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Mitigating the Intensity of Therapist Self-Criticism: A Grounded Theory Analysis

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MITIGATING THE INTENSITY OF THERAPIST SELF-CRITICISM: A GROUNDED THEORY ANALYSIS

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ABSTRACT

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Research on how therapists-in-training experience their development and education has been gaining attention in the psychotherapy literature. In this study, developing therapists were interviewed about their experience of self-criticism related to psychotherapy practice and these interviews were subjected to a grounded theory analysis generating a model of these self-critical processes. Results highlighted the intensity of self-criticism in therapists' training experiences, especially when they related to their clients from an "expert role". The results also described ways in which self-criticism is mitigated by a sense of interpersonal safety and clinical freedom and flexibility in therapists' training. The implications for future psychotherapy research and clinical training are discussed, supported by guidelines for supervisors and trainees on how to address self-criticism within academic training environments.

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Within the last two decades, research on self-criticism has been gaining emphasis in the psychopathology and psychotherapy literature (Bergner, 1995; Blatt, 1974; Cox Enns, & Clara, 2004; Kannan & Levitt, 2010; Shahar, 2001; Whelton & Greenberg, 2004; Zuroff, 1994). Excessive self-criticism has been shown to lead to adverse outcomes such as depression and perfectionism (Beck, 1967; Blatt, Quinlan, Chevron, McDonald, & Zuroff 1982; Hewitt & Flett, 1991) and while self-criticism may be experienced universally, there can be differences in its form, severity, and consequences for each individual (Whelton & Henkelman, 2002). For example, self-criticism has been conceptualized as constructive and adaptive (Chang, 2008; Rogers, 1951), destructive and damaging (Bergner, 1995; Firestone, 1988), and utilized for multiple reasons and serving different functions (Gilbert, Clarke, Hempel, Miles, & Irons, 2004). The focus of the present study is on therapist self-criticism as a conscious evaluation of oneself that can be a healthy and reflexive behavior, but also can have harmful effects and consequences for an individual. This definition was drawn from psychotherapy researchers' writing on self-criticism, and positions the meaning of self-criticism on a continuum of healthy to maladaptive aspects of experience (Blatt, 1974; Chang, 2008; Whelton & Greenberg, 2005).

Adaptive Functions of Self-Criticism

Self-criticism has been associated with numerous psychological conditions such as anxiety, personality disorders, and even suicide (e.g., Cox et al., 2004; Firestone, 1988; Zuroff, 1994), but has most often been studied in relation to clinical depression and perfectionism (Blatt et al., 1982; Carver & Ganellen, 1983; Klein, Harding, Taylor, &

Dickstein, 1988; Rector, Bagby, Segal, Joffe, & Levitt, 2000; Shahar, Blatt, Zuroff, Krupnick, & Sotsky, 2004). As this literature is primarily focused on clinical populations, the findings in these studies may be less relevant to the experiences of developing therapists. In contrast, emerging research also has focused on the adaptive and positive functions of self-criticism (Chang, 2008; Gilbert et al., 2004; Gilbert & Procter, 2006; Norem, 2001). For instance, Gilbert and colleagues noted that the process of being self-critical can have different functions, and expanded their perspective of self-criticism to include reasons for being self-critical. They used the *Functions of Self-Criticism Scale* (Gilbert et al., 2004) and conducted a principal components analysis on the measure to evaluate which items produced the highest loading in a sample of undergraduate students. The first of the two specified components for the functions of self-criticism was related to *self-correction* (e.g., to make me concentrate) and the second component was related to *self-persecution (e.g.,* to take revenge on part of myself). The authors noted that the first component was associated with a productive form of "self-coercion" (p. 39) where the goal was not to hurt, but to improve the self. The development of such models of self-criticism can promote our understanding of the adaptive functions of developing therapists' self-criticism, and its role in facilitating or obstructing therapy goals.

Similiarly, Norem (2001), a personality researcher, discussed how self-criticism could be utilized in an adaptive manner. She noted that "defensive pessimism" (p. 90) is a strategy that individuals may use to deal with anxiety by lowering their expectations and reflecting on what might go wrong in particular situations (Norem & Cantor, 1986). So, individuals can, "mentally rehearse both what might happen and what they could to prepare for, mitigate, or prevent the negative outcomes they imagine" (Norem, 2001; p.

90). For example, a therapist who anticipates alliance difficulties with a client might be motivated to seek out supervision or additional skills to use in session before meeting with that client. Here, self-criticism is used as a positive tool where the purpose is self-improvement or goal fulfillment. While the research on adaptive aspects of self-criticism is still developing, the present study hopes to gain a fuller understanding of when self-criticism can aid therapist development.

Self-Criticism and Therapist Development

In Wampold's (2001) scientific presentation of the psychotherapy literature, he wrote, "The essence of therapy is embodied in the therapist…therapists within a given treatment account for a large proportion of the variance. Clearly, the person of the therapist is a critical factor in the success of therapy." (p. 202). For example, therapist competence, therapist expectations, and the therapeutic relationship, all have demonstrated links to therapy outcome (Abouguendia, Joyce, Piper & Ogrodniczuk, 2004; Ackerman & Hilsenroth, 2001; Horvath & Greenberg, 1986; Horvath & Symonds, 1991; Wampold, 2001). Self-criticism also has been inversely and significantly correlated with aspects of emotional intelligence such as attention to emotions, clarity of emotions, ability to repair emotions, and discern others' emotions (Myers, 2007). These studies point to some of the implications for how self-criticism might impact therapists' ability to attend to client emotion in session and develop therapeutic relationships.

Research on how developing therapists experience their training has been gaining importance in the psychotherapy literature (e.g., Ellis & Ladany, 1997; Hill, Stahl, & Roffman, 2007; Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003; Norcross & Prochaska, 1983; Ronnestad & Skovholt, 2003; Schroder & Davis, 2004;

Stoltenberg & McNeill, 2009). Research on topics such as dealing with feelings of anger and countertransference towards clients (Hayes, 2004; Shahar, 2001; Sharkin, 1989; Sharkin & Gelso, 1991; Singer & Luborsky, 1994; Vane, 2004) and difficult therapist experiences (Oliviera & Vandenberghe, 2009; Orlinsky & Ronnestad, 2005; Shroeder & Davis, 2004) are now gaining momentum. For instance, in descriptions of the empirical and conceptual literature on therapist development, Skovholt and Ronnestad (2003) described seven main challenges for beginning therapists relating to (1) self-consciousness and performance related fears, (2) multiple levels of professional scrutiny to ensure ethical clinical practice, (3) self-regulation of therapists' emotional boundaries with clients, (4) insecure sense of self as a developing practitioner, (5) inadequate conceptual maps, (6) glamorized expectations of therapy outcome, and (7) the need for supportive supervisors. These challenges were seen as universal for beginning therapists and speak to the difficulties in transitioning from the classroom setting to clinical work and practice.

Hill et al. (2007) conducted a qualitative study on a group of novice therapists (N = 5) who had been through a semester long training that included components of experiential skills training, psychological theory, and individual supervision. Therapists were then instructed to make weekly journal entries about their experiences (e.g., therapist competence, anxiety, self-efficacy, self-criticism, reactions to supervision). The authors described therapists' criticism as:

> Problems with self-awareness in sessions (e.g., being fully present with the client, being aware of their own feelings and reactions, not being distracted by hindering self-awareness and self-consciousness), worry about their therapeutic

> abilities (i.e., feeling incompetent and impatient with themselves)…and lack of clinical skills (not being able to get the client to go beyond storytelling and into more substantive disclosure, pushing too hard, being too sympathetic, getting into negative thinking, making poor transitions between topics, and not having good termination skills). (p. 439)

The authors concluded that self-criticism was prominent across multiple aspects of therapist development, suggesting that self-criticism is not an isolated phenomenon, but that therapists are likely to come up against their critical thoughts frequently in their training (Hill et al., 2007).

Enhancing Coping and Therapists' Self-Efficacy. Oliviera and Vandenberghe's (2009) addressed ways in which therapists with up to 3 years of experience in independent practice might cope with upsetting experiences in session. The most distressing experience for therapists in the study ($N = 5$) was when clients closed themselves off in session and resisted therapists' attempts at deeper exploration of presenting issues. Therapists reported subsequently feeling self-critical, insecure about their effectiveness, and angry towards the client. The authors reported a number of coping strategies used by the therapists in dealing with their feelings such as disclosing the nature of their distress to the clients and reframing client hostility in supervision so as to explore the specific function that the interaction may have had in their relationship.

