. M. (1961). Conceptual systems and personality organization. New York: Wiley.

Heppner, P. P., & Roehlke, H. J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. Journal of Counseling Psychology, 31, 76-90.

Hess, A.K. (1986). Growth in supervision: Stages of supervisee and supervisor development. The Clinical Supervisor, 4, 51-67.

Hess, A. K., & Hess, K. A. (1983). Psychotherapy supervision: A survey of internship practices. Professional Psychology: Research and Practice, 14, 504-513.

Hill, C.E., Charles, D., & Reed, K.G. (1981). A longitudinal analysis of changes in counseling skills during doctoral training in counseling psychology. Journal of Counseling Psychology, 28, 428-436.

Hogan, R. A. (1964). Issues and approaches in supervision. Psychotherapy: Theory, Research, and Practice, 1, 139-141.

Hunt, D. E. (1971). Matching models in education: The coordination of teaching methods with student characteristics. Toronto: Ontario Institute for Studies in Education.

Krause, A. A., & Allen, G. J. (1988). Perceptions of counselor supervision: An examination of Stoltenberg's Model from the perspectives of supervisor and supervisee. Journal of Counseling Psychology, 35(1), 77-80.

Leddick, G.R., & Bernard, J.M. (1980). The history of supervision: A critical review. Counselor Education and Supervision, 19, 186-196.

Littrel, J. M., Lee-Borden, N., Lorenz, J. (1979). A developmental framework for counseling supervision. Counselor Education and Supervision, 19, 129-136.

Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. The Counseling Psychologist, 10(1), 3-42.

Lukin, M., Dowd, E.T., Plake, B.S., & Kraft, R.G. (1985). Comparing computerized vs. traditional psychological assessment in a counseling setting. Computers in Human Behavior, 1, 49-58.

Mahler, M. S. (1979). Separation-individuation. The selected papers of Margaret S. Mahler, M.D., (Vol. II). New York: Wiley.

Matarazzo, R.G., & Patterson, D.R. (1986). Research on the teaching and learning of therapeutic skills. In S.L. Garfield & A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed., pp. 821-843). New York: Wiley.

McColley, S. H., & Baker, E. L. (1982). Training activities and styles of beginning supervisors: A survey. Professional Psychology: Research and Practice, 13, 283-292.

McCracken, G. (1988). The long interview. Newbury Park: Sage.

McNeill, B. W., Stoltenberg, C. D., & Pierce, R. A. (1985). Supervisees' perceptions of their development: A test of the counselor complexity model. Journal of

Counseling Psychology, 32(4), 630-633.

McNeill, B. W., Stoltenberg, C. D., & Romans, J. S. (1992). The integrated developmental model of supervision: Scale development and validation procedures. Professional Psychology: Research and Practice, 23(6), 504-508.

Miars, R. D., Tracey, T. J., Ray, P. B., Cornfeld, J. L., O'Farrell, M., & Gelso, C. J. (1983). Variation in supervision process across trainee experience levels. Journal of Counseling Psychology, 30, 403-412.

Miller, P. H. (1989). Theories of developmental psychology. (2nd Ed.). New York: W. H. Freeman and Company.

Miller, R. (1982). Supervision: A conceptual model. The Counseling Psychologist, 10(1), 47-48.

Norcross, J. C., Prochaska, J. O., & Gallagher, K. M. (1989). Clinical psychologists in the 1980s: Theory, research, and practice. The Clinical Psychologist, 42(3), 45-53.

Piaget, J. (1970). Structuralism. New York: Basic Books.

Piaget, J. (1971). Biology and knowledge: An essay on the relations between organic regulations and cognitive processes. Chicago: University of Chicago Press.

Rabinowitz, F. E., Heppner, P. P., & Roehlke, H. J. (1986). Descriptive study of process outcome variables of supervision over time. Journal of Counseling Psychology, 33(3), 292-300.

Reising, G. N., & Daniels, M. H. (1983). A study of Hogan's model of counselor development and supervision. Journal of Counseling Psychology, 30, 235-244.

Robiner, W. N., & Schofield, W. (1990). References on supervision in clinical

and counseling psychology. Professional Psychology: Research and Practice, 21(4), 297-312.

Rosenthal, R. (1966). Experimenter effects in behavioral research. NY: Appleton-Century-Crofts.

Rosenthal, R., & Rosnow, R.L. (1975). The volunteer subject. NY: John Wiley & Sons.

Sansbury, D.L. (1982). Developmental supervision from a skills perspective. The Counseling Psychologist, 10(1), 53-57.

Stoltenberg, C. D. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. Journal of Counseling Psychology, 28(1), 59-65.

Stoltenberg, C.D., Ashby, R.H., Leach, M., McNeill, B.W., Eichenfield, G., & Crethar, H.C. (1996). Effects of supervisee reactance on the supervision relationship and satisfaction. Poster presented at the annual meeting of the American Psychological Association, Toronto, Ontario, Canada.

Stoltenberg, C. D., & Delworth, U. (1987). Supervising counselors and therapists. San Francisco: Jossey-Bass.

Stoltenberg, C. D., McNeill, B. W., & Crethar, H. C. (1994). Changes in supervision as counselors and therapists gain experience: A review. Professional Psychology: Research and Practice, 25(4), 416-449.

Stoltenberg, C.D., McNeill, B.W., & Delworth, U. (1997). IDM: The Integrated Developmental Model of Supervision. San Francisco: Jossey-Bass.

Stoltenberg, C. D., Pierce, R. A., & McNeill, B. W. (1987). Effects of

experience on counselor trainee's needs. The Clinical Supervisor, 5(1), 23-32.

Tracey, T. J., Ellickson, J. L., & Sherry, P. (1989). Reactance in relation to different supervisory environments and counselor development. Journal of Counseling Psychology, 36(3), 336-344.

Tryon, G.S. (1996). Supervisee development during the practicum year. Counselor Education and Supervision, 35, 287-294.

Wiley, M. O., & Ray, P. B. (1986). Counseling supervision by developmental level. Journal of Counseling Psychology, 33(4), 439-445.

Wiley, M.O. (1982). Developmental counseling supervision: Person-environment congruency, satisfaction, and learning. Paper presented at the annual meeting of the American Psychological Association, Washington, DC.

Worthen, V., & McNeill, B.W. (1996). A phenomenological investigation of "good" supervision events. Journal of Counseling Psychology, 43, 25-34.

Worthington, E. L., Jr. (1984). Empirical investigation of supervision of counselors as they gain experience. Journal of Counseling Psychology, 31(1), 63-75.

Worthington, E. L., Jr. (1987). Changes in supervision as counselors and supervisors gain experience. Professional Psychology: Research and Practice, 18(3), 189-208.

Yogev, S. (1982). An eclectic model of supervision: A developmental sequence for beginning psychotherapy students. Professional Psychology, 13, 236-243.

Yogev, S., & Pion, G. M. (1984). Do supervisors modify psychotherapy supervision according to supervisees' level of experience? Psychotherapy, 21(2), 206-208.

Zucker, P. J., & Worthington, E. L., Jr. (1986). Supervision of interns and postdoctoral applicants for licensure in university counseling centers. Journal of Counseling Psychology, 33, 87-89.

Appendix B

University of Oklahoma, Norman Campus Informed Consent Form

Explanation of Study

The present research project is entitled, "Counselor Development and Supervision: An Exploratory Study of the Integrated Developmental Model of Supervision" conducted by Rachel Hanselmann Ashby, M.Ed. The purpose of this study is to investigate counselors' perceptions of the quality and process of supervision received, the quality of the supervision relationship, and their supervision needs. In addition, supervisors will respond to their perceptions of the supervisees' skills, the quality of supervision given, and the quality of the supervision relationship. The following questionnaires will be administered three times across fall and spring semesters: Supervision Evaluation Scale, Supervisee Levels Questionnaire-Revised, The Supervisee Needs Questionnaire, Supervisory Working Alliance Inventory, and the Supervision Attitude Inventory. The Critical Incident Questionnaire will be completed after every supervision session. In addition personal interviews, lasting approximately one hour and following up on responses to the questionnaires will be conducted six times for each subject across the same time period. The study involves limited risk on the part of the participants. Prior to completion of the study, identification numbers will be assigned by the experimenter for subsequent data analysis. Results of the questionnaires and interviews will not be shared with supervisees or supervisors. After completion of data collection one supervisor (who is the faculty sponsor) will have access to refined data (summarized interviews, questionnaire scale scores) that will not include names or obvious identifying data. Anonymity of general responses cannot be assured in regards to this supervisor. However, all efforts will be made to limit specific information to this individual within the constraints of supervision of the research project. None of the supervisees supervised by the faculty sponsor have him as a supervisor again in the future. Program policy is such that supervisees are supervised by any given faculty member only once throughout training. Thus, supervisees supervised by the faculty sponsor will not have him as a supervisor again in the future as per program policy. As a volunteer in this study, you may withdraw at any time without penalty. Your cooperation and conscientious efforts will greatly contribute to making this a beneficial study. If you have any questions about research participant's rights, contact Rachel Hanselmann Ashby, M.Ed. at (405) 325-5974.

