Constructing personal identity through an online community: Distance supervision in a graduate counseling and a graduate marriage and family therapy program

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Constructing personal identity through an online community: Distance supervision in a graduate counseling and a graduate marriage and family therapy program

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Charles Wayne Perry

Abstract

While distance education is solidly entrenched in the American educational scene, clinical training using distance learning technology is not yet so clearly accepted. A review of the literature found very few studies of the use of Internet technology for clinical training. This study used semi-structured interviews combined with Giorgi's method of phenomenological analysis of experiences of students and site supervisors involved in the Amridge University clinical training program. The purpose of the study was to examine the process by which master's degree students are able to construct their professional identity in a virtual environment. Both supervisors and students reported phenomenological evidence that professional identity can in fact be constructed through group interactions based in an Internet class experience.

Table of Contents

List of Tables and Figures

Chapter 1 – Introduction

Need for the Study

Since its earliest days, the entire mental health profession has been predicated on the assumption that trainees do better with clinical supervision than they would by merely taking didactic class work alone (Storm, Todd, Sprenkle, & Morgan, 2001). How this supervision would take place was never in doubt. Supervision would be face to face, just as training and mentoring in professions had always been. In the days of Freud, Jung, and Adler, technology simply did not allow for anything else. For decades, this traditional vision persisted. Supervision, to be proper, must be conducted with the supervisor and the trainee in the same room. For example, Version 10.1 of the standards of the Commission on Accreditation on Marriage and Family Therapy Education (COAMFTE) specifically stated that telephone supervision was not acceptable and further defined supervision as a face-to-face activity (COAMFTE, 2002). While those standards are no longer the norm, they do document what was, up to that point, the standard in the profession.

The technological revolution has come to the mental health profession. In 2000, Ambrose (2000) published an article in the American Association for Marriage and Family Therapy (AAMFT) *Supervision Bulletin* arguing for the appropriateness of using the Internet for supervision. She cited her three years' experience of using the Internet, specifically email, as an adjunct to her face-to-face supervision. Just four years later, Bernard and Goodyear (2004) in their textbook on supervision also advocated for "e-supervision" as "an excellent adjunct to" face-to-face individual or group supervision" (p. 228). Further, they cited twelve articles from 1999 to 2001 on the feasibility of using the Internet or satellite for therapy or supervision. Like Ambrose, Bernard and Goodyear specifically defined "e-supervision" as taking place via email,

which is, of course, a text-based, asynchronous medium. Ambrose's article was not one of the ones they cited, and as a further brief scan of the literature will show, there were many more.

The American Counseling Association published an entire volume dedicated to the delivery of educational material via the Internet (Bloom & Waltz, 2000). Though this volume focuses far more on counseling and didactic coursework delivered via various technological modes than it does supervision, it still stands as a mark of how things were changing in the early part of this current century. This is all the more impressive since, as Bernard and Goodyear (2004) claim, the majority of psychotherapy was delivered in a manner Sigmund Freud and the other early pioneers would have recognized: face to face in the same room as the client.

Southern Christian University (as it was then known – now Amridge University) began using technology for its clinical training programs in 1996. Though the practicum classes did not count toward the students' hours for licensure due to reluctance of license boards to accept supervision delivered, first via video tape, and later through streaming video on the Internet , the students still received what would be recognized as group supervision if the participants were all in the same room. I was the one who instituted these distance-based practicum programs at Southern Christian University, and I can testify that the substance of these classes was essentially the same as I would have conducted in a traditional group supervision session. As technology improved and real time interaction became more possible, and especially as two-way video became more feasible and reliable, this isomorphism with traditional supervision became even more pronounced.