Also related to effective coping, a growing body of research has focused on the construct of therapist self-efficacy (TSE). Self-efficacy as defined by Bandura (1986) refers to "people's judgments of their capabilities to organize and execute courses of action required to attain designated types of performances" (p. 391). Findings indicated

that TSE does relate to developing therapists affective state and skill during therapy. For instance, trainees reporting higher TSE beliefs report less anxiety, greater positive affect, and enhanced skills (Hanson, 2006; Larson & Daniels, 1998; Lent, Hill, & Hoffman, 2003). Self-efficacy also was found to relate to trainees' interests and plans to continue in a career as a therapist (Lent et al., 2003). However, not all studies have found a significant relationship of TSE to trainee performance (Johnson, Baker, Kopala, Kiselica, & Thompson, 1989). How self-efficacy is related to therapist self-criticism remains an empirical question; it is possible that therapists may have high self-efficacy but still remain critical of their performance as therapists.

Lent et al. (2009) asked Masters' level trainees about perceived changes in their self-efficacy across five sessions of therapy. The most frequently reported sources of change were trainees' performance in session (e.g., successful use of reflection or cognitive strategies) and observations about their clients' responses to therapy (e.g., "the client was easy to talk to"). The authors stated in their discussion, that the results suggested an interpersonal dimension to their efficacy, as therapists often relied on cues from their clients or the context of the therapy relationship to gauge their own efficacy. Koob (2003) has argued that a traditional model of supervision (e.g., that focuses on therapists' mistakes or weaknesses) does not increase developing therapists' sense of self-efficacy. A survey study revealed that supervisors who implemented components of a solution-focused supervision model (i.e., focus on therapists' successes and process of development) effectively contributed to therapists' positive perceived self-efficacy. Across these studies, attending to interpersonal and emotion-focused aspects of therapist development appeared to enhance coping and positive self-efficacy beliefs.

Developmental Processes in Therapist Training and Supervision. Models of supervision that are developmentally-based have received attention in the therapist training literature (e.g., Loganbill et al., 1995; Reising and Daniels, 1983; Stoltenberg, McNeill, & Delworth, 1998). Stoltenberg et al. (1998) saw therapists as passing through three broad levels and described therapist and supervisor responses at these levels. For instance, Level 1 therapists were described as typically having high anxiety and high motivation, having dependency on the supervisor, and being afraid of evaluation. Supervisor responses at this level included being supportive and structured in their feedback. At Level 2, therapists were described as experiencing autonomy–dependency conflicts with fluctuating confidence levels. At this level, the supervisor focused on trying to attain a balance between autonomy and support. Level 3 therapists usually were comfortable with autonomy with increased confidence, and had greater insight. Level 3 supervisors focused on helping therapists continue to develop their independent identities in a supportive manner. Ronnestad and Skovholt (1993) in their work on therapist development wrote, "At the advanced student level, feedback serves the purpose of aiding the student to clarify one's own position or perspective on conceptual and methodological issues…" (p. 401). At an advanced level of training then, both studies suggested that therapists may benefit from relating to their supervisors through a more egalitarian lens. Further examination of supervisee-supervisor tasks and responses at different stages of training can be useful in determining what types of responses might facilitate and hinder therapist development.

Supervisee Experiences of Shame and Self-Criticism. There are a variety of ways in which self-criticism and feelings of incompetence among supervisees has been conceptualized in the literature on psychotherapy supervision: Some researchers have examined the role of self-criticism in the guise of its impact on client outcomes (Watkins, 2011; Wheeler & Richards, 2007), the role of the supervisory alliance and supervisor style in aiding self-criticism (Gard & Lewis, 2008; Gray, Ladany, Walker, & Ancis, 2001), and the developmental process of learning to be a competent and confident therapist (Aronov & Brodsky, 2009; Hill et al., 2007; Mehr, Ladany, & Caskie, 2010). Watkins (2011) in his meta-analysis of 18 outcome studies on the effects of supervision on therapy outcome over the past 30 years found that the supervisory alliance was related to client satisfaction as well as theoretical orientation coherence between the supervisor and supervisee. Ladany, Walker, and Melincoff (2001) also have developed a body of work that indicates that supervision can powerfully influence the therapist-client relationship and that directs the next wave of supervision research towards the supervisor-supervisee alliance. For instance, some research has explored trainees' attributed counterproductive or hindering experiences in supervision to their supervisors dismissing their thoughts and feelings and weakening of the supervisory relationship (Gray et al., 2001).

In a survey study on supervisor characteristics completed by 87 supervisees (Bucky, Marques, Daly, Alley, & Karp, 2010) trainees reported that the supervisory alliance could improve with: the provision of balanced feedback with both negative and positive elements to the supervisee, consideration of the unique needs of the supervisee (e.g., specific training objectives identified by the supervisee, feedback from supervisee

evaluations), and written expectations and goals at the commencement of supervision based on the supervisees strengths and weaknesses. Furthermore, a grounded theory analysis of supervisee shame and feelings of incompetence (Theriault & Gazzola, 2010) found that supervisee experiences of incompetence may be deepened if supervisors responded with more structure and directiveness in supervision, a practice that could seem coercive to supervisees. The authors suggested that, instead, increasing self-awareness about feelings of incompetence could serve to normalize their experience. Westefeld (2011) interviewed five prominent or expert counseling psychologists about supervision, and some of the recommendations from the interviews included, "an increased emphasis in training programs on teaching people *how* to supervise" and "the development of more effective evaluation instruments that can be utilized in the supervision process" (p.312). The recommendations across studies in this literature suggest the need for understanding how supervision can best be constructed to promote healthy therapist self-criticism and growth despite feelings of self-doubt and shame.

Study Objectives

The primary objective of this study is to develop an understanding of how developing therapists experience and cope with self-criticism in the context of their training and therapy experiences. Secondary aims are to examine ways in which self-critical experiences impact therapists' training, and to develop recommendations based on the findings for supervisors and therapists in addressing self-criticism.

Method

Participants

Researcher. The researcher is a 30-year-old East-Indian female doctoral student in the clinical psychology program at the University of Memphis. The researcher has interests in constructivist therapies and has an integrative theoretical orientation. The researcher believes that self-criticism is a universal phenomenon that can be an adaptive experience. She also believes that self-critical and self-questioning attitudes are salient for many beginning therapists, and that supervisory experiences can help shape the ways in which therapists learn to cope with their self-criticism.

Therapists. Therapists ($N = 14$) in this study included graduate students in clinical and counseling psychology doctoral programs ($N = 13$) that were receiving supervised training in psychotherapy at the University of Memphis. In addition, a recent graduate who was training at the post-doctoral level was included in the study ($N = 1$). Most participants ($N = 12$) changed their supervisors every year, so the number of years in training was a proxy for the number of supervisors therapists had. A therapist demographic questionnaire was used to collect information about the therapists, their level of experience, and their psychotherapy orientations (see Table 1 for therapist demographics).

Procedure

Recruitment. In this study, therapists were recruited from (a) the University of Memphis clinical psychology program ($N = 12$), and (b) the University of Memphis counseling psychology program ($N = 2$). Therapists were individually approached to invite participation in the study via email and an electronic letter was sent to therapists at the University of Memphis, who were known to the researcher (see Appendix A). Additionally,

this letter was sent by the researcher to faculty and supervisors who had access to other trainees and agreed to forward the letter to their supervisees. Therapists who responded to the invitation letter and indicated their interest in the study were contacted individually by the researcher to schedule an in-person ($N = 13$) or a telephone interview ($N = 1$) based on therapists' availability. All interviews were audio-recorded and transcribed.

Qualitative Method

Retrospective recall interviews. Immediately prior to the interview, each participant was oriented to the study and informed consent procedures were reviewed (see Appendix B and C) and any questions or concerns therapists may have had were addressed. Interviews were semi-structured, and the interviewer had a pre-determined set of open-ended questions prepared in consultation with the researcher's advisor and project committee in order to guide the inquiry, and questions were added or altered as needed to fully explore therapists' experiences (see Appendix E). The overarching interview question was, "What is your experience of self-criticism as it relates to learning and performing psychotherapy across your training?" Additional questions were asked to clarify the role of other factors that may impact therapist self-criticism (e.g., supervision style, therapy alliance, therapist emotion). Using the retrospective recall method for this study was advantageous in that this method is likely to elicit durable criticisms, which might be more likely to influence future session performance of participants, as well as point to multiple sources of self criticism that can arise from training experiences (e.g., supervision, peer interaction, therapy).

Each interview lasted 30-45 minutes and therapist consent was obtained to audio record and transcribe the interviews. Therapists were informed that they could request to exclude parts of the interview from the transcript and/or the analysis, if the content disclosed

during the interview was experienced as sensitive. None of the therapists in the study asked for any part of their transcript to be excluded from the analysis or the transcripts. Additionally, any identifying information (such as names of supervisors, students, training sites) was removed from the analysis and interview transcripts. At the end of each interview, therapists were asked several questions about their experience of the interview to check on the credibility of the interview process and gain more understanding about the information gathered therein (view section on credibility checks). The audio recordings of these interviews were then transcribed by the researcher and subjected to a grounded theory analysis enabling the development of a model of therapists' experiences of self-criticism.