Statement of Consent and Agreement

I, the undersigned, attest that I have read the Explanation of Study. I am freely participating in this research without duress nor undue influence.

Signature of Participant

Date

Appendix C

Critical Incident Questionnaire

For the purpose of this study a critical incident is defined as an occurrence which results in a significant change; which is recognizable as a kind of turning point, resulting in change(s) in the supervisee's effectiveness as a counselor/psychotherapist.

(a) Please describe any such incident in your supervision this session.

(b) What made this a critical incident for you?

(c) What were you wanting to gain from this supervision session?
(Did you receive it?)

Appendix D

SUPERVISEE LEVEL QUESTIONNAIRE - REVISED

Instructions: In terms of your own current behavior, please answer the items below according to the following scale as explained previously.

NEVER	1
RARELY	2
SOMETIMES	3
HALF THE TIME	4
OFTEN	5
MOST OF THE TIME	6
ALWAYS	7

1. I feel genuinely relaxed and comfortable in my counseling/therapy sessions.

1 2 3 4 5 6 7

2. I am able to critique counseling tapes and gain insights with minimum help from my supervisor.

1 2 3 4 5 6 7

(I do not review tapes _____)

3. I am able to be spontaneous in counseling/therapy, yet my behavior is relevant.

1 2 3 4 5 6 7

4. I lack self-confidence in establishing counseling relationships with diverse client types.

1 2 3 4 5 6 7

5. I am able to apply a consistent personalized rationale of human behavior in working with my clients.

1 2 3 4 5 6 7

6. I tend to get confused when things don't go according to plan and lack confidence in my ability to handle the unexpected.

1 2 3 4 5 6 7

7. The overall quality of my work fluctuates; on some days I do well, on other days, I do poorly.

1 2 3 4 5 6 7

8. I depend upon my supervisor considerably in figuring out how to deal with my clients.

1 2 3 4 5 6 7

9. I feel comfortable in confronting my clients.

1 2 3 4 5 6 7

10. Much of the time in counseling/therapy, I find myself thinking about my next response, instead of fitting my intervention to the overall picture.

1 2 3 4 5 6 7

11. My motivation fluctuates from day to day.

1 2 3 4 5 6 7

12. At times, I wish my supervisor could be in the counseling/therapy session to lend a hand.

1 2 3 4 5 6 7

13. During counseling/therapy sessions, I find it difficult to concentrate because of my concern with my own performance.

1 2 3 4 5 6 7

14. Although at times I really want advice/feedback from my supervisor, at other times I really want to do things my own way.

1 2 3 4 5 6 7

15. Sometimes the client's situation seems so helpless, I just don't know what to do.

1 2 3 4 5 6 7

16. It is important that my supervisor allow me to make my own mistakes.

1 2 3 4 5 6 7

17. Given my current state of professional development, I believe I know when I need consultation from my supervisor and when I don't.

1 2 3 4 5 6 7

18. Sometimes I question how suited I am to be a counselor/therapist.

1 2 3 4 5 6 7

19. Regarding counseling/therapy, I view my supervisor as a teacher/mentor.

1 2 3 4 5 6 7

20. Sometimes I feel that counseling/therapy is so complex, I will never be able to learn it at all.

- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
21. I believe I know my strengths and weaknesses as a counselor sufficiently well to understand my professional potential and limitations.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
22. Regarding counseling/therapy, I view my supervisor as a peer/colleague.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
23. I think I know myself well and am able to integrate that into my therapeutic style.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
24. I find I am able to understand my clients' view of the world, yet help them objectively evaluate alternatives.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
25. At my current level of professional development, my confidence in my abilities is such that my desire to do counseling/therapy doesn't change much from day to day.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
26. I find I am able to empathize with my clients' feeling states, but still help them focus on problem resolution.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
27. I am able to adequately assess my interpersonal impact on clients and use that knowledge therapeutically.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
28. I am adequately able to assess the client's interpersonal impact on me and use that therapeutically.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
29. I believe I exhibit a consistent professional objectivity, and ability to work within my role as a counselor without undue over-involvement with my clients.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
30. I believe I exhibit a consistent professional objectivity, and ability to work within my role as a counselor without excessive distance from my clients.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|

Appendix E

Supervisee Needs Questionnaire

Instructions: In terms of your own current needs/expectations for supervision, please answer (circle) the items below according to the following scale.

NEVER	1
RARELY	2
SOMETIMES	3
HALF THE TIME	4
OFTEN	5
MOST OF THE TIME	6
ALWAYS	7

In supervision, I need/expect to:

1. Have clear goals for my progress within supervision established by my supervisor.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

2. Receive as to how to write appropriate interview notes and case summaries.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

3. Have audio tapes of my therapy sessions listened to and critiqued on a regular basis.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

4. Receive written/verbal evaluations from my supervisor at both semi-annual and annual reviews.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

5. Receive positive feedback about what I am doing right, rather than receiving criticisms about what I am doing wrong.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

6. Receive help in developing my self-confidence as a therapist.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

7. Receive help from my supervisor for personal problems, which may be occurring at the time of supervision.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

8. Have my supervisor provide me with alternative ways of conceptualizing my clients cases.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
9. Have my supervisor available for emergency consultations.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
10. Be allowed/encouraged to participate in co-therapy with my supervisor.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
11. Have my supervisor provide me with alternative interview strategies.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
12. Set my own goals/criteria for supervision.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
13. Receive instruction as to the proper policies/procedures to be used in the supervision setting/agency.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
14. Have relevant literature/references on specific treatment/assessment techniques made available to me.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
15. Have my supervisor observe me (either live or videotaped) in actual therapy sessions.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
16. Receive explicit feedback regarding specific behaviors and techniques while conducting
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
17. Be treated as an equal professional by my supervisor.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
18. Have my supervisor role-play proper assessment/treatment techniques.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
19. Have my supervisor model appropriate therapeutic task-oriented skills.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
20. Receive extensive instructions on the proper use of assessment instruments.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
21. Receive encouragement to experiment with new and different assessment and/or treatment approaches.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|

22. Have my supervisor provide the structure and direction for our supervision sessions.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
23. Have someone I can rely on to "help out" when I am lost with a particular client.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
24. Have most of my supervision session focused on overall professional development, going beyond client concerns.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
25. Assess my own therapeutic strengths and weaknesses rather than relying on my supervisor.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
26. Receive explicit feedback regarding my own needs/defenses, which may be affecting my therapeutic performance.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
27. Receive frequent emotional support and encouragement.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
28. Work together with my supervisor in jointly forming conceptualizations of my clients' cases.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
29. Have my supervisor available to me at times other than regularly scheduled meetings.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
30. Be allowed/encouraged to observe my supervisor (live or taped) during an actual therapy session.
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|

Appendix F

SUPERVISORY WORKING ALLIANCE INVENTORY

Trainee's Version

Instructions: Please answer (circle) the items below according to the following scale:

NEVER	1
RARELY	2
SOMETIMES	3
HALF THE TIME	4
OFTEN	5
MOST OF THE TIME	6
ALWAYS	7

1. I feel comfortable working with my supervisor.

1 2 3 4 5 6 7

2. My supervisor welcomes my explanations about the client's behavior.

1 2 3 4 5 6 7

3. My supervisor makes the effort to understand me.

1 2 3 4 5 6 7

4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.