Yet, with all of this interest and with the various attempts at using the Internet as a means of supervision, there have been practically no studies of the effectiveness of doing so. Lahey's (2008) dissertation is one of the very few. Lahey compared the supervisor's working relationship

in a traditional setting with the supervisor's working relationship in a distance learning setting. She found no significant differences in the working relationship in the two modalities. This will become important later in this dissertation due to the similarity between the program Lahey was investigating and the program this author is investigating. At this point in the paper, what is most significant is that there is a need for much more research into this area. The many articles supporting the concept show that the interest is there. The current paucity of research shows that the need for a study of the effectiveness of doing supervision using distance learning technology is there.

Statement of the Problem

According to Internet World Stats (2009), 73.1 percent of households in North America had access to the Internet in 2008, a 218 percent growth from the number of households with Internet access in 2000. This increase in the number of households with Internet access roughly parallels the shift from dial-up to cable and DSL as the primary means of accessing the Internet (see Definitions later in this chapter for definitions of these terms). In turn, these shifts in technology create a totally new situation from the one envisioned by earlier authors. When Ambrose (2000); Fialkov, Haddad, and Gagliardi (2001); and Bernard and Goodyear (2004) were writing, they suggested using email as the primary mode of Internet supervision. As the search of the literature in Chapter two shows, at the time of their writing, Internet and satellite video were too expensive and the Internet connections were too slow to be practical for video to be considered. That is no longer the case. Even a cursory glance at any store counter full of new laptop computers will verify that the vast majority of laptops now come with a webcam fully integrated into the monitor. More desktop computers are coming similarly equipped. Technologically, the dream of providing interactive education, including clinical education, via

Internet is more possible than it has ever been. “Face to face” supervision may take on a completely new meaning.

The question now is, is using this technology an effective means of providing supervision as a part of a university’s program? To further clarify the problem, a brief statement of context is in order.

Currently, Amridge University offers a master of arts (MA) in marriage and family therapy (MFT), and a master of arts (MA) in professional counseling. The university offers 31 other degree programs, for a total of 33 degree programs. Amridge University offers all of these online, and simultaneously offers many of them on campus. All degree programs at Amridge University are accredited by the appropriate regional accrediting body, the Commission on Colleges of the Southern Association of Colleges and Schools (see the statement of accreditation retrieved from http://www.amridgeuniversity.edu on 1 May 2009). However, this study focuses only on the two license-track programs already listed.

Though at the time of this writing neither the MA in MFT nor the MA in professional counseling were accredited by COAMFTE or by the Council on Accreditation of Counseling and Related Educational Programs (CACREP), respectively, Amridge University’s two license track programs do closely follow the standards of those accrediting bodies. For that reason, all students involved in the clinical training portion of their degree program work with a site supervisor who is physically located in their area. In keeping with traditional practice to satisfy current requirements of most license boards, this site supervision takes place face-to-face in the same physical room. The student intern also meets face-to-face with clients in the student’s local area. By actual count, in the Spring 2009 semester, there were 34 students from 17 states involved in

some phase of clinical training. From my experience, this is a decrease from the more typical average of approximately 50 students per semester.

Using guidance provided by Amridge University, students locate a clinical training site and a site supervisor in their home area (generally defined as being within a 50 mile radius of the student's home). Ideally, site supervisors will be AAMFT Approved Supervisors or Supervisor Candidates for MFT student interns, or state license board-approved supervisors for professional counseling students. When the ideal is not possible, site supervisors must meet three criteria and provide verification of doing so to the Amridge University Clinical Training Director: a) be a licensed mental health professional; b) have at least five years' experience as a licensed mental health professional; and c) hold at least a master's degree in a mental health discipline acceptable to the state license board.

All Practicum (first semester) students meet together in one class each week, and all Clinical Training (second and succeeding semesters) students meet together in a different class each week. These classes are conducted online via streaming Internet video so that the instructor and all participants can interact with each other visually and auditorially in real time. Additionally, the University records these classes so students may review the class interactions later. The Clinical Program Director assigns students to groups of no more than six, usually three or four, students for presentations, and twice each semester individual students make presentations of their case materials to other students. Numerous safeguards are in place to protect client confidentiality.