Grounded theory analysis. The data was analyzed using grounded theory analysis (Glaser & Strauss, 1967) performed in the manner developed by Rennie, Philips, and Quartaro (1988). This method has been advanced in psychological research to explore subjective experience and facilitate the development of theories. It is an inductive process in which the researcher is guided by the analysis of data to develop an understanding of phenomena grounded in empirical observation.

Once the interviews were transcribed, the data was divided into meaning units (MU's), which are segments of texts that contain one main idea (Giorgi, 1970). In the initial stages of the analysis, the MUs were labeled in a manner that remains very close to the language used by the therapists in the study. The MUs were then compared and organized according to their similarities, creating lower-level *categories* of meaning units, which were further grouped into higher order *clusters* based upon the commonalities among the lower-level categories. During this process of analysis, interviews continued until *saturation* was reached; specifically, the point at which

transcripts added to the hierarchy did not result in additional higher order categories or clusters. In this study, saturation was achieved at the 11th interview, and the last three transcripts did not add any new data to the model. To facilitate the organization and categorization of the data the Nvivo (version 8.0) software program was utilized.

The researcher also kept a record of thoughts and developing theories about therapists' experiences of self-criticism throughout the process of analysis. According to Rennie (2000), memoing allows the researcher to keep a record of salient points occurring during analysis, to ensure that they are represented in the final analysis of the data. Second, memoing is a process that allows researchers to be more fully aware of their biases so as to keep them from clouding the results of the analysis**.** In order to enrich the analysis and avoid any omissions of relevant data, the researcher frequently referred to the memos throughout the analytic process.

Credibility checks. In order to enhance the credibility of the study, three kinds of credibility checks were used. First, participants were asked credibility questions at the end of each interview to address any distortions in the data that could have arisen from the data collection process. Therapists were also asked if anything relevant to their experiences of self-criticism had been omitted in the interview that they would like to add and if they had any suggestions for future studies or for the researcher (see Appendix E).

Second, a process of consensus was used in the creation of categories and the development of the model of self-criticism with the researcher's study advisor, Dr. Heidi Levitt. This procedure of investigator triangulation provides a check on biases in data analysis to limit the bias that can result from having a single analyst. The interpretation of the data was discussed between the researchers during weekly meetings and consensus was

sought to increase the credibility of the findings.

Third, therapists were asked for feedback on the results of the analysis in order to enhance the credibility of the analysis. A summary of the findings was emailed by the researcher to all therapists in the study to elicit feedback on the main findings in the analysis. Therapists were informed that the results represented the experiences of all therapists in the study and were asked to submit their assessment of the analysis via email to the researcher.

Measures

The measure in this study was created to gather data for descriptive purposes, so that the researcher could gain an understanding of the background of the sample.

Therapist demographic questionnaire. Therapists were given a brief demographic form containing 19 questions asking about details of their training such as their exposure to different types of clients, clinical settings, supervision models, and psychotherapy courses (see Appendix D). Demographic information collected was used to describe the sample of participants.

Table 1

Therapist Demographics

Age	Gender	Race/ Ethnicity	# Year(s) conducting Therapy	# Hours of Supervision	# of Therapy Courses	Most influential Theoretical Orientation
28	Male	Caucasian	4	176	4	CBT
28	Female	Caucasian	0.5	25	3	Humanistic/Existential
26	Female	Caucasian	3.5	400	1	Interpersonal
29	Female	Caucasian	6	80	2	Humanistic/Existential
42	Female	Caucasian	5	700	3	Humanistic/Existential
28	Male	Caucasian	3	300	2	CBT
25	Female	Caucasian	2	144	1	CBT
26	Female	Caucasian	3	100	2	CBT
24	Female	Caucasian	1	60	1	CBT
26	Female	Caucasian	1	25	1	CBT
28	Male	Black	3	150	2	CBT
29	Female	Caucasian	3	239	4	CBT
48	Female	Caucasian	4	300	5	Humanistic/Existential
27	Female	Caucasian	2.5	170	3	CBT/Humanistic

Results

The data derived from the interview transcripts ($N = 14$) was first divided into meaning units (MU's) that each contained one main idea (Giorgi, 1986). This initial-level analysis yielded 517 meaning units across all transcripts in this study. Some

meaning units were assigned to more than one lower-level category; therefore the final hierarchy included 543 total meaning units. The MUs were then compared and organized according to their similarities into lower level sub-categories, which were then grouped into higher level categories, and then cluster-level categories. This multi-level, conceptual hierarchy resulted from 34 *sub-categories*, 14 *categories*, 5 *clusters*, and one final *core category* (see Table 2 below).

Table 2

Clusters and Corresponding Categories

Clusters	(N)	Categories	(n)
Cluster 1: I am more vulnerable to my self-criticism when I feel entirely responsible for solving my clients problems.	13	My self-criticism increases when I am doubtful about how to direct the session, especially if I am viewed as an expert.	8
		Early termination and poor alliance with clients creates feelings of inadequacy and self-criticism.	9
		Accepting that the client plays a part in making therapy successful can relieve my self-criticism.	6
		Contrasting clinical perspectives and opinions make me question my efficacy as a therapist.	6
Cluster 2: My self-criticism functions as an interpersonal barometer that sometimes makes me question my efficacy, but also normalizes my clinical experiences.	14	My self-criticism is normalized when supervisors share their past clinical struggles and give me feedback on the appropriateness of my self-criticism.	9
		Sharing my self-criticism with peers is a supportive experience and relieves my sense of isolation in my struggles.	6
		When I compare my performance to an ideal standard or with a supervisor whom I respect, I am less forgiving of my clinical mistakes.	7
Cluster 3: Negative judgments by my supervisor can lead me to don a facade of competence in my training and hide my intense shame.	13	Painful self-criticism about my incompetence can result from being critiqued in self-revealing exercises and videos in supervision.	12
		Fears of being viewed negatively by my supervisor leads me to masquerade as a competent therapist and hide my feelings.	8
Cluster 4: My Self-Criticism can be harsh, but is being tempered over time through experience and increased clinical freedom versus overly prescriptive supervision.	14	Self-criticism hinders my development, especially taking the form of a meta-critical process in my therapy.	14
		Anxiety about supervision intensifies self-criticism when supervision is rigid and prescriptive.	5
		My anxious self-criticism decreases as I become more comfortable with interventions.	14
Cluster 5: Supervision can sometimes be a holding environment where it's safe to be imperfect and self-divulging, and to learn from self-criticism.	14	Feeling supported by my supervisor makes it easier to show my clinical weaknesses and learn from them.	7
		Supervision is a safe space for open dialogue about how my feelings can impact my growth as a therapist.	14

The results section of this paper will contain a description of each of the main clusters (i.e., second layer) and categories (i.e. third layer) of the hierarchy, in turn, followed by a description of the single core category (i.e., top layer). Descriptive markers will be used to indicate how many therapists contributed to each cluster and category in the hierarchy (i.e., 0 = None, 1-3 = Few, 4-6 = Some, 7-9 = Many, 10-13 = Most, 14 = All). Because therapists were not asked about each subcategory directly, this number suggests how salient the cluster or category was for the therapists within the interview but does not indicate how many therapists agreed with the category. However, a sense of how many therapists agreed with the clusters is presented later in this section via the participant feedback. Therapists were contacted twice via email to provide feedback on the results of the study. For those therapists that did provide feedback ($N = 10$), when asked whether the research findings overall reflected their experiences of self-criticism, the mean response on a 7-point Likert scale was 6.6 (1 = Not At All, 7 = Very Much). When asked if the research findings contradicted their experiences of self-criticism, the mean response was 1.2 (1 = Not At All, 7 = Very Much).

Cluster 1: I am more Vulnerable to Self-Criticism When I Feel Entirely Responsible for Solving my Clients' Problems.

Therapists who contributed to this cluster ($N = 13$) described feeling as though they were solely responsible for the outcome of therapy. Interviewees' perceptions of their connection with clients and their ability to successfully guide them towards better outcomes appeared to make them more vulnerable to the effects of self-criticism. There were three categories in this cluster.

Category 1 of Cluster 1: My self-criticism increases when I am doubtful about how to direct the session, especially if I am viewed as an expert. In this category ($N = 8$), many therapists' self-criticism was activated when they were unsure about how to direct their clients in session. One therapist said,

> Like if in session…maybe you planned a general plan… and things go a completely different way or the client says something that you weren't expecting or, just in general in session I feel like, "Should I have said that? Or should I have said something more?" Or just sort of issues when I'm not sure if I handled the situation correctly and wondering, getting lost in my head, thinking about it, and what I should do next. (T-7)

Therapists' self-doubt about how to lead clients in session was particularly heightened when clients expected ready solutions for their problems. For instance, one interviewee said, "Anytime they're [clients] turning to me like, 'You're the expert tell me what to do,' then that's when I start to…like I don't want to over-represent my self-criticism but these are times when I am self-critical" (T-1). Ironically, having their self-confidence and expertise undermined in these ways could lead to a cyclical process wherein the therapists would enter the next session with even less certainty and then be perceived as less experienced.