1 2 3 4 5 6 7

5. My supervisor is tactful when commenting about my performance.

1 2 3 4 5 6 7

6. My supervisor encourages me to formulate my own interventions with the client.

1 2 3 4 5 6 7

7. My supervisor helps me talk freely in our sessions.

1 2 3 4 5 6 7

8. My supervisor stays in tune with me during supervision.

1 2 3 4 5 6 7

9. I understand client behavior and treatment technique similar to the way my supervisor does.

1 2 3 4 5 6 7

10. I feel free to mention to my supervisor any troublesome feelings I might have about him/her.

1 2 3 4 5 6 7

11. My supervisor treats me like a colleague in our supervisory session.

1 2 3 4 5 6 7

12. In supervision, I am more curious than anxious when discussing my difficulties with clients.

1 2 3 4 5 6 7

13. In supervision, my supervisor places a high priority on our understanding the client's perspective.

1 2 3 4 5 6 7

14. My supervisor encourages me to take time to understand what the client is saying and doing.

1 2 3 4 5 6 7

15. My supervisor's style is to carefully and systematically consider the material I bring to supervision.

1 2 3 4 5 6 7

16. When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client.

1 2 3 4 5 6 7

17. My supervisor helps me work within a specific treatment plan with my clients.

1 2 3 4 5 6 7

18. My supervisor helps me stay on track during our meetings.

1 2 3 4 5 6 7

19. I work with my supervisor on specific goals in the supervisory session.

1 2 3 4 5 6 7

Appendix G

SUPERVISION ATTITUDE INVENTORY

Instructions: Please answer (circle) the items below according to the following scale:

STRONGLY DISAGREE	1
DISAGREE	2
AGREE	3
STRONGLY AGREE	4

1. If I feel my needs are not being met, I make an attempt to let my supervisor know.

1 2 3 4

2. I resent supervisors who try to tell me what to do.

1 2 3 4

3. I find that I often have to question supervisors.

1 2 3 4

4. I like when other counselors argue with their supervisors.

1 2 3 4

5. I have a strong desire to maintain my personal freedom in supervision.

1 2 3 4

6. I enjoy playing "Devil's Advocate" whenever I can in supervision.

1 2 3 4

7. I am easily persuaded by my supervisor.

1 2 3 4

8. Nothing turns me on as much as an argument with my supervisor.

1 2 3 4

9. It would be better to have more freedom to do what I want as a counselor.

1 2 3 4

10. When my supervisor tells me what to do, I often do the opposite.

1 2 3 4

11. I am easily persuaded by my supervisor.

1 2 3 4

12. It really bothers me when supervisors tell counselors what to do.

1 2 3 4

13. It does not bother me to change my plans because a supervisor wants me to do something else.

1 2 3 4

14. I don't mind supervisors telling me what to do.

1 2 3 4

15. I enjoy debates with supervisors.

1 2 3 4

16. If my supervisor asks me to do something, I will think twice about what she or he is really after.

1 2 3 4

17. I am not very tolerant of supervisors' attempts to persuade me.

1 2 3 4

18. I often follow the suggestions of my supervisors.

1 2 3 4

19. I am relatively opinionated about counseling.

1 2 3 4

20. It is important to me that my supervisors not be in a powerful position relative to me.

1 2 3 4

21. I am very open to solutions to my problems from my supervisors.

1 2 3 4

22. I enjoy "showing up" supervisors who think they are right.

1 2 3 4

23. In supervision, I consider myself more competitive than others.

1 2 3 4

24. I don't mind doing something for my supervisor when I don't know why I am doing it.

1 2 3 4

25. I usually go along with my supervisors' advice.

1 2 3 4

26. In supervision, I feel it is better to stand up for what I believe than to be silent.

1 2 3 4

27. With my supervisor, I am very stubborn and set in my ways.

1 2 3 4

29. It is very important for me to get along with my supervisor.

1 2 3 4

Appendix H

SUPERVISION EVALUATION SCALE-REVISED

Supervisee

Instructions: Using the following scale, please respond to each of the following items as it pertains to your supervision.

VERY STRONGLY DISAGREE	1
STRONGLY DISAGREE	2
DISAGREE S	3
NEUTRAL	4
AGREE	5
STRONGLY AGREE	6
VERY STRONGLY AGREE	7

1. I enjoy being supervised by my supervisor.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

2. I feel comfortable with my supervisor.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

3. My supervisor's style does not at all fit with what I want from supervision.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

4. I don't like the way my supervisor deals with me.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

5. I learn a lot with my supervisor.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

6. I increase my confidence as a counselor with my supervisor.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

7. My supervisor helps me learn more about myself.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

8. I feel a need to disagree with my supervisor quite a bit.

1 2 3 4 5 6 7

9. My supervisor greatly helps me with my clients.

1 2 3 4 5 6 7

10. My supervisor is not supportive of me.

1 2 3 4 5 6 7

Appendix I

Table I1: Alan's Themes Across Interviews 1-6

Supervision	Supervisor	Practicum	Prac Supervisor	Competence (Professional Role/Identity)		Coursework	Clients
1 more global; I've asked to be challenged, not much hand holding. Feel I should be directing myself more; want more reading & direction, unsure of supervision rules	Faculty -- expert, more experience & knowledge; evaluation of me more important, more nervous to get feedback; concerned about what supervisor has not said			Want to be competent right away		Busy -- class, assistantship, research & teaching; not enough time; more responsibility	
2 supervision roles not defined, but more comfortable; wanted to hear I was doing OK & was normal -- didn't hear it so assumed I was doing badly; focus on questions	"the walk"; you're trying to do too much; supervisor appears more overwhelmed now	Case presentation a good experience; good to hear peers asking same questions I'm asking; peers support me!!!; learn from peers	Different prac supervisor -- hurt in terms of getting cases; get another side/view	Not as good as I thought I was, but realizing I'm where I should be; personal expectations more than they should be (I got frustrated); too much work; I set ultimate goals -- not little		Less overwhelming; new advisor	1 client -- 1 1/4 years dysthmic; 2 client - haven't seen yet; 2012
3 supervision a lot easier if I do it his way; this semester focused on my question asking; sup. late & forgot appt.- not comfortable, on edge; get along outside of supervision	Disagree with sup. on hx taking methods; sup. focus on negatives; sup. likes things done his way; I'm frustrated with him; he takes my mistakes personally & he is still figuring out his style	This semester helped me realize I'm on par with everyone else; more helpful than individual supervision case presentation chance to talk with classmates	He didn't have any clue about my clients	Very sensitive to sup comments; few clients -- not learning a lot counseling-wise; don't feel like I'm improving		Evaluation -- no deficits, average on most	Picked up 2 more clients recently; frustrated with only one client; next semester -- want more clients

(table continues)

Supervision	Supervisor	Practicum	Prac Supervisor	Competence (Professional Role/Identity)		Coursework	Clients
4 more productive, enjoyable; check in with sup. instead of expecting him to tell me what to do - just started research on my own & it made it easier; I've been directive in supervision; cue my tape to positives; resist sup. telling his suggestions	Sup. & I understand each other better/ on target (lets me disagree with him); more positive feedback; sup. more focused - also teaching prac II helped him be more realistic about where I should be; he's always late	I'm more open to hear about different cases; peers able to give good feedback		Confident!! I've done more work this semester than last; confidence with crisis		Not very helpful to clinical work	4 clients
5 only 2 sessions last 5 weeks, sup. cancels; continues to be positive, I do the legwork, just check in, focus on affect; not worried about roles anymore, looked to sup. to provide confidence	Happier with sup.; last semester I think he thought I should be further along - discouraged me	Becoming redundant - the same different views; not looking for support from prac like last semester				Terrible	3 clients: 1 - 57 sessions (depression) 1 - December (compulsive) 1 - January
6 collegial, no power difference; positives this semester - done my own work & just check in with sup.(changed my approach); helpful:more positives validation; learned a lot about myself	Sup. know me better than other people; struggled through first semester together, then through the fun, enjoyable part this semester; I completely trust him, more genuine; same sup. all year - really got to know me		Supervisor this semester did better job of tracking who has clients		Inhibited growth: 1. lack of clients 2. rely on supervisor to do research 3. not understanding my role in supervision	Marriage class most helpful	1. dysthymic male (don't know what I'm doing) 2.compulsive male (behavioral) 3. depressed male (sporadic) 4. new couple (ICT) 5. 3 y/o female doesn't come