The first purported advantage of this process is that students can interact with students from other regions of the country. Through vicarious learning, they experience more different cultural contexts than might be available in their home area. Thus, multicultural education and

sensitivity become, at least potentially, more existentially real for students. The second purported advantage of this process is that students get to experience a much broader range of presenting problems than might other wise be possible. Students perform their clinical work in a wide variety of settings, ranging from inpatient mental health facilities to prisons to domestic violence shelters to outpatient drug and alcohol treatment centers. By discussing presentations from settings which are much different from the student's own setting, the interns potentially gain a broader appreciation of the full range of presenting problems they may potentially experience as licensed mental health professionals. The third purported advantage of this process is that all students receive supervision from at least two different supervisors – their clinical training instructor and their site supervisor(s). Though the supervision received in class does not, as of the writing of this study, count as supervision hours toward licensure in most states, the process is the same as stated in the COAMFTE and CACREP standards, except that the class meets face to face via webcam rather than by being in the same room. At least theoretically, then, the benefit to the students should be same. Again the question arises, is using Internet technology an effective means of providing supervision as part of a university's clinical degree program?

Purpose of the Study

Though the technology used has evolved over time at Amridge University, this basic process now is the same as it was in 1996 when the clinical work began. Yet, to date there has been no research to investigate the efficacy of the process. This study provides that investigation. Specifically, this study seeks to answer the following research questions.

Research Question One: What is the phenomenological experience of the students involved in the clinical training process at Amridge University? Do the students engaged in the process find it helpful? Do they find that the purported benefits translate into actual benefits in

their, the students', own experience? How well prepared and trained do they feel compared to other student interns they encounter? The assumption behind this research question is that if the process under investigation is in any sense valid, there will be some degree of perceived benefit on the part of those undergoing the process.

Research Question Two: What is the phenomenological experience of the site supervisors involved with student interns at Amridge University? How well prepared do these supervisors perceive the Amridge students compared to other student interns these supervisors have known and/or supervised? How helpful do the supervisors perceive the connections with Amridge University to be, especially given the issues of distance and even time zones? The first assumption behind this research question is that the supervisors will, by virtue of their experience as licensed mental health professionals, have a broader gaze than the students. This broader gaze will, in turn, give them a larger basis from which to make judgments. The second assumption behind this question is that if the process under investigation is in any sense valid, the supervisors will perceive some degree of similarity between the quality of student interns at Amridge University and other student interns they have known. While this current study will not seek to quantify any similarity uncovered, I will attempt to capture the subjective experience of supervisors who experience that similarity.

Research Question Three: What phenomenological evidences of growth in professional identity are evident as a result of this process? To what degree do student interns perceive themselves as more competent, more "at home", in their chosen profession? To what degree do they attribute the Amridge University clinical training process a help to that growth? To what degree do supervisors perceive their student interns have grown in their identity as mental health professionals? The underlying assumption behind this research question is that a primary purpose

of graduate clinical training is growth in professional identity. Basically, growth professional identity represents a dynamic epistemological shift from what one was previously to "professional." This professional identity goes beyond a mere focus the actions one does to encompass a way of identifying with a profession's ways of seeing and treating problems (Wilcoxon, Remley, Gladding and Huber, 2007). The basis of this assumption is spelled out in the Review of the Literature chapter of this study. If growth in professional identity is a primary purpose of graduate clinical training, then it is reasonable to conclude that the Amridge University clinical training process, if it is valid, will contribute in some measure to the perceived growth in professional identity on the part of the student interns.

Delimitations

Lahey (2008) described a very similar process in use at Regent University. They, too, make use of site supervisors who are geographically located near the student intern while also employing university faculty to conduct the practicum/internship classes. A reasonable assumption would be that other universities employing distance-learning technology to their clinical training programs would also deploy a similar process. Nevertheless, this study is not a comparison with other university programs, either distance-learning based or more traditionally based. This study focuses only on the experience of Amridge University students and their site supervisors.