Category 2 of Cluster 1: Early termination and poor alliance with clients creates feelings of inadequacy and self-criticism. Participants' ($N = 9$) perceptions of poor alliances with clients were associated with feeling like a "bad therapist," especially when clients dropped out or abruptly terminated therapy. According to one participant,

> [A client had] tremendous anxiety and I definitely felt…his decision to not continue after two sessions was, "I just want to try medication I'm not sure I can handle the emotions - it's really frightening." But even from that I remember processing it in my supervision class and…I felt I must have pushed him too much or maybe I'm not good enough for him to want to try therapy with me. (T-4)

Similarly, another therapist talked about the working alliance impacting her sense of responsibility,

> Internalizing every reaction I had with her [client] (p.03). I just started to put all of the focus on me being the one who has control and… I assumed that all the responsibility was on me...and then was beating myself up for it. I thought about her over the whole break. Like I wonder what she is doing right now, if she's doing okay…because I thought I've done something wrong, and now this is my fault. (T-3)

Instead of working to explore the alliance in session with their clients, therapists who assume responsibility for shaky alliances may not empower themselves to take steps that might strengthen the alliance, such as talking openly with clients about relational difficulties.

Category 3 of Cluster 1: Accepting that the client plays a part in making therapy successful can relieve my self-criticism. Some therapists ($N = 6$) expressed that when they considered clients' responsibility in participating in therapy, this tended to buffer the harsh impact of self-criticism on their perceptions of their therapy. One participant said, "I think I've become less critical as I come to see therapy as more of a

collaborative process rather than me being in charge of the direction of how things are going" (T-6). Additionally, when clients shared with their therapist what they learned in therapy, therapists were less critical about their work. Based on the results within this cluster, a guiding principle for both therapy practice and supervision is to discuss how responsibility is shared between the client and therapist, as a way to mitigate therapists' self-criticism. When participants were asked to give feedback on whether this cluster fit with their experience of therapist self-criticism, the mean response on a 7-point Likert scale was 6.1 (1 = Not At All; 7 = Very Much).

Cluster 2: My Self-Criticism Functions as an Interpersonal Barometer that Sometimes Makes me Question my Efficacy, but Also Normalizes my Clinical Experiences.

All therapists ($N = 14$) revealed that their self-criticism often was characterized by a drop or an increase in their self-criticism, as determined by their interpersonal interactions with clients, peers, and supervisors. There were four categories in this cluster.

Category 1 of Cluster 2: Contrasting clinical perspectives make me question my efficacy as a therapist. When some therapists ($N = 6$) encountered peers' contrasting clinical perspectives or a different theoretical orientation, they were critical about their own therapeutic methods and beliefs. One therapist described her self-criticism when encountering differences,

> It [self-criticism] can come in little things, like do you use the overhead lights [in session] or do you use the lamps. And I thought, "Well of course, you shouldn't use those overhead lights; it's like an interrogation room." But one of

> the girls [peer] was like, "I've read the literature on this and apparently clients are more honest and divulge more with the lights bright." So then it threw my whole vision of therapy. "Have I been doing it all wrong? Should I have turned the lights on?" And that still creeps up in my mind when I walk in the room. (T-3)

When discussing the dynamics of the group supervision process at the outset of supervision, supervisors may emphasize that sharing peer perspectives could help students develop their own approach and enhance the learning process.

Category 2 of Cluster 2: My self-criticism is normalized when supervisors share their past clinical struggles and give me feedback on the appropriateness of my self-criticism. Many therapists ($N = 9$) appreciated their supervisors' candidness and self-disclosures about their own mistakes in their training as it helped normalize their clinical experiences. One therapist emphatically stated,

> Yeah! That's one thing I really like about [supervisor name]. He would share stories about things like had happened to him…like learning moments that he had…it's kind of humbling…I think a lot of times we put supervisors up on pedestals like they never make any mistakes. To know that they were like us would be helpful. (T-5)

Some therapists also talked about how they would like their supervisors to help them differentiate their self-criticism according to their level of training, as a way of normalizing self-criticism. For instance, one therapist said,

> I want it to be a more complex self-criticism that knows how to differentiate the things I should be critical about vs. the things I shouldn't be and I don't think

> that's going to happen until I have just lots of experience on top of lots of education. Now it touches everything instead of discriminating against what I should be critical about and what I shouldn't be. (T-3)

When supervisors were candid about their own developmental process and errors in clinical judgment, therapists were less likely to perceive their mistakes as failures, but more as a building block in their training towards honing their skills.

Category 3 of Cluster 2: Sharing my self-criticism with peers is a supportive experience and relieves my sense of isolation in my struggles. Some therapists (*N* = 6) valued and sought out the interpersonal support of their peers as a means of minimizing feelings of isolation when faced with challenges in their therapy. One therapist said, "They [peers] have gone through something similar so they can say oh this is how I handled it, I've been through the same situation" (T-10). Therapists also found it helpful to share their self-criticism with their peers because it resonated with their own struggles in therapy in a supportive and non-evaluative manner.

Category 4 of Cluster 2: When I compare my performance to an ideal standard or with a supervisor whom I respect, I am less forgiving of my clinical mistakes. Half the therapists in the study (*N* = 7) noted that they were less forgiving of their mistakes in training, especially when they compared their skills and knowledge to that of their supervisors, or when they held themselves to a perfect or ideal standard in order to best help their clients. For instance, one therapist said, "That's the thing that I've learned about myself that I tend to have a very high almost unattainable standard and ideal. And so I see there is a gap between where I'd like to be and where I'm at" (T-

4). Another therapist talked about how her self-criticism was triggered in the presence of her supervisor,

> I've never really thought about it like that but that's what it is…how good could I be one day compared to you [supervisor] and if you're that good then I've really got to show my very best because you're [supervisor] just going to think what I do is terrible! (T-3)

The results of this cluster indicate that transparency from supervisors about their own personal development and weaknesses humanized supervisors and enabled supervisees to have more self-compassion when confronted with their clinical weaknesses. When participants were asked to give feedback on whether this cluster fit with their experience of self-criticism as a developing therapist, the mean response on a 7-point Likert scale was 6.4 (1 = Not At All; 7 = Very Much).

Cluster 3: Negative Judgments by my Supervisor can Lead me to Don a Facade of Competence in my Training and Hide my Intense Shame.

Participants (N = 14) discussed their beliefs about how they were perceived by their supervisors, an experience that could elicit feelings of shame and incompetence that they sometimes preferred to hide. There were two categories in this cluster.

Category 1 of Cluster 3: Painful self-criticism about my incompetence can result from being critiqued in self-revealing exercises and videos in supervision. Most therapists (N = 12) described experiencing a sense of shame about their perceived competence, which was intensely activated during role-play exercises in the presence of peers and when therapists received negative feedback from their supervisors. One therapist discussed intense feelings of hurt in response to her supervisor's feedback,

> I responded [to supervisor feedback] with crying [in supervision].... it was hurtful feedback to get and it wasn't critical feedback of, "You did this wrong and you did this good." It was just all bad…and I tried to get specific examples so I could improve because I don't expect I'm perfect…I couldn't get any of that. I even suggested that we role-play so I can understand what to do better and that didn't go over well. (T-12)

Another therapist described a supervisor's feedback as leading to depression,

> Well I feel like, the supervisor is supposed to be such a great therapist and if they say that you're bad, you're going to believe that. Either that or they're out to get you -- I don't know. You start to believe it and if you believe it then that's going to hurt you even more as that leads to depression and all that other stuff.... I expect to be critiqued but I don't expect everything to be negative. (T-2)

The critical implication of this category is that supervisors may want to recall how sensitive the supervision process can be for therapists, so that feelings of hurt and shame can be gently explored. However, therapists were more receptive to feedback when supervisors acknowledged both their strengths and weaknesses, as they were perceived as more constructive, balanced, and supportive.