Table I2: Alan's Themes Across Interviews 1-6 Categorized by the Integrated Developmental Model

Intervention Skills Competence	Assessment Techniques	Interpersonal Assessment	Client Conceptualization	Individual Differences	Theoretical Orientation	Treatment Goals & Plans	Professional Ethics
1 need more direction looking for info/ no knowledge of family therapy (have a family)/ want to be competent now! "I don't know what I'm doing", want instruction cook book					Uncomfortable without theoretical orientation/ don't feel grounded/ don't understand theory application		
2 pattern of firing questions/ only 1 client – counseling's boring, view counseling as a puzzle/ wish there was an instruction book			Case presentation helped me learn I can conceptualize/ want supervision to allow me to conceptualize and tell me if it's accurate or not		Rely on CBT, but likes Biopsychosocial		
3 feeling ineffective/ supervisor still not providing readings/ counseling frustrating/ disagree with sup. on history/ no manual to tell how to do it and not enough clients/ still asking questions			Believe case presentation helped him the most with conceptualize and look at research		Want to be more therapy driven		

(table continues)

Intervention Skills Competence	Assessment Techniques	Interpersonal Assessment	Client Conceptualization	Individual Differences	Theoretical Orientation	Treatment Goals & Plans	Professional Ethics
4 more clients, I do readings and preparation/ more confident, control/ get away from question after question/ no pressure to solve (clicked)/ I'm managing the client	Assessment clinic has been great for me		Feel I can conceptualize but find it difficult to apply it in session		Feel less pressure to tie myself to a theoretical orientation/ don't really know my theoretical orientation/ Maria's study helped me to see a certain therapy applied/ goal= use therapy better		
5 let go of need to have step by step approach, it is a process - experience helpful: just get to know client and listen/ still hit hurdles, but less frustrating/ my reading - give understanding	Assessment clinic good I feel a lot more confident in doing assessment	I defend against talking about emotions, to protect myself			Last semester said CBT, but I wasn't -- I am more CBT now		
6 focus on client emotions/ feel I am doing better at counseling overall/ have more clients - allow me chance to try out tech/ more comfortable as a counselor	Done 7 this semester, 12 across the year/ comfortable with testing/ report writing - move away from fancy language and just say it clear and straight - more black and white, easier than counseling	In session - focus on affect/ convey my understanding of client emotions			Confused - been saying CBT, but client centered/ I am OK not knowing my theoretical orientation, because I feel like I do a good job with my clients and I'm still learning about theories		Colleague - ethical violation

Appendix J

Table J1: Dirk's Themes Across Interviews 1-6

Supervision	Supervisor	Practicum	Prac Supervisor	Research (Professional)	Efficacy of Counseling Role/Identity)	Coursework	Clients
1 motivational, inspirational, encourage me to look at things I haven't or look at literature; still want some reassurance; treatment planning	Distracted lately						
2 erratic schedule; talk about professional issues then specific issues about clients; schizophrenia (psychosis); don't look at tapes	Laid back, eats popcorn, sense of humor, help burnout; offers different point of view; question if sup. reads notes, but sup. knows what's going on	Similar experience level & knowledge base; everyone dealing with insecurities; normalize my experience; learn to handle emotions professionally; different insights	Excellent - own practice; help us with interdisciplinary; disagree with prac supervisor on schizo diagnosis	Irrelevance of research disheartening		Busy - not too stressed; learned a lot about psychology counseling - disheartening irrelevance of research; learn experience & clinical lore more used than research/ data	Individual
3 wanted to work on conceptualization & treatment planning	Relaxed; I don't think he's blowing me off at all; gotten to know each other better; respect each other	Different perspectives; normalizing influence; sounding board for ideas	Provide another view				2 individual, new couple; should have done more observations

(table continues)

Supervision	Supervisor	Practicum	Prac Supervisor	Research (Professional)	Efficacy of Counseling Role/Identity)	Coursework	Clients
4 laid back; couples stuff; left up to me to structure which is OK with me; I'd rather have this control, don't watch tapes; also discuss research & program issues; want a little more structure; feels need to concur with ind. sup.	Last semester he focused on getting a feel for my level of development; he has accurate feel; gives verbal praise; not critical; research & academic advisor; teacher	More practitioner oriented more current; case presentation not as devastating as 1 st semester; offers different perspectives & theoretical orientation	New adjunct supervisor; private practice; political climate; HMO's; prescription privileges psychiatrists; can disagree with prac sup.	Research of efficacy of counseling	More convinced of efficacy of counseling	Masters comps coming up	2 clients; auto-pilot, not threatened
5 bouncing my experiences off someone else's experiences; maintaining, floating, been focused on masters comps; works best if I come in with questions (he appears to know what to ask now)		Best prac ever; feels like a support group		Believe research is helping to understand peoples behavior is most useful; researching everything to death is a farce - people talk about intuition & feelings, not research	Seeing more progress this semester with clients - encouraging; does not value politics	6050 - waste of time; marital - helpful; procedures - no impact on clinical practice; took comp this week	3 individuals: dysthymic, depression & transvestic fetishes; 1 couple; will pick up 1 couple soon (cotherapy); days sees clients more stressful, but feel good
6 met twice; talked about depressed clients; centered around acute situations or needs; sup. modeled how to sort out important from unimportant stuff	Helpful - 1. Wrote out session plan; 2. Given me materials; 3. Challenges my thinking; 4. Things he said or made me think about, things that never occurred to me; sometime late - don't mind, bec he never blew off serious concern	Prac 1 st semester - normalizing; 2 nd open to different perspectives			Contributed to growth: 1. Maturity 2. Clearer with own emotions 3. Year off - Columbia; empathy & regain faith in psychology 4. Marital course 5. Prac 6. Personal readings		49 y/o dysthymic (schizo) 6 mo. maintenance; 37 y/o depression, client centered 5-6 weeks; 19 y/o depression (schizo?), client centered; couple (cotherapist) few weeks, systems; premarital couple (12, 9 y/o girls) 3 sessions, ICT

Table J2: Dirk's Themes Across Interviews 1-6 Categorized by the Integrated Developmental Model

Intervention Skills Competence	Assessment Techniques	Interpersonal Assessment	Client Conceptualization	Individual Differences	Theoretical Orientation	Treatment Goals & Plans	Professional Ethics
1 getting back into the swing of things (1 & ½ years gone)/ supervisor helping & encouraging me to look at literature/ OK with adjustment issue	Assessment clinic		Feel shaky		CBT - supervisor / more comfortable / sink my teeth into / don't feel I've picked up theories very well	Want more help then provided in supervision / I think taken for granted I know how to treatment plan	
2 professional readings / counseling as an art, religion, intuitive nature/ view tapes -- notice microskills, looking for specific direction with couples	Gaining experience through assessment clinic in Pauls Valley (IQ, Behavior) / learning some about testing special populations (MR)	Empathy for psychotic patient/ personal values effecting his treatment	I need help conceptualizing		More comfortable with cognitive type therapy / see need for other theoretical orientations / but need to pick one and stick to it	How do I get a client to have insight? How do you manage their stress level?	
3 new area - couples / supervisor provides a detailed session for couples & readings "very helpful"/ semester - more readings would be helpful			Goal this semester was to work on conceptualization		No change	Goal this semester to work on treatment planning	

(table continues)