For reasons that the author spells out in more detail in the next section, and in even more detail in the Methodology chapter of this study, this is a qualitative study. There is no attempt to quantify or numerically express any of the results. The focus is solely on the student interns' and the supervisors' phenomenological experience of Amridge University's clinical training process.

Moreover, this is not a longitudinal study in the truest sense of that term. This study is based on the experience of one semester's aggregate of clinical training students. The longitudinal aspect (i.e., the answers to the growth in professional identity question) will come from the selection of students who have already experienced the beginner and intermediate phases of development, and are now in the advanced stage (Nelson, 1999). In other words, the participants will be those who have experienced the full extent of the clinical training program at Amridge University and will have had approximately one year of lived experience on which to reflect.

Methodology

Conceptually, this study is grounded in the Individual Psychology of Alfred Adler. Adler called his system "Individual Psychology" because he believed we each respond individually and idiosyncratically to life experiences (Sweeney, 1989; Wood, 2003). Therefore, Adler made very few generalizations, and methodologically this study will follow suit in making few generalizations. Adler believed that each of us uniquely constructs a "private fiction" which becomes the guiding principle of the person's life (Sweeney, 1989). He called it a "private fiction" because it does not matter whether, objectively speaking, the constructed narrative is true or not. The person will respond as though it were true regardless of the objective facts. Though Adler did not, of course, use the term "social construction," the concept of private logic is very similar to the construction of meaning and "reality" proposed by Gergen (1999) in his discussions of social constructionist thought. The person's private logic becomes codified into habitual methods of behaving, which Adler referred to as the person's "style of life" (also called more simply "life style" by many modern Adlerian therapists (e.g., Maniacci, 2002)).

It is because of this fundamentally social constructionist, Adlerian epistemology that I, in my role as the Clinical Training Director at Amridge University, specifically encourage student interns to construct their own professional identity. They are to do so based on the formal, didactic course work in the various theories of therapy, combined with the experiential learning of clinical training. Students are not required to master only a single theory of therapy. On the contrary, I strongly encourage students to knowledgeably and comfortably employ a variety of theories of therapy. The student selects which theory to use with which client based on the student's own emerging professional identity (i.e., what best fits "me") and the needs of the client the student intern is working with. Totally in keeping with the principle of equifinality – there are many "right" paths to the same end (Hansen, 1995; Cummings, Davies, Campbell, 2000) – students learn there are many "right" ways to work with clients. Therefore, the methodology of this study must be respectful of these multiple "right" paths.

The chosen methodology is a qualitative, phenomenological inquiry to inductively construct answers to the research questions. Phenomenology describes the meaning for several individuals of a common lived experience, or phenomenon (Creswell, 2007). It seeks to understand the commonalities of the experience without violating the individual nature of the lived experience (Dhal & Boss, 2005).

The basic process for data analysis follows the classic procedure given by Giorgi (1895). I solicited participants in the study from students in the Spring 2010 [January – April 2010] class of Clinical II or Clinical III (see the Definitions for these terms), and their site supervisors. To be selected for the study, both the student intern and the supervisor must agree to participate, and participation for both is purely voluntary. Early in that semester, I conduct telephonic interviews with each participant, both student and site supervisor. Then I will record these interviews and

have them transcribed for later analysis. Once the analysis is complete, I will email each research participant a copy of the results for feedback and confirmation of the validity of the conclusions (Dhal & Boss, 2005). I will then take the data, as confirmed and/or modified by the participants, and write the final document on which I will base my answers to the research questions.