Category 2 of Cluster 3: Fears of being viewed negatively by my supervisor leads me to masquerade as a competent therapist and hide my true feelings. Many therapists' ($N = 8$) fears about being perceived as incompetent by their supervisors caused them to assume a posture of professional competence, regardless of how they internally experienced their efficacy. One therapist talked candidly about her fears of displaying incompetence,

> I hate to say this but my fear is always that they won't let me practice. That's my neurosis that somebody is going to realize that I shouldn't be allowed to be a therapist and they'll stop me. So I'm like, there is some kind of dialogue I have about if people knew who I really was then they would kick me out. So if my environment says I already have this competency, my first reaction is I'm going to do my damndest to fake it and be it and somehow make it up and read all night and figure this out. (T-9)

Additionally, many therapists tended to hide their anxiety and weaknesses in supervision if they felt that they might be criticized or dismissed by their supervisor for admitting their mistakes. One therapist said, "I guess also feeling a little put down...with the two supervisors what I needed to say wasn't important enough to hear? Certainly a feeling of being dismissed or less important than I wanted to feel" (T-8). A guiding principle for supervision could be to help supervisees understand what it means to be "competent" at various stages of training. Future research might work to develop benchmarks to promote increased accuracy of assessment by supervisors and a helpful tool in alleviating supervisees' fears. When therapists were asked to give feedback on whether this cluster fit with their experience of self-criticism as a developing therapist, the mean response on a 7-point Likert scale was 6.0 (1 = Not At All; 7 = Very Much).

Cluster 4: My Self-Criticism can be Harsh, but is Being Tempered Over Time Through Experience and Increased Clinical Freedom Versus Overly Prescriptive Supervision.

The results in this cluster ($N = 14$) underscores the salience of therapists' self-criticism at the beginning stages of their training as well as factors that help moderate

their self-criticism over time and experience in their training. There were three categories in this cluster.

Category 1 of Cluster 4: Self-criticism hinders my development, especially taking the form of a meta-critical process in my therapy. All therapists in this study ($N = 14$) expressed self-critical thoughts and feelings about themselves and viewed self-criticism as hindering their development. In addition, therapists engaged in a meta-critical process of thinking, where they expressed being critical about having self-criticism. One therapist stated, "But then I also get frustrated with myself for being overly critical…then I'm like criticizing myself for being critical" (T- 5). Another therapist described the obstructive effect of self-criticism at the beginning phases of her development,

> It's [self-criticism] just a blanket right now until I hear otherwise. I pretty much assume that my work is not as good as it should be until I get praise and then I think that's one area I don't have to worry about so much in this case...so I feel the more I get shaped in the years to come it will just be more dynamic and complex and sophisticated. It won't be this huge blanket just covering every client and case. (T-3)

Therapists often used words such as "beating myself up" and "ruminating" to describe how their criticism evolved. One therapist said,

> I think it's more like monitoring or ruminating. That's sort of like the lowest stage to be…the beginning stage is kind of ruminating and not letting go and moving on…and then it gets worse… becomes inhibitive and the fear and embarrassment builds. (T-1)

These hindering aspects of self-criticism could be generalized to multiple aspects of clinical work and could emerge over the course of training.

Category 2 of Cluster 4: Anxiety about supervision intensifies self-criticism when supervision is rigid and prescriptive. Some therapists ($N = 5$) described their anxiety about being evaluated in supervision as affecting their ability to be effective clinicians. According to one therapist, "It [self-criticism] has affected me so much that I have had an [internal] panic attack in a couple of sessions. So it's been pretty destructive I couldn't concentrate…it was hard" (T-2). They noted that when their supervisors were more dogmatic about following set rules in their therapy, their self-criticism intensified. One therapist said,

> I feel like I just wasn't getting anywhere by pushing back so I just capitulated and said "Okay. I'm just going to go by the rules because in the end you evaluate me." In the end he decided that I became a better therapist and I know that's because I capitulated. (T-8)

Another therapist described what helps her self-criticism and builds her confidence by stating,

> I would check with my supervisor, "This is what I'm going to do this week"....and as long as you have a rationale he runs with it and lets you do what you want…as long as you can back it up and it's effective. So I have a lot of freedom. (T-12)

Supervisors who were viewed as overly controlling tended to strengthen therapists' self-criticism about their clinical skills. In contrast, supervisors who granted them flexibility in their interventions while guiding them to consider the reasons for and effects of their

choices prompted therapists to reflect upon their approaches to treatment and develop confidence.

Category 3 of Cluster 4: My anxious self-criticism decreases as I become more comfortable with interventions.

All therapists ($N = 14$) endorsed anxiety about conducting unfamiliar interventions in therapy that could trigger self-criticism and interfere with their ability to conduct therapy effectively. One therapist describes anxiety around implementing a new intervention,

> There's a right or wrong way to deliver some of these things or introduce a specific skill or intervention...one I can think of is chairing. I've never had a formal introduction to what I would consider the more emotion-focused technique and my supervisor suggested using this technique…I think I tried to do it maybe twice and both times I felt a little bit ridiculous. I don't think you can just implement some technique out of context and out of how you've been interacting in session and expect it to be met with open arms and to have the potential that it has to work. (T-14)

Additionally, therapists saw their self-criticism as being tempered through a developmental process of learning where they could come to rely on their clinical experience and growing comfort with training activities over time. One therapist said,

> I know I'll never know it all…and I don't know that I believe that there is one truth to therapy to know...so sort of a catch 22. But I feel like even more than knowing the literature or knowing theories...having experience to fall back on to

> say I went through this once with a client and I got through it this way… here it is again… that's something you can't get through reading books. (T-3)

One principle for supervisors to integrate into their training approach is discussing explicitly how their style of supervision relates to their theoretical orientation and how that might match with supervisees' own orientations and expectations of supervision and the learning process. For therapists, difficulties in adapting to new clinical experiences and supervision styles could be an important point of reflection in supervision, given the inevitability of encountering diverse perspectives in training. When interviewees were asked to give feedback on whether this cluster fit with their experience of self-criticism as a developing therapist, the mean response on a 7-point Likert scale was 6.3 (1 = Not At All; 7 = Very Much).

Cluster 5: Supervision can Sometimes be a Holding Environment Where it's Safe to be Imperfect and Self-Divulging, and to Learn From Self-Criticism.

All therapists ($N = 14$) acknowledged that their personal and professional growth was greatly enhanced and nurtured by the supervision process. Supervision represented a holding environment for these therapists, where they could use this time for self-reflection and to better understand how to improve as a therapist, with the guidance of their supervisors. There were two categories in this cluster.

Category 1 of Cluster 5: Feeling supported by my supervisor makes it easier to show my clinical weaknesses and learn from self-criticism. Many therapists ($N = 7$) noted that feeling supported by their supervisors in their clinical efforts made it easier to be vulnerable in supervision about their clinical weaknesses, and allowed them to be more open to learn from their mistakes. One therapist described how her supervisor was

accepting of mistakes that were made yet didn't lose sight of the strengths of her supervisee,

> I guess it is creating an environment where you feel more free to show your bad stuff. Where you're not going to be villanized for every bad move...what I love about my supervision is I walk in feeling all self critical and feeling like I did a terrible job (laugh) and she [supervisor] will stop the tape, I'll say what I think went wrong, and she'll tell me the good that she saw in it and also point me in a good direction. So I feel like we're not ignoring the fact that something wasn't good, we're pointing out the things that were good and finding new direction. That's just great! (T-1)

In addition to providing balanced feedback, therapists felt supported when their supervisors turned their mistakes into teaching moments, so that therapists could experience them as motivation to improve their skills. For instance, one therapist said,

> This is the time when the supervisor is here to specifically, spot you. It's like the gymnastics analogy...you may fall but you're not going to get the move unless you go through those falls… it's exactly like you do with a client. You don't go, "You screwed up!" You go, "What can we learn from this? Good for you for trying something new!" And I think supervisors can model that too. (T-9)

This category has implications for how supervisors can align with their supervisees' to help relieve their self-criticism and enhance their learning through supporting their falls and triumphs.

Category 2 of Cluster 5: Supervision is a safe space for open dialogue about how my feelings can impact my growth as a therapist. All therapists ($N = 14$) noted

that supervision could be a safe space in which they could examine their self-critical feelings and ways in which self-critical processes could impact their clinical work. One therapist talked about how her supervisor encouraged her process of self-examination,

> He [supervisor] addressed it with me and kind of got me to take a look at why is it that I'm irritated with her [client]...or why am I surprised or any other emotion besides curious. And that kind of directed me to this feeling of inadequacy… this feeling of self-criticism that I must have been having that I hadn't really put my attention to? That's why I felt like I wasn't doing the right thing because I was criticizing myself instead of moving forward and using the information wisely in therapy. (T-3)

Similarly, another therapist talked about reframing self-criticism in a productive way,

> [My supervisor] has a lot of confidence that clients are in a marketplace in that; you're not the only therapist they will ever have access to. You don't fall apart because you can't be everything to everyone or because somebody else has a talent that I don't have. But to use it to build my awareness of, "Oh well I could grow in that area, maybe I could try." (T-9)

The principle based on the results in this cluster is to provide supervisees positive support and encouragement as a buffer for self-criticism and also a framework in which self-criticism is explicitly conceptualized as a learning experience in supervision. Discussion in supervision could clarify what supervisees might want to learn based upon their self-criticism. When therapists were asked to give feedback on whether this cluster fit with their experience of self-criticism as a developing therapist, the mean response on a 7-point Likert scale was 6.7 (1 = Not At All; 7 = Very Much).