Intervention Skills Competence	Assessment Techniques	Interpersonal Assessment	Client Conceptualization	Individual Differences	Theoretical Orientation	Treatment Goals & Plans	Professional Ethics
4 (more clients) I enjoy counseling more now / little more of a sense of competence with individual adult / don't need detailed plan / still a little overwhelmed with couples	Assessment clinic going good as specialty prac		Conceptualizing getting easier / use what makes it easier for me to conceptualize (efficacy studies) / still need help sometimes, I ask for it		Applying theory easier / use what makes it easier to conceptualize - what makes sense / doesn't matter what theory you use as long as you use it well (efficacy studies)		
5 totally paying attention to the client / I feel useful & productive / get into clients' world better / more confident, experience with clients / see progress	2 clients in assessment clinic / Spanish assessment (interpret qualitatively)	Overwhelmed be every single thing screwed up in depressed client's life - difficult to pick out sit. to work on			Cognitive, but broadening - experimental systems or client centered		
6 focus on what client is really saying / affect / don't think about everyday stuff anymore / more clients - got used to it	Assessed 6 males (9-21 y.o.) / I believe assessment is one of my strengths / makes sense to me / more objective / better interview then use to be would like more Spanish testing	Focus on client affect / express my emotions effectively & dealing with other's emotions / maintain boundary - emotionally / developing coping mechanisms / not personalizing / empathize with clients better			IDK -- Eclectic / don't see the rationale of picking just one / trying to learn 2 or 3 well and pick and choose within their parameters		Career threatening ethical dilemma regarding a colleague / prac class as a whole dealt with "what is our liability?" / intake with 2012 student

Appendix K

Table K1: David's Themes Across Interviews 1-6

Supervision	Supervisor	Reactance	Supervising	This Study	Practicum	Supervisory Relation	Clients
1 had one year of supervision with Maria's; challenges me, helps me learn my biases; focus on conceptualization now, not teaching; don't like – laying myself open	Focused, work ethic; tremendous respect for supervisor	Don't like laying self open to be critiqued; personal aversion to critique	Increase my competence, feelings; I can see how far I have come				Couples, depressed female
2 turbulent!! Unpredictable some really good, some really uncomfortable; learn a lot but not fun; I feel manipulated; want feedback on affect; really pushed but I'm growing (double edged sword), more confident	Intentional discomfort he's not relaxed; no chit chat; watches tapes, picks S.T. important & starts in "saddle up, Cowboy"; very good observer	"leave me alone attitude lessened"	I enjoy supervising; realize I know more than I thought I did; it's a challenge – I like it aware of trainee's comfort level	Useful – makes me focus on what I've learned			
3 things turned for the better – but question if this is part of sup.'s plan (a set up)	He started lightning up; pushed me enough to make me defensive & question (uncomfortable)		Started out building rapport, then thought I was being too easy & I started pushing (similar to my sup.); I like challenging them		Occasionally useful; last year prac more helpful, I was searching for more	Tentative, started improving – good; rapport building early on could have helped	

(table continues)

Supervision	Supervisor	Reactance	Supervising	This Study	Practicum	Supervisory Relation	Clients
4 less structure, less serious, more easy going; last semester focus on affect; "just cruising"	Dramatic change, more animated, more jovial				This semester: more structure, focus on per. dis., MSE, good history, jabs back & forth about theory (fun)		
5 focus on affect based tx, feminist, interpersonal; kind of open, loose; last semester, seriousness aspect served as catalyst	Friendly with everyone	I have this feeling like I could go on without supervision; I don't do enough work between sessions that I probably should	Has brought up a lot I hadn't thought about: silence, allow client to take the lead	Avoiding specialty prac; intern applications and generals	Discussions more focused and guided	Great!	2 depressed, 1 exhibitionist
6 coasting - no major change; reemphasis on affective based counseling; support from sup. still important	Sup. admitted he might have done things different; mid term last semester was turning point; I was cautious but time & consistency helped; he seems more personable, small talk, just seems more comfortable with the program	I feel humbled - less cocky than September		Growth from: 1. Strong, directive sup. 2. Supervising trainee 3. Being open to comments regarding my lack of use of affect Factors hindering: 1. Negative feeling toward sup. 2. Stubbornness initially thinking I knew more than I did	Nothing really stands out - some good discussions about personality disorders	Could have accomplished the same thing & been personable; last semester negative emotions elicited by calculated condescension "saddle up, cowboy"; having perception that a sup. is serious & that you are expected to work & be equally serious & motivated	2 marital; 1 depressed; 1 exhibitionist

Table K2: David's Themes Across Interviews 1-6 Categorized by the Integrated Developmental Model

Intervention Skills Competence	Assessment Techniques	Interpersonal Assessment	Client Conceptualization	Individual Differences	Theoretical Orientation	Treatment Goals & Plans	Professional Ethics
1 comfortable working with couples and depressed women/ compare self to pros	Neuropsych testing			Depressed women	CBT -- trained with Maria's study		
2 my work with clients better -- allow myself to be more flexible and slow down	Focus on clients symptomatology to get full clinical picture	Awareness of my feelings about what client is saying and using that affect in me to direct my interventions/ focus on therapeutic relationship/ empathy is there -- need to express it					
3 not questioning my abilities/ don't feel as effective, but know I am learning and becoming proficient		More of an appreciation for what the client feels and experiences/ goal = become more rounded -- affect counseling, greater focus on affect	Conceptualization has grown	Feminist therapy	Goal = integrate approaches, augmenting to my approach		

(table continues)

Intervention Skills Competence	Assessment Techniques	Interpersonal Assessment	Client Conceptualization	Individual Differences	Theoretical Orientation	Treatment Goals & Plans	Professional Ethics
4	Appreciation for suicide assessment	Need more growth in affect-based strategies			Supervisor encouraging other modes of therapy/ want a deeper understanding of Becks approach (CBT) and better appreciation of as many approaches as I can		
5 using literature to guide interventions with clients	More aware of history taking and client symptoms	Affect -- getting better at focusing and using but still not where I want to be/ supervisor models focus on self and client affect					
6 trying to be more animated in session		Animation and tie it in with affect	Helping my trainees conceptualize their cases has helped me think through a lot of things		My focus has shifted from a naïve loyalty to CBT to trying to learn more about it, because they're not always as effective as I would have thought/ not willing to give up CBT, but willing to incorporate affective stuff		Gift from client

Appendix L

Table L1: Phil's Themes Across Interviews 1 - 6

Supervision	Supervisor	Supervisory Relationship	Coursework	Supervising	Practicum	Outside Issues	Clients
1 Kind of a guide: -place to go with clients -things I may look over past 5 weeks: no so much direction as getting me over humps	Quality of supervisor increased - amount of understanding						
2 trying to empower me to confront the couple & tell them I'm angry & frustrated, "role played" confrontation; I don't care attitude	Sup. supports my conceptualization so it adds to my confidence in my abilities; matches interventions to trainees style; very positive	I feel a level of acceptance by my sup.; I feel more comfortable due to sup. and how I view my own abilities	Gives me more understanding but I don't think it effects what I do in session	Frustration & anger toward on trainee; need to confront trainee; defining supervisory role; sees trainee style as inadequate	Classmates do not respect my opinion or my views; sup. supportive in prac		Trouble with couple
3 looked at the battered woman syndrome; lots of last minute things & personal issues (advisor)	Saw couple as a good case to practice different techniques; goal is for me to confront; more supportive in individual supervision than in prac	Very good relationship; acceptance, faith in my abilities, positive outlook for future		I felt it gave me more insight into my own counseling approaches & style if they implement your suggestions & it works, it builds confidence in my knowledge & abilities	Don't listen to peers opinions; not beneficial; I don't get anything out of it	My advisor is leaving; holidays & finals effect ability to focus; planning specialty prac	Couple terminated - relief/ happy; 2 female clients: divorce counseling, stress, ACA issues

(table continues)

Supervision	Supervisor	Supervisory Relationship	Coursework	Supervising	Practicum	Outside Issues	Clients
4 choose to follow individual sup.; also turn to sup. as advisor (program, specialty prac, internship)	Sees him as an expert, due to books written, degrees & experience; sup. values & supports my approach				New prac sup.- don't agree with my individual sup. on techniques; I hate prac, it's really confusing, defer to individual sup.	Use sup. as advisor - program, specialty prac, internship	2 new couples (CBT - study); 2 individuals: OCD male (CBT), relationship female
5 40 minutes used on cases, rest used asking questions about CPSA, interviews, advisory committee, program info; focus on my own values					Get nothing out of it, skipping it; decrease motivation		OCD male; abused woman/couple; Maria study couple
6 focus on my values coming out of therapy & selfdisclosure (not enough); looked for guidance & support (new views)	Understand my feelings & what my issues were with counseling & he let me go & do something that I felt appropriate for me; he worked to mold me from where I was & who I am	Collegial/ peer; mentor, teacher (this semester); comfortable & productive	Advanced child - helpful in working with adolescents	1. didn't enjoy it; 2. Not what I want to do 3. I wasn't invested 4. wasn't challenging or interesting		Direction - what I want to (growth) - I sought out experience; preparing for internship	OCD male; 2 couples