Definition of Terms

One of the core concepts of this study is the concept of "professional identity." In keeping with the Adlerian/social constructionist framework of this paper, I define professional identity to mean a set of values, attitudes, skills and concepts which enable the person to say, "This is who I am as a therapist (or counselor). This is what I am trying to do and to be in the world" (Winslade, 2003). Thus, one's professional identity incorporates the overarching narratives of the profession with the person's personal narrative to form a coherent private logic (or narrative) which guides the person's actions as a professional. Further, the professional identity is consistent with the person's personal identity – who I am as a person. This coherence between personal and professional identities is critical. Studies of the factors that contribute to effective therapy show that the person of the therapist accounts for approximately 45 percent of the change during therapy, while the accurate application of skills accounts for only 15 percent of the change (Hubble, Miller & Duncan, 1998).

The world of distance learning has its own vocabulary, and Amridge University has developed a specific vocabulary to talk about its clinical training program. The following operational definitions apply throughout this study.

- Clinical training program – the entire experiential process of clinical training at Amridge University. It normally requires 50 weeks of work, during which students will complete at least 500 hours of client contact plus 100 hours of supervision by their site supervisors

of that client contact. The clinical training program also requires weekly participation during the academic semester, either in the physical classroom or via Internet , in the appropriate three-hour class with the University Clinical Training Director.

- Practicum – the first of the three required semesters of the clinical training program.
- Clinical I and II – the second and third semesters, respectively, of the clinical training program. Students who do not reach the required minimum of 500 hours of client contact by the end of Clinical II can take Clinical III until they do reach that minimum. These classes may also be referred to as "internship" to maintain commonality with university programs which do not use the Amridge University vocabulary.
- Intern – a student enrolled in the graduate degree program in either MFT or professional counseling. Interns have not yet graduated from the university. In the Amridge University vocabulary, an intern may be either in practicum or in one of the internship courses.
- Basic Skills Evaluation Device (BSED) – A device developed by Dr. Thorena Nelson and used by many COAMFTE-accredited schools to evaluate student growth and competence in certain critical skill areas. The BSED features prominently in the Amridge University system of evaluating student progress during the clinical training program.
- Cable – a means of connecting to the Internet provided by a cable service company. Cable is by definition a broadband means of connecting to the Internet (see below).
- DSL (Digital Subscriber Line) – a means of connecting to the Internet provided by a telephone company and using the standard telephone lines. DSL is another broadband means of connecting to the Internet , though typically not quite as fast as cable.

- Bandwidth - the transmission capacity of a computer network or other telecommunications system. Video-based instruction and supervision systems require more bandwidth, that is, more capacity to carry large amounts of data.
- Broadband – the ability to transmit successfully multiple bits of data simultaneously. Though there does not appear to be a precise definition, for the purpose of this paper, broadband is defined as the ability of a computer system to successfully transmit and receive at least 200,000 bits of information per second. A standard telephone dial-up connection would transmit and receive only around 56,000 bits per second and therefore would not meet the definition of broadband. By contrast, most DSL and cable systems would meet the definition, as would many WWAN (wireless wide area network – i.e., cellular data, now commonly referred to as 3G for third generation) networks. Some satellite systems would meet the broadband definition for upload capacity, though most would meet it for download capacity.
- Webcam – a device designed to take video images and transmit them to a computer, where these images can in turn be sent out over a computer network and received by others connected on the network. In many laptop computers, the webcam is physically and electrically integrated into the computer. In other computers, the webcam is an external device, usually connected to the computer through a USB (universal serial bus) port.
- Asynchronous communication – communication which takes place not necessarily at the same time. Email and posts to blogs (web-logs) would be just two examples of asynchronous communication. A primary advantage is that participants do not have to

arrange to be present at the same time, and therefore schedules and time zone differences become less significant.

- Synchronous communication – communication at the same time. This is also called "live" communication. Chat rooms and webcam conferences are just two examples of synchronous communication. A primary advantage of synchronous communication is that interaction can flow more naturally and rapidly than is possible via asynchronous communication.
- Online Community – a pattern of relationships formed primarily or exclusively through interaction, synchronous or asynchronous, via the Internet .

Organization of the Paper

This introductory chapter has provided an argument for the need for the study, and a broad overview of the study. Succeeding chapters provide much greater detail about the areas that have only been touched on in this introduction.