Core Category: The Intensity of my Self-Criticism is Mitigated as I Shed the Expert Role for Authenticity — a Learning Process that is Strengthened by my Sense of Interpersonal Safety and Clinical Flexibility in my Development.

The core category in a grounded theory analysis represents the central finding of the analysis. The core theme in this analysis underscored the ways in which therapists' self-criticism was mitigated so they developed their identity as therapists in a productive manner. Therapists emphasized that they were engaged in the intensive experience of learning how to be authentic in relationships with their clients and supervisors. Self-criticism could make that learning process all the more difficult; particularly when they felt pressured or socialized to adopt an expert role as clinicians. When supervision was viewed as a "safe" space in which supervisors saw the process of learning as positive, therapists were better able to be authentic and explore and learn from their self-criticism as it impacted their clinical work. The process of being authentic about their evolving identities as therapists also was strengthened by working within a supervision model that allowed for flexibility in making clinical decisions and selecting interventions. Supervisors allowing for therapists input and creativity in executing and personalizing interventions so they are a better fit for themselves and their individual clients increased therapists' self confidence. This core category has implications for how self-criticism can be shaped within training to be a constructive force, and supervisory teams might actively consider how therapeutic expertise might differ from having ready solutions for problems, following rigidly laid out interventions, or being perfect as a therapist.

A guiding principle for supervisors is to frame supervision as a forum to consider therapists' authentic connection to their clients and evaluation of their own

competencies. Also, acknowledging the complexities of practice and the burden of responsibility that developing therapists encounter could empower them to approach their training more openly within a safe supervisory environment. When therapists were asked to give feedback on whether this core theme fit with their experience of self-criticism as a developing therapist, the mean response on a 7-point Likert scale was 6.4 (1 = not at all; 7 = very much).

Discussion

In this study, participants' descriptions of self-criticism yielded several themes that were salient aspects of their training. The core category, *The intensity of my self-criticism is mitigated as I shed the expert role for greater authenticity — a process that is strengthened by my sense of interpersonal safety and clinical flexibility in my development,* underscored that the majority of therapists felt that their self-criticism could be more productive and motivate them to better their skills when they felt they could have connected relationships with clients, experienced interpersonal connection and safety with supervisors, and were allowed greater clinical freedom in making treatment decisions. This section explores the limitations and strengths of the study and the implications of the findings as they relate to therapist development and supervision.

Study Limitations and Strengths

In this study, all therapists recruited were students of a university in a metropolitan area in the Mid South region of the U.S and most were White and in their 20s; therefore, caution should be exercised before extending the findings to different types of graduate training programs and therapists. Additionally, 12 of the 14 therapists in this study came from within the same graduate program and some had training

experiences with the same supervisors. These findings are also less applicable to some supervision formats such as in-vivo/live supervision or large group/class format. More diversity was present in other characteristics, for instance, supervisors led supervision using different formats (individual and small groups of 3-4 students) and participants reported that their supervisors used multiple theoretical approaches (such as cognitive-behavioral, constructivist, interpersonal, humanistic, and family systems). Additionally, most of the therapists ($N = 12$) in the study had experiences in more than one supervision group at the time of the interview. Also, participants in this study reported different theoretical orientations themselves (see Table 1 on therapist demographics).

The credibility of this study was further enhanced by three credibility checks that were performed by the investigator. First, therapists were asked credibility questions at the end of each interview to check on the thoroughness of the data collection process. Throughout the data collection and analysis phases, the interviews and the developing hierarchy were reviewed by the researcher's project advisor, who has expertise in the grounded theory analysis method and qualitative interviewing. She gave feedback on the interviewing and guidance on the analytic process. Also, she worked with the researcher to obtain researcher consensus, which lends credibility to the analysis by demonstrating that this interpretation of the data can be seen from more than one perspective. Also during the data collection and analysis phases, the researcher kept a log of her beliefs, perceptions, and developing theories pertaining to therapist self-criticism to reduce the biasing effect they may have had on the study by explicitly recognizing these assumptions. Third, the credibility of the conceptual model was augmented further by the positive feedback offered by 10 of the 14 participants who provided feedback after

they reviewed a summary of the results of the study. Finally, saturation of the conceptual categories was achieved and new categories did not appear to be forthcoming with the addition of the last three interviews, which suggests that the analysis was comprehensive.

Implications for Therapist Learning

Most of the therapists in the study believed that their self-criticism was a hindering force in their training. The analysis revealed that the harshness of therapist self-criticism could be buffered by factors such as the quality of the supervisory relationship, clinical flexibility, and experience conducting psychotherapy. Despite the hindering impact of self-criticism, none of the therapists in the study viewed self-criticism as a force to be eradicated from their training. In contrast, therapists expressed ways in which they wished to see their self-criticism become more constructive, so it could motivate them to better themselves in the context of their training. This section focuses on principles for development and future implications for therapists in developing a healthy and productive form of self-criticism.

Relative-competence assessment as a principle to guide healthy-self-criticism. Interviewees' self-criticism was based upon a striving towards a sense of competence in their clinical work with clients. Specifically, the results within this study indicated that their experience of self-criticism resembled an "interpersonal barometer" that could increase or decrease as they compared their skills and knowledge to their peers and supervisors and with each new session. Competence in the context of professional psychology has broadly been defined as "observation of those skills and behaviors in the trainee that are generally agreed upon by educators to be facilitative of

therapeutic and/or academic growth" (Deemer, Thomas, & Hill, 2011, p. 38). However, the literature does not address ways in which therapists can learn to practice effectively within their developing competence levels at early stages of training. Many participants tended to perceive the gaps in their skill base as a lack of competence as opposed to an evolving competency that would continue to grow. These findings suggest that it might aid therapists to learn to see their therapy skills within a developmental framework.

Some therapies have developed specific skills such as cognitive self-talk protocols from cognitive-behavioral therapy, self-critical chair-work in emotion-focused therapy, compassionate mind training in compassion focused therapy, and working with transference and counter-transference in psychodynamic therapies, which can be effective in developing healthy and less harsh self-criticisms (Kannan & Levitt, 2012). Additionally, the practice of mindfulness from the many versions of mindfulness therapies might be promising in teaching developing therapists to stay present with their clients in session as well as be able to hear and receive feedback in supervision without excessive self-judgment (Bruce, Manber, Shapiro, & Constantino, 2010). Helping clients work with self-criticism using approaches such as these might mitigate therapists' own self-criticism as well as lead to interesting self-reflections in supervision. Future research could examine if relative competence-based assessments act to moderate the effects of harsh self-criticism in training.

The role of agency in enhancing authentic identity development. Many participants noted that while they were novice therapists, they often thought they had to maintain an external façade of expertise in order to demonstrate a higher level of proficiency to their clients and supervisors and so would lose their sense of real

connection with clients in session. Angus and Kagan (2007) in their work on empathic relational bonds stated that in order for therapist agency and authenticity to be optimized, a safe and trusted relationship with the supervisor is needed, a sentiment that was voiced by all participants in this study. This research adds to this literature that therapists' authenticity might be fostered through developing their agency and confidence as therapists (cf. Williams & Levitt, 2007; on developing client agency).

Another way to foster therapist authenticity is for supervisors to guide trainees to think about their approach to learning so they reconstrue supervisor feedback as a form of nurturance, rather than punishment, and seek feedback to support their practice, rather than dreading it. Supervision was better received when seen as a place to learn and present concerns rather than a place to present their best moments. A supervision course or lecture series might explicitly addresses concerns that supervisees typically experience in their training, and future quantitative methodologies might examine learning processes and styles of supervisory feedback.

Implications for Supervision and Training

Supervisor self-disclosure: A relational tool. Supervisor's self-disclosure of their training experiences normalized participants' fears of incompetence and encouraged supervisees to reveal self-critical concerns instead of concealing them. Both a recent qualitative and quantitative review of therapists' self disclosure (Henretty, 2010; Henretty & Levitt, 2010) found that self-disclosure had a small but significant positive influence on clients' perceptions of their therapists generally, their liking or attraction to their therapist, and their willingness to disclose. Although there is not a direct concordance between the therapy and supervision context, this literature also suggests

that disclosure can have a positive relational effect. Additionally, it can vivify the complexity of learning psychotherapy, dispelling notions that novice therapists should demonstrate great expertise. Supervisors that model the inevitability of mistakes in therapy can help therapists become open and less restricted by a sense of shame (Klein, Bernard, & Schermer, 2011). Future task-analyses of moments of supervisee self-criticism could identify specific supervision processes that can aid self-criticism.