Table L2: Phil's Themes Across Interviews 1-6 Categorized by the Integrated Developmental Model

Intervention Skills Competence	Assessment Techniques	Interpersonal Assessment	Client Conceptualization	Individual Differences	Theoretical Orientation	Treatment Goals & Plans	Professional Ethics
1 comfortable with adults / novice with couples work / focus on permission to confront and be tough		Supervision kind of opened my eyes to how my frustration was interacting with my treatment					
2 confident in abilities / frustration with couple, worry about confronting, fearful about confronting individuals with severe pathology		Confrontation difficulties	Have conceptualized (looked at) my clients and my cases from other approaches but continue practicing Rogerian treatment		Figuring out the style that I enjoy working with / client centered, strengths - rapport, empathy, genuineness / confident with my style and approach		
3 comfortable with divorce counseling / physical/emotional abuse / trying to empower her, I have a better focus when I go into session / comfortable with clients now		On evaluation got 4's out of 5 confrontation and expressing feelings toward clients / my confrontation style is not hard core	Batter woman approach / I have a better idea where to go and what needs to be done and where things need to be, what things need to be addressed	Seeking out information on women and feminist therapy	Remain client - centered		

(table continues)

Intervention Skills Competence	Assessment Techniques	Interpersonal Assessment	Client Conceptualization	Individual Differences	Theoretical Orientation	Treatment Goals & Plans	Professional Ethics
4 last semester -- confront couple. This semester -- confront individual / successful experiences with clients using his approach builds confidence, use research to choose intervention		Personalize experience with couple	Sees mother - child pattern in couple relationships		Humanistic use research to chose intervention		Aware of termination coming in May evaluating client needs
5 concrete intervention with OCD client - motivated / more experience with couples, increase comfort with his skills / interesting clients - more exciting, more motivated, not motivated to work with clients, not willing to work		Empathy for physically abused women, turned out she was physically abusive to her husband / awareness of own values and morals, but not always use it or express it / let clients express emotions	I feel more confident because I know where to go with my clients / uses research literature to help conceptualize		Rogarian with individuals / hodge-podge/CBT with couples		Responsibility to transfer clients as he leaves the clinic
6 more focus on cognitions / growth - couples treatment (Maria's study)	Confident - assessment clinic for 2 years / TA for intelligence, personality and projective / experience assists my conceptualization skills	I don't focus on my affect / last fall focus on affect, this semester cognitions / need to express my anger and frustration, but comfortable with own style / focus more on client affect than own			Humanistic and CBT / research backed CBT with OCD client		Terminating and transferring clients

Appendix M

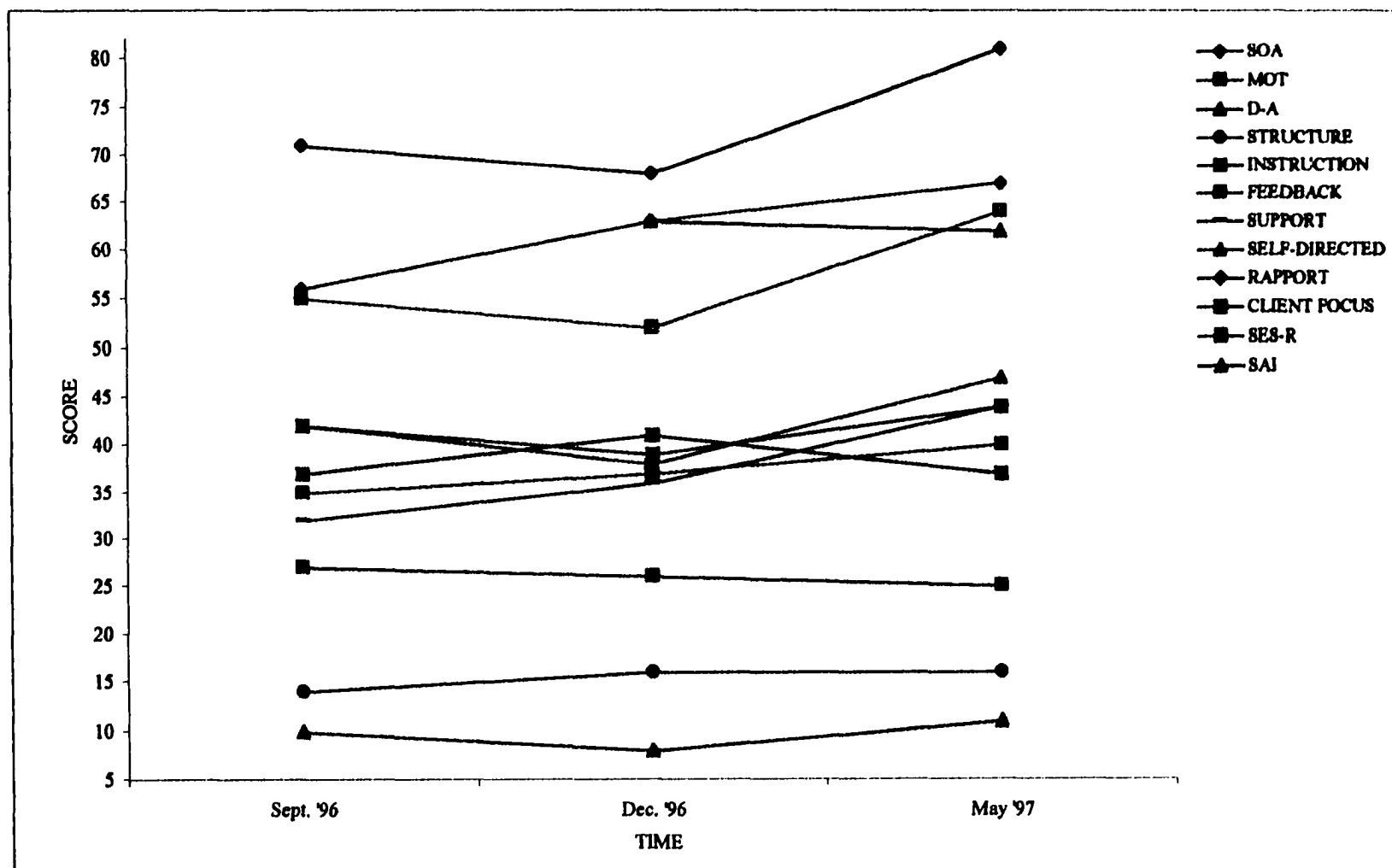


Figure M1. Alan's scores on the SLQ-R subscales (Self and Other Awareness, Motivation, Dependence-Autonomy), SNQ subscales (Structure, Instruction, Feedback, Support, Self-Directed), SWAI (Rapport and Client Focus), SES-R, and SAI in September 1996, December 1996, and May 1997.