Chapter 2 contains a Review of the Literature. In this chapter, I examine some of the recent literature on distance learning, on supervision, on supervision by distance and on professional identity. An integral part of this chapter is an analysis of the sources cited in terms of their contribution to the task at hand and the author's evaluation of the adequacy and importance of the source to the field.

Chapter 3 is the Research Methodology chapter. This chapter gives full details of my frame of reference, and of the methodology employed in this study. Readers who carefully study Chapter 3 should easily be able to replicate this research, should they so desire.

Chapter 4 contains the Results of the study. In this chapter I present the various meaning units discovered during the research, and suggest some general conclusions about commonalities

that I discovered in the process of this research. This chapter will answer the research questions proposed in the Introduction.

Finally, Chapter 5 presents some discussion regarding the findings presented in Chapter 4, as well as some suggestions for further research. It should be a fitting conclusion to this piece of research.

Chapter 2 – Review of the Literature

Since one of the aspects of this research is distance education, this review of relevant literature begins with a brief look at some of the representative literature on distance education. The next section focuses on supervision in both marriage and family therapy and in counseling. The third section briefly reviews the relevant literature on professional identity. Finally, this chapter concludes with the author's phenomenological experience of distance education.

Distance Education In the U.S.

Brief History of Distance Education.

There are some claims that distance education in the United States can be dated to the late 1700s, in the early days of America's existence as a new nation (e.g., Wilson, 2002; *The Book of Discipline*, 2008). While there may be some argument that distance learning, in any form we would recognize it, goes back quite that far, there is general scholarly agreement that it can be legitimately dated to the Nineteenth Century in America. In 1873, Anna Ticknor started a correspondence education for women of all classes of society which eventually reached 10,000 women over its 24 year history (Nasseh, 2006). In the same year, Illinois Wesleyan University began offering correspondence, non-resident courses leading to bachelor's, master's, and doctoral degrees. This was the first higher education institution in the USA to offer courses for credit that were taken by correspondence (MacKenzie, Christensen, & Rigby, 1968). In 1881 William Rainey Harper, a professor of Hebrew at Yale University, created a correspondence course in Hebrew for Baptist Theological Seminary in Illinois, and in 1883, he founded more correspondence work through the Chautauqua College of Liberal Arts (MacKenzie, Christensen, & Rigby, 1968). Later, in 1892, Harper began the University of Chicago's Extension Division (Morabito, 1999). By 1915, the popularity of distance education had grown to the point that the

National University Extension Association was formed to both broaden the application and acceptance of correspondence distance education, and to establish universal policies for accepting such course work for credit (Nasseh, 2006).

Throughout history, changes in technology have led to paradigmatic shifts in educational technology (Frick, 1991). The shift to correspondence education was powered by the ability of more Americans to read and write. This text-based mode of education formed what Taylor (2001) called the first generation of distance learning. The next big shift came in 1933 when the University of Chicago decided to attempt using radio as an instructional medium. There were, at the time, 202 colleges and universities in the United States with a federally-licensed radio station, so the move seemed very appropriate. Unfortunately, the change to instructional radio did not prove to be very popular prior to World War II; only one credit course was offered by that medium (Lin & Atkins, 2007). However, the attempt by the University of Chicago did pave the way for the use of the new post-war technology, television (Nasseh, 2006).

As early as 1953, the University of Houston was experimenting with using television as a medium of instruction. There were other attempts, but it was not until 1962, when Congress set aside a frequency spectrum specifically for educational purposes, that the use of television as an educational medium began to take off. Just five years later, in 1967, President Lyndon Johnson signed into law the Public Broadcasting Act, which authorized the formation of the Corporation for Public Broadcasting, an agency dedicated to the non-commercial use of television (Slotten, 2000). The use of radio, television, and, when technology changed again, video tape to provide educational material forms the second generation of distance education (Taylor, 2001). In this second generation, as in the first, interaction with the instructor was primarily through written correspondence, though some institutions were beginning to make use of telephone to connect

the student and the instructor (Nasseh, 2006). Both the first and second generations of distance learning were solidly asynchronous.