Supervisory alliance as a bridge to an integrative supervision model. For many participants, their perceived relationship with their supervisor determined whether they shared self-criticisms. Recent research on the importance of supervision on therapy outcome has suggested the importance of the supervisory alliance (Angus & Kagan, 2007; Boswell, Nelson, Nordberg, Mcaleavey, & Castonguay, 2010; Sarnat, 2010). The only trend ($N = 3$) linked to the supervisors' therapist orientation in this study was that models of supervision that viewed therapy as purely intervention driven (versus a relational activity or process) tended to ignore the supervisor-supervisee alliance. Supervisors might benefit from a supervision model that teaches intervention-based skills while deepening the cohesiveness of the supervision group and strengthens the alliance between the supervisor-supervisee dyad.

In addition, all therapists in this study expressed the wish for more discussion with supervisors who they felt safe and connected with around negative reactions to clients, difficult alliances, and anxiety about their skills. This finding might prompt consideration from supervisors that tend to focus their supervision centrally on structured interventions and therapy outcome (see Ladany, Klinger, & Kulp, 2011, on coping with therapist shame). Psychodynamic approaches to supervision traditionally

have viewed supervision as parallel to the therapy process, and can be models for discussing the centrality of intrapersonal dynamics, covert thoughts, internalized shame, and feelings about threatening aspects of practice that guide behavior of both supervisees and supervisors (e.g., Bradley & Ladany, 2001; Shahar, 2001). Future research that explores the perceived quality of the working alliance across different models of supervision and its impact on supervisees' satisfaction is recommended.

Common factors approach to facilitate effective learning. Although the research on this topic is scant, Lampropoulos (2003) has described similarities between the supervision process and the psychotherapy process, noting the importance of supervisor empathy and support, supervisee self-exploration, and instillation of hope as important common ingredients for any supervisory relationship. Based on the results that emerged within this study, factors that aid the feedback process and reduce the intensity of self-criticism are a sense of safety, open communication about supervisors' and trainees' expectations about supervision, permissibility and normalization of clinical errors, willingness to explore the "person of the therapist," and supervisor disclosures of past clinical mistakes, despite differences in theoretical orientation. Although more structured guidance from supervisors may be welcomed at beginning stages of training, supervisors might gradually reduce prescriptive practices over time, as it seemed to hinder therapist learning. For instance, encouraging peer feedback in group supervision might increase students' autonomy (Mastoras & Andrews, 2011).

Graduate programs may wish to consider developing a supervision course that reviews research in this field to help supervisors obtain skills in this area. Research on some of these "common factors" in supervision might shed light on how these factors

can facilitate learning and promote productive self-criticism. Training programs also may make available lists of community therapists who could provide affordable therapy to graduate students, as a way of exploring their self-criticisms without the fear of being evaluated. In conclusion, the findings in this study illustrate the complexity of the professional and personal journey as a therapist-in-training. As developing therapists have authentic interaction and exercise agency within a safe and flexible training environment, their self-criticism can be come to productively inform their learning and practice of psychotherapy.

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Appendix A: Recruitment Email

This email was sent to psychology training programs to invite participation in the study:

Sample recruitment email to participants

Do you reflect on your reactions or emotions in your work with clients? Do you ever critique your own work as a developing therapist? If you have had these experiences in your training, please consider participating in this project! This is a great opportunity to talk about your experiences as a therapist-in-training and contribute to the literature on therapist development and psychotherapy research. Additionally, you will be provided with a copy of the guidelines for therapist development after the completion of the analysis of the results!

I am a Clinical Psychology Doctoral student at the University of Memphis and I am conducting a qualitative research project on "Self-Critical Experiences in Developing Psychotherapists" under the supervision of Dr. Heidi M. Levitt. If you are (1) over 18 years of age, (2) are a graduate student therapist or counselor-in-training, and (3) are currently receiving supervision; and would be willing to participate in an interview about your therapy experiences, please contact me at the information provided below.

Thank you for taking the time to consider participating in this research! Please feel free to forward this e-mail to others who you think might be interested in participating in this study. You can contact me at dkannan1@memphis.edu if you would like to participate in this study.

Sincerely,
Divya Kannan

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Appendix B

INFORMED CONSENT

I, ..., agree to participate in a psychotherapy research project. I understand that this research project is being run under the supervision of Dr. Heidi Levitt, an associate professor at the University of Memphis, and is designed to investigate developing therapists' experiences of psychotherapy within their training. I am aware that I can contact Dr. Levitt through the Department of Psychology at the University of Memphis (678-5489) if I have any questions about this project or if any problems arise from this research. Also, I can contact Divya Kannan at dkannan1@memphis.edu (901-340-4625) if I have any questions. For concerns about participants' rights, I may contact the Chair of the Committee for the Protection of Human Research Participants at 678-2533.

I understand that my participation in this study entails me:

- 1) Consenting to an interview with the primary researcher about my therapy experiences which will be audio-recorded, transcribed, and subjected to qualitative analysis.
- 2) Providing feedback to the researcher after receiving a copy of the final results of the study.

I have been informed that my participation in this project is completely voluntary, and I would not be paid money for participation. To protect my confidentiality, I have been informed that only a code number will identify participants on the audio-recordings and that these audio-recordings will be stored on a password-protected computer in a locked room; that all information will be stored under lock and key; that only Dr. Heidi Levitt and Divya Kannan will have access to the collected data; and that once this study is completed all data will be deleted or shredded.

I understand that my participation in this research project will contain minimal foreseeable risks to me, and that the University of Memphis does not have any funds budgeted for compensation for injury or damages. In terms of benefits, this psychotherapy research may identify ways to improve the treatment of clients and the training of psychotherapists by examining the processes in therapists that lead to insights about or changes in their performance. Plus, the interview offers the opportunity for me to reflect on my experience of psychotherapy and further process my goals and development as a therapist thus far. I understand that I can withdraw my participation from the research at any time; my participation is totally voluntary. Refusal to participate or a decision to discontinue the project will involve no penalty. If I withdraw from this project, any information collected will be immediately destroyed. I understand that if I experience any distress from this study, I can talk with my supervisor. Add limits of confidentiality. My signature indicates that I have read and understood the content of this Consent Form and the Therapist Instructions Form and that I consent to participate in this project.

_____ _____

Signature Date

Appendix C

Instructions to Therapists

Thank you for agreeing to participate in this study. The following interview is an attempt to understand some of your training experiences as a developing therapist. In particular, we hope to develop an understanding of the experience of self-criticism in your therapy training. We encourage you to be as honest as you can as we are very interested in learning about your self-critical or self-questioning experiences that have impacted your growth as a therapist.

When answering the questions about your experiences across your training, be sure to avoid mentioning any identifying data about your clients. **The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule** (http://privacyruleandresearch.nih.gov/pr_08.asp) states that, "Health information that is de-identified can be used and disclosed by a covered entity, including a researcher who is a covered entity, without authorization or any other permission specified in the Privacy Rule. The Privacy Rule allows a covered entity to de-identify data by removing all 18 elements that could be used to identify the individual or the individual's relatives, employers, or household members." The following identifiers below must be removed during your participation in this study.

1. Names. (e.g., the client's name, names of other people in the client's life, siblings, professors, friends, employers)
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP Code, and their equivalent geographical codes, except for the initial three digits of a ZIP Code if, according to the current publicly available data from the Bureau of the Census:
    a. The geographic unit formed by combining all ZIP Codes with the same three initial digits contains more than 20,000 people.
    b. The initial three digits of a ZIP Code for all such geographic units containing 20,000 or fewer people are changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
4. Telephone numbers.
5. Facsimile numbers.
6. Electronic mail addresses.
7. Social security numbers.
8. Medical record numbers.
9. Health plan beneficiary numbers.
10. Account numbers.
11. Certificate/license numbers.

12. Vehicle identifiers and serial numbers, including license plate numbers.
13. Device identifiers and serial numbers.
14. Web universal resource locators (URLs).
15. Internet protocol (IP) address numbers.
16. Biometric identifiers, including fingerprints and voiceprints.
17. Full-face photographic images and any comparable images.
18. Any other unique identifying number, characteristic, or code, unless otherwise permitted by the Privacy Rule for re-identification

In addition, we ask that you also avoid mentioning topics that could identify your client such as courses they are taking, their major area of study, where they received services and names of clubs or organizations they belong to.

By signing below, you confirm that you have read and received a copy of this agreement. If you have any further questions regarding your participation or any other study-related questions, please contact Divya Kannan at dkannan1@memphis.edu or Dr. Heidi M. Levitt at hlevitt@memphis.edu. If you have any questions regarding your rights as a subject in this study, you may contact Dr. Corinna (Bunty) Ethington, chair of the Institutional Review Board for the Protection of Human Subjects, at (901) 678-2533.