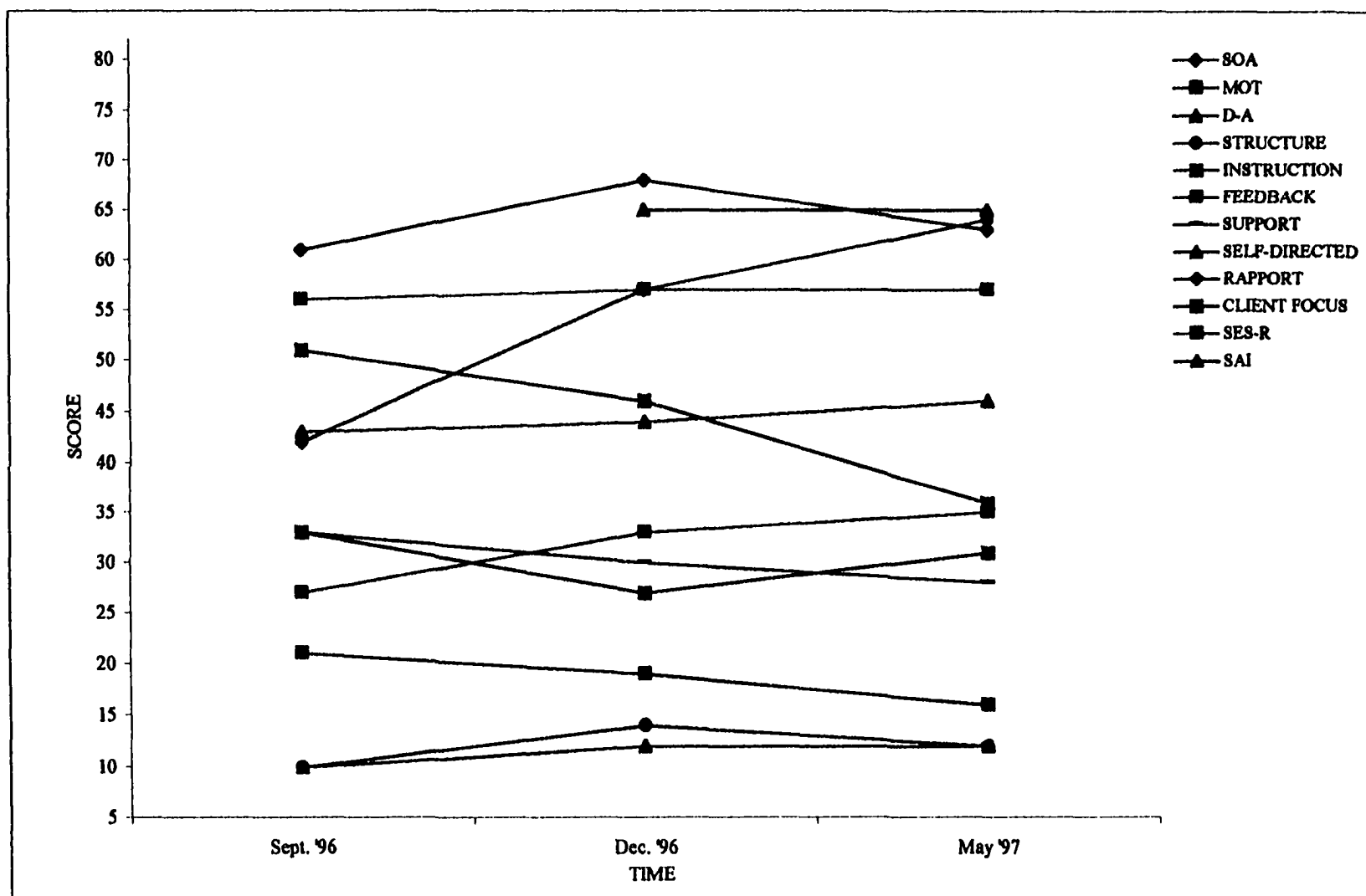


Figure M2. Dirk's scores on the SLQ-R subscales (Self and Other Awareness, Motivation, Dependence-Autonomy), SNQ subscales (Structure, Instruction, Feedback, Support, Self-Directed), SWAI (Rapport and Client Focus), SES-R, and SAI in September 1996, December 1996, and May 1997.

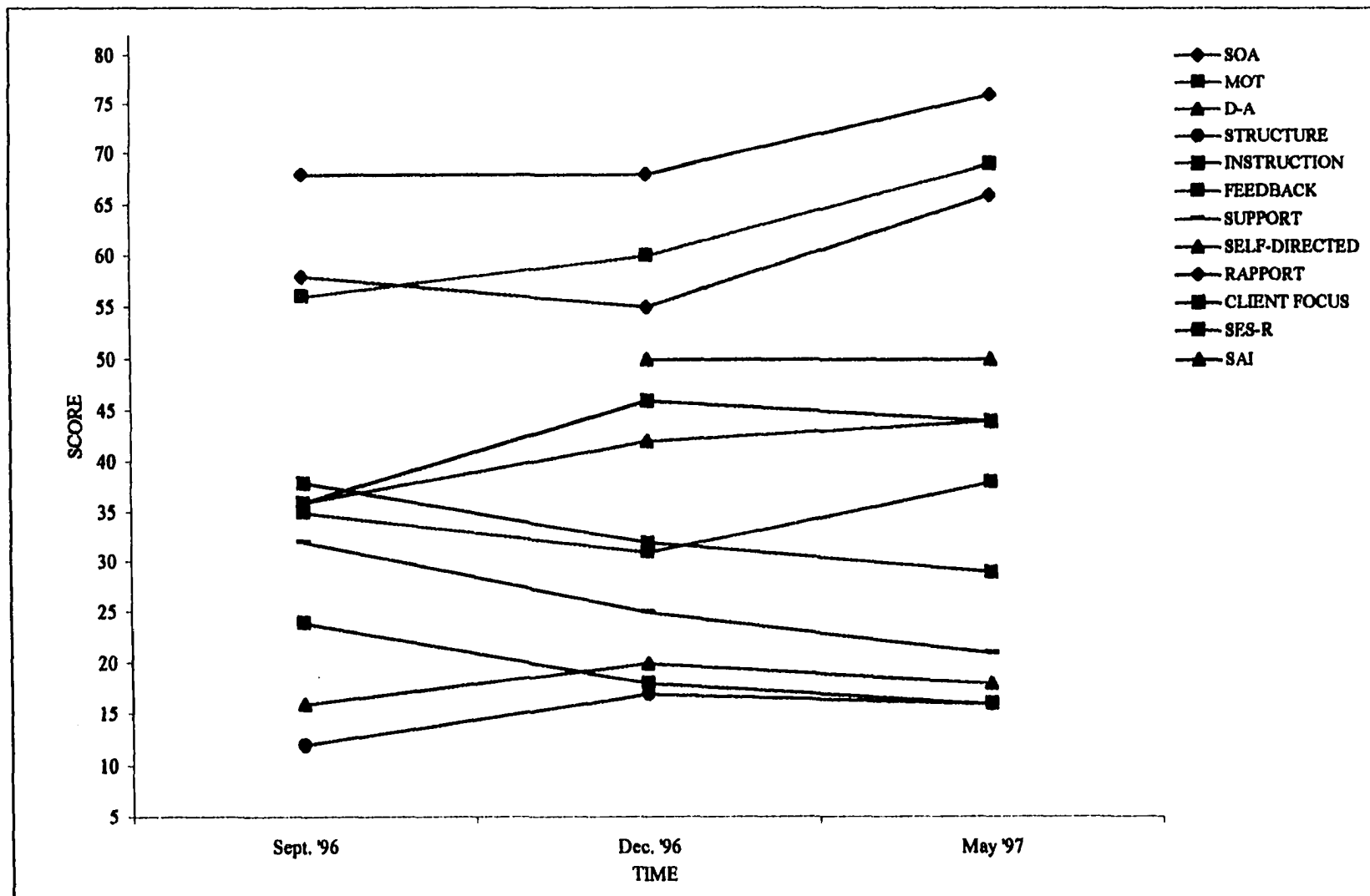


Figure M3. David's scores on the SLQ-R subscales (Self and Other Awareness, Motivation, Dependence-Autonomy), SNQ subscales (Structure, Instruction, Feedback, Support, Self-Directed), SWAI (Rapport and Client Focus), SES-R, and SAI in September 1996, December 1996, and May 1997.