Distance learning in the United States was being influenced by similar advances in other countries. As early as 1946, the University of South Africa (http://www.unisa.ac.za) was offering post-secondary degree programs via distance learning. In the 1970s England started the Open University (http://www.open.ac.uk) to offer distance learning courses to adults through radio and television, supplemented with print materials, video cassettes, and access to tutors. About the same time, Canada started a very similar program called Athabasca University (http://www.athabascau.ca). All of these have continued to expand their offerings as technology, such as the internet, made other options more possible.

The third generation of distance education, the "telelearning generation", came with the technology to make interactivity in distance education possible. Third generation technology includes the early audio-conferencing and video-conferencing programs, a major technological step forward over previously totally asynchronous models (Taylor, 2001). This generation roughly corresponds to the rise of the personal computer. With the personal computer, synchronous and asynchronous communication became much easier (Lewis, Whitaker, & Julian, 1995). As the Internet matured and technology continued to develop, computers became smaller, more powerful, and less expensive. Combined with increasingly high-speed modems, it was possible for instructors to easily transfer assignments to learners and receive assignments from learners, and then return the graded assignments (Wilson, 2002). In 1984, the first online undergraduate courses in the United States were delivered by the New Jersey Institute of Technology (Newman, 2003).

By 1999, the growth in Internet-delivered distance education had grown to the point that the U.S. Department of Education (USDE) elected to begin a five-year study to determine if this new medium were effective enough to allow Federal funds to be used to fund it. The study, called the Distance Education Demonstration Project, was authorized by Higher Education Amendments of 1998, and involved fifteen accredited post-secondary educational institutions: Capella University (Minnesota, private-for profit), Community Colleges of Colorado (public), Connecticut Distance Learning Consortium (public and private), Florida State University (public), Franklin University (Ohio-private), LDS Church Education System (Utah, Idaho, Hawaii-private), Masters Institute (California-for profit) (no longer participating), New York University (private), North Dakota University System (public), Quest Education Corp American Institute for Commerce/Hamilton College now Kaplan College (Iowa-for profit), Southern Christian University (renamed Amridge University in 2008) (Alabama-private, non-profit), Texas Tech University (public), University of Maryland University College (public), Washington State University and Washington Community and Technical College System (public), and Western Governors University (Utah, Colorado-private, not-profit) (USDE, 25 June 1999). During the five year tenure of the Demonstration Project, participant institutions made reports to the USDE every six months and received periodic on-campus inspections from representatives of the USDE. The end result of the Distance Education Demonstration Project was that both the USDE and the General Accounting Office (GAO) recommended that Congress change Federal law to remove restrictions on the use of Federal funds to support students involved in distance education. (GAO, 2004). Congress subsequently followed those recommendations (the current Federal

guidelines are available from Information for Financial Aid Professionals, retrieved from http://www.ifap.ed.gov/ifap/ on 26 June 2009).

This was a watershed study and warrants further inspection. The GAO noted that participation in distance education had quadrupled from 1995 to 2001, and by the 2000-2001 school year nearly 90 percent of public 4-year colleges were offering at least some courses by distance education. According to the GAO, by the end of 2001, 31 percent of all students at these public colleges took their entire degree by distance learning. Further, the GAO noted that though there were differences in specific policies, all six regional accrediting bodies had established policies and procedures for accrediting distance learning programs (GAO, 2004).