Therapist Name

_____

Therapist Signature Date Signed

_____

Appendix D: Therapist Demographic Questionnaire

1. Does your program of training aim to prepare you to perform psychotherapy or counseling?

(a) Yes (b) If no, please discontinue survey

2. Age: _____

3. Sex:_____

4. Sexual Orientation _____

5. Ethnicity:

(a) Caucasian

(b) African American

(c) Hispanic

(d) Asian/Pacific Islander

(e) Other _____

6. Location/State: _____

7. What type of degree are you currently seeking?

(a) Masters of Arts (M.A.)

(b) Masters of Science (M.S.)

(c) Doctorate of Philosophy (Ph.D)

(d) Doctorate of Psychology (Psy.D)

(e) Other _____

8. In what program is the degree you are seeking?

(a) Clinical psychology

(b) Counseling psychology

(c) Counseling

(d) Social Work

(e) Other _____

9. Please provide an estimate of the number of years of experience you have conducting psychotherapy or counseling: _____

10. Please provide an estimate of the number of hours of supervision you have had _____

11. What are the types of courses you have had in psychotherapy/counseling. Please check all that apply.

(a) ___Humanistic/Existential therapy

(b) ___Psychodynamic therapy

(c) ___Feminist/Multicultural therapy

(d) ___Cognitive/Behavior therapy

(e) ___General Psychotherapy (no specific orientation)

(f) ___Other _____

12. What are the types of supervision you have had in psychotherapy/counseling. Please check all that apply.

(a) ___Humanistic/Existential therapy

(b) ___Psychodynamic therapy

(c) ___Feminist/Multicultural therapy

(d) ___Cognitive/Behavior therapy

(e) ___General Psychotherapy (no specific orientation)

(f) ___Other _____

13. What are the types of settings you have worked in psychotherapy/counseling. Please check all that apply.

(a) College Counseling Center

(b) Community Mental Health Center

(c) Hospital Setting (VA, state or local hospitals)

(d) Other (please describe) _____

14. What kind of therapeutic orientation/approach has been <u>most</u> influential in your work? Please rank order with 1 being most influential.

(a) ___Humanistic/Existential therapy

(b) ___Psychodynamic therapy

(c) ___Feminist/Multicultural therapy

(d) ___Cognitive/Behavior therapy

(f) ___Other _____

15. Which of the following kinds of clients have you worked with? Please check all that apply.

(a) Male clients____ (b) Female clients_____

(c) Racial minorities____ (d) Sexual minorities____

(e) Persons with lower Socio-economic status___ (f) College students____

(g) Psychiatric clients ____ (h) Persons with disabilities____

(i) Geriatric populations ___ (j) Children or adolescents ____

(k) Couples or families ____

If other, please specify:

---

16. What forms of supervision have you had? Please check all that apply.

(a) Individual

(b) Group

(c) Peer supervision

(d) Other (please describe) _____

17. How much attention do your supervisors generally give to the following in your supervision? Rank order with 1 = most attention.

____ interventions

____ therapy or counseling process

____ client-therapist relationship

____ therapist attitudes, reactions, or feelings

____ treatment plan

____ other (please describe) _____

18. Check the supervisory styles have you had the most exposure to

_____ Non-directive

_____ Process oriented

_____ Treatment/outcome oriented

_____ Feminist/ Multicultural

_____ Directive

_____ Other (please describe)

_____

19. Which aspects of supervision create the most self-criticisms for you?

a. Supervision with Peers (Group Supervision)

1	2	3	4	5	6	7
Not at all			Somewhat			Very much

b. Individual Supervision

1	2	3	4	5	6	7
Not at all			Somewhat			Very much

c. Watching Tapes

1	2	3	4	5	6	7
Not at all			Somewhat			Very much

d. Role Play

1	2	3	4	5	6	7
Not at all			Somewhat			Very much

e. Client Conceptualization

1	2	3	4	5	6	7
Not at all			Somewhat			Very much

f. Case Presentation

1	2	3	4	5	6	7
Not at all			Somewhat			Very much

g. Supervisor watching a live/ongoing session

1	2	3	4	5	6	7
Not at all			Somewhat			Very much

Appendix E: Interview Protocol

"What is your experience of self-criticism as it relates to learning and performing psychotherapy?"

Main Interview Questions

1. How do you define or understand your self-criticism within your training as a therapist?

2. Are there events, feelings, and thoughts trigger self-criticism in your therapy or training?

3. Have there been any changes or shifts in your self-criticism about your therapy across time?

3. Does the client's relationship with you trigger any self-criticism in your therapy?

4. How would you like to improve your coping with/how have you coped with or managed your self-criticism within your training and development?

5. What are the more important or significant aspects of your self-criticism in your growth and development as a therapist?

6. How do you think your peers and supervisors would respond to your disclosing self-criticism in the context of your training?

7. Does your self-criticism relate to your sense of confidence as a therapist?

8. Do you ever experience self-criticism in supervision? Could your supervisor mitigate/alleviate your self-criticism or help you to use it in a productive way? How?

9. Does the nature of the therapy supervision influence self- criticism in any way? Are there factors about supervision that are helpful/unhelpful regarding self-criticism?

10. Does the therapy orientation being taught influence self-criticism?

11. Does what you do in supervision (role plays, observe supervisor conduct therapy, etc) influence self-criticism?

12. Does your relationship with your supervisor influence your self- criticism? How?

13. To what degree to you respect your supervisors' assessment of your work – why?

14. Does focusing on the client-therapist relationship in supervision vs. interventions influence your self- criticism? Why?

15. Have you ever kept anything hidden from your supervisor? Why?

End of Interview Questions

1. Do you feel that there is anything else I should know to better understand your experience of self-criticism?

2. Were there any questions that weren't asked in this interview that seem important to you in relation to your self-criticism?

3. Do you have any feedback for me on how I could make this interview an easier or better experience?

4. Is there anything that you think would be helpful for you to continue to talk to your supervisor or clients about in your next meeting?

5. Do you think there was anything you might not have revealed because you know me as a researcher? If so, what?

Table 1

Therapist Demographics

Age	Gender	Race/ Ethnicity	# Year(s) conducting Therapy	# Hours of Supervision	# of Therapy Courses	Most influential Theoretical Orientation
28	Male	Caucasian	4	176	4	CBT
28	Female	Caucasian	0.5	25	3	Humanistic/Existential
26	Female	Caucasian	3.5	400	1	Interpersonal
29	Female	Caucasian	6	80	2	Humanistic/Existential
42	Female	Caucasian	5	700	3	Humanistic/Existential
28	Male	Caucasian	3	300	2	CBT
25	Female	Caucasian	2	144	1	CBT
26	Female	Caucasian	3	100	2	CBT
24	Female	Caucasian	1	60	1	CBT
26	Female	Caucasian	1	25	1	CBT
28	Male	Black	3	150	2	CBT
29	Female	Caucasian	3	239	4	CBT
48	Female	Caucasian	4	300	5	Humanistic/Existential
27	Female	Caucasian	2.5	170	3	CBT/Humanistic

Table 2

Clusters and Corresponding Categories

Clusters	(N)	Categories	(n)
Cluster 1: I am more vulnerable to my self-criticism when I feel entirely responsible for solving my clients problems.	13	My self-criticism increases when I am doubtful about how to direct the session, especially if I am viewed as an expert.	8
		Early termination and poor alliance with clients creates feelings of inadequacy and self-criticism.	9
		Accepting that the client plays a part in making therapy successful can relieve my self-criticism.	6
		Contrasting clinical perspectives and opinions make me question my efficacy as a therapist.	6
Cluster 2: My self-criticism functions as an interpersonal barometer that sometimes makes me question my efficacy, but also normalizes my clinical experiences.	14	My self-criticism is normalized when supervisors share their past clinical struggles and give me feedback on the appropriateness of my self-criticism.	9
		Sharing my self-criticism with peers is a supportive experience and relieves my sense of isolation in my struggles.	6
		When I compare my performance to an ideal standard or with a supervisor whom I respect, I am less forgiving of my clinical mistakes.	7
Cluster 3: Negative judgments by my supervisor can lead me to don a facade of competence in my training and hide my intense shame.	13	Painful self-criticism about my incompetence can result from being critiqued in self-revealing exercises and videos in supervision.	12
		Fears of being viewed negatively by my supervisor leads me to masquerade as a competent therapist and hide my feelings.	8
Cluster 4: My Self-Criticism can be harsh, but is being tempered over time through experience and increased clinical freedom versus overly prescriptive supervision.	14	Self-criticism hinders my development, especially taking the form of a meta-critical process in my therapy.	14
		Anxiety about supervision intensifies self-criticism when supervision is rigid and prescriptive.	5
		My anxious self-criticism decreases as I become more comfortable with interventions.	14
Cluster 5: Supervision can sometimes be a holding environment where it's safe to be imperfect and self-divulging, and to learn from self-criticism.	14	Feeling supported by my supervisor makes it easier to show my clinical weaknesses and learn from them.	7
		Supervision is a safe space for open dialogue about how my feelings can impact my growth as a therapist.	14