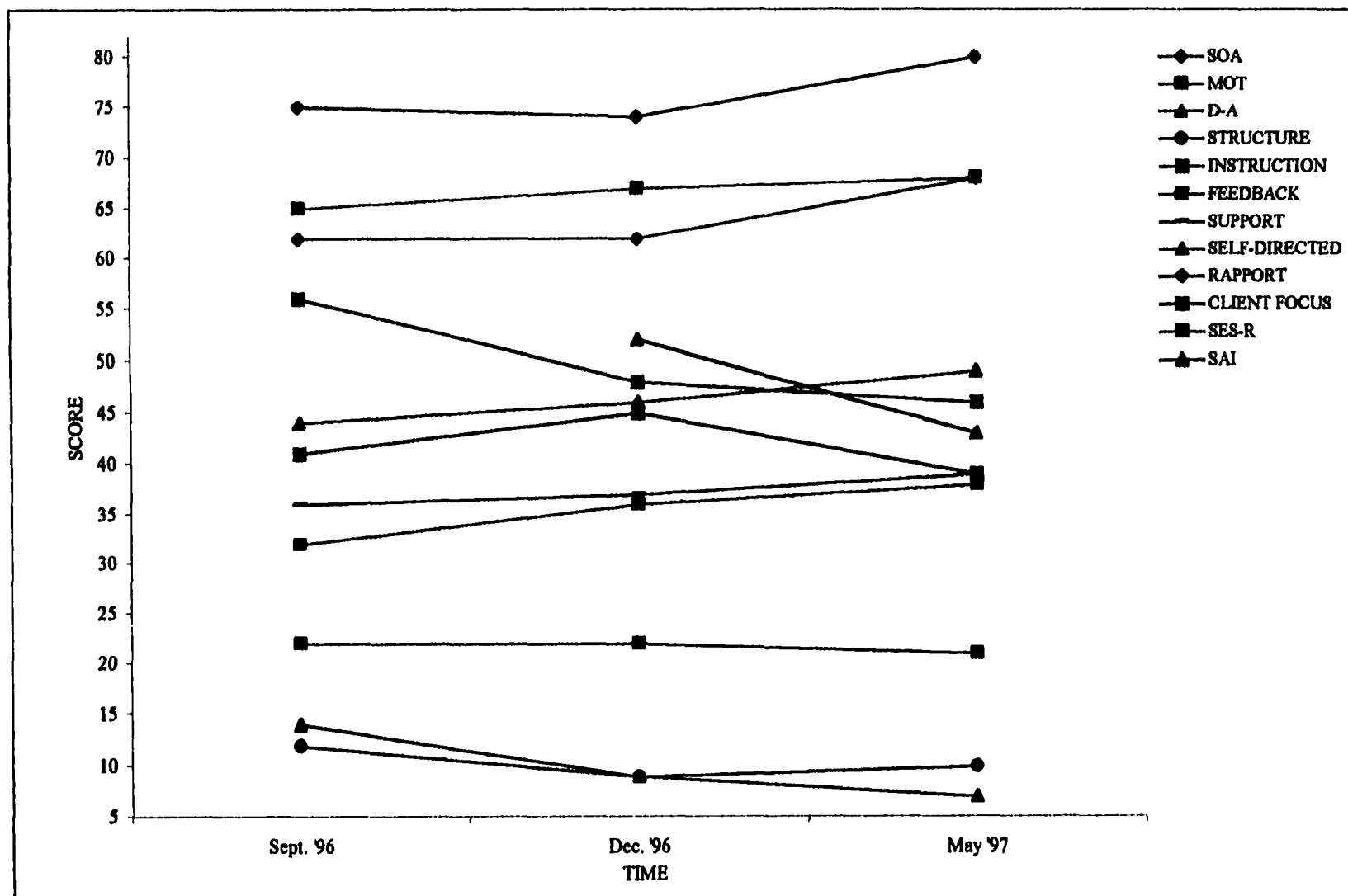


Figure M4. Phil's scores on the SLQ-R subscales (Self and Other Awareness, Motivation, Dependence-Autonomy), SNQ subscales (Structure, Instruction, Feedback, Support, Self-Directed), SWAI (Rapport and Client Focus), SES-R, and SAI in September 1996, December 1996, and May 1997.



The University of Oklahoma

OFFICE OF RESEARCH ADMINISTRATION

September 13, 1996

Ms. Rachel Hanselmann Ashby
Educational Psychology
University of Oklahoma

Dear Ms. Ashby:

Your research proposal, "Counseling Supervision: A Process Study," has been reviewed by Dr. E. Laurette Taylor, Chair of the Institutional Review Board, and found to be exempt from the requirements for full board review and approval under the regulations of the University of Oklahoma-Norman Campus Policies and Procedures for the Protection of Human Subjects in Research Activities.

Should you wish to deviate from the described protocol, you must notify me and obtain prior approval from the Board for the changes. If the research is to extend beyond 12 months, you must contact this office, in writing, noting any changes or revisions in the protocol and/or informed consent form, and request an extension of this ruling.

If you have any questions, please contact me.

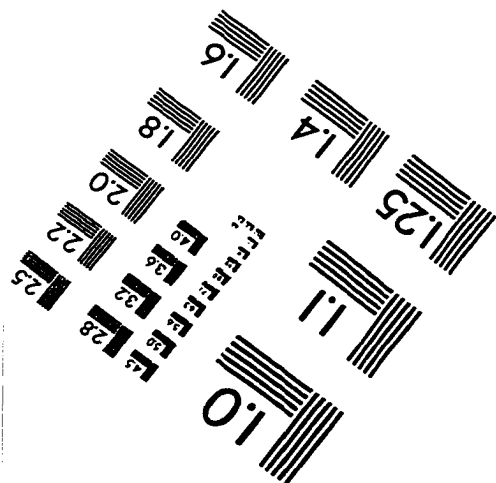
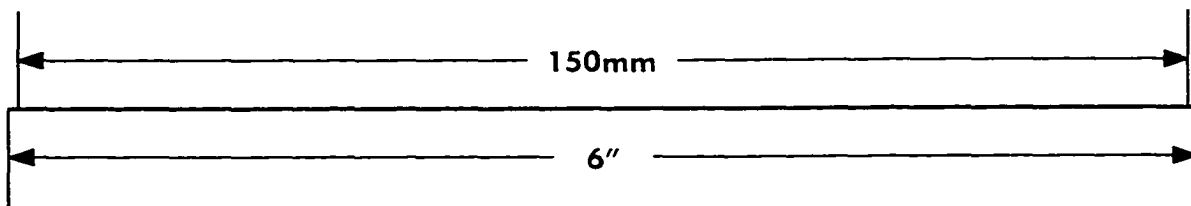
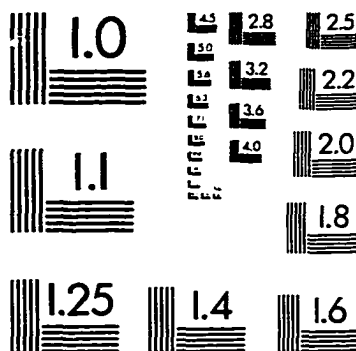
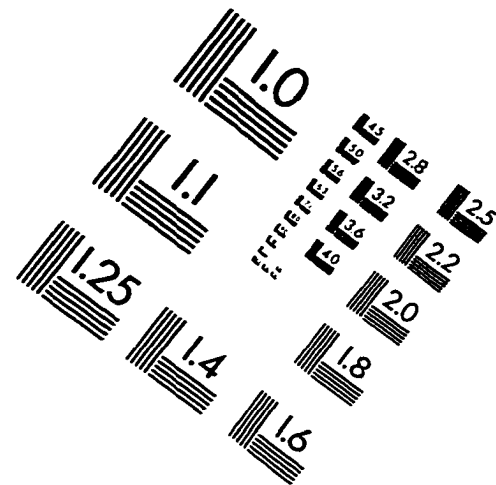
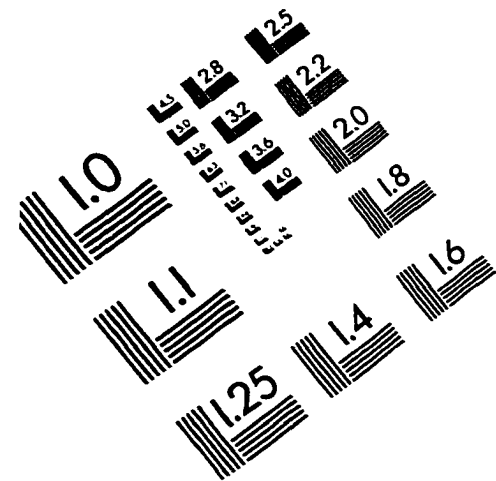
Sincerely yours,

Karen M. Petry
Administrative Officer
Institutional Review Board

KMP:sg
97-034

cc: Dr. E. Laurette Taylor, Chair, IRB

IMAGE EVALUATION TEST TARGET (QA-3)



APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

© 1993, Applied Image, Inc., All Rights Reserved