While the GAO study was, naturally, most focused on the risk of fraudulent use of Federal funds and student defaults on Federal loans, there was sufficient information on the quality of the fifteen programs involved in the Distance Education Demonstration Project to draw some conclusions. First, the GAO, the USDE, and the six regional accrediting bodies were all confident enough in the quality of the educational content delivered to recommend removal of restrictions on the use of Federal funds for such programs. This was the first time the Federal government had formally investigated the distance learning phenomena, and they found that students were in no sense receiving an inferior product by receiving their education through distance learning. Second, distance learning was rapidly becoming mainstream in higher education. While in the 2000-2001 school year 39 percent of college graduates had not taken a single distance learning course, nearly as many (31 percent) had completed their entire degree online (GA0, 2004).

Garrison and Anderson (2003) believe that the Internet allowed distance education programs to achieve a degree of quality not realized in prior distance education generations. Further, they suggest a paradigmatic shift in education practice:

> Third-generation distance education systems embraced constructivist learning theories to create opportunities for students to create and recreate knowledge, both for themselves and as members of learning groups. This knowledge construction takes place within the negotiation of content, assignments, and projects and is elaborated on in the discussion, collaborative projects, and resource- or problem-based curriculum designs that define quality, third-generation programming (p38).

In other words, the Internet allowed distance learning programs shift from a more or less one-way delivery system for information, to a community where knowledge is socially constructed. I will have more to say about that in the section on the effectiveness of distance education.

Even as the USDE Distance Education Demonstration Project was going on, technology continued to drive change into the fourth generation of distance education, the "Flexible Learning Model" (Taylor, 2001). This generation combines all the attributes of previous generations and includes the ability to retrieve massive amounts of information via the Internet, a growth in computer-assisted programming such as Java, enhanced delivery of Web content using Shockwave and Flash, and learning management systems such as eCampus, Blackboard, and WebCT (Garrison & Anderson, 2003).

In 2000, data traffic, meaning all forms of Internet communication, first surpassed voice traffic as the majority of the load being carried by the telecommunication infrastructure in the U.S.A. Although not quite half of the homes in the U.S. had a personal computer in 2000, desk top computers and workstations had become the standard in U.S. business (Internet World Stats, 2009). That same report indicated that by 2008 over 78 percent of U.S. homes had at least one personal computer, a 218 percent growth in just eight years. As previously cited, this growth in

the number of home computers roughly paralleled the change from dial-up connections to various forms of broadband connection, which in turn fueled the shift to the characteristic of the fourth generation, computer-mediated interactivity.

In 2005 the Sloan Consortium, "a consortium of institutions and organizations committed to quality online education" (retrieved 29 June 2009 from http://www.sloan-c.org/), issued its first report on online education in the U.S. Allen and Seaman (2005) found that by the Fall of the 2004 school year, 65 percent of all accredited institutions were offering at least some of their courses by Internet. The difference between the Sloan Consortium figures and the earlier GAO figures is that the GAO counted only public institutions, while the Sloan Consortium counted both public and private post-secondary institutions. Indeed, Allen and Seaman found that it was the larger public universities which were the most likely to offer courses by Internet or other forms of distance learning, a finding which supported the earlier GAO finding. Significantly for this study, Allen and Seaman found that this was not just an undergraduate phenomena; 44 percent of accredited graduate schools offered master's degree courses online. Contrary to what some thought might be the case, Allen and Seaman found that overwhelmingly, these courses were being taught by core faculty, not by adjuncts. A majority (56 percent) of chief academic officers interviewed for the 2005 study said that distance learning was part of their long-term strategy. Clearly, distance learning via Internet was already very much in the mainstream.

The trend in distance education continued in the following year. Allen and Seaman (2006) found that chief academic officers overwhelmingly declared that distance education is at least as effective as traditional, in-classroom education. Students were at least as positive about distance education's benefits as the chief academic offices. In the Fall 2004 semester, 2.3 million students had been taking at least one online course. By Fall 2005 that had grown to 3.1 million

students, 440,000 of whom were graduate students. This represents a growth of 35 percent over the previous year. Furthermore, the researchers found no resistance from employers to hiring someone whose degree had come from an accredited distance learning program. The only resistance Allen and Seaman found came from the faculty who had to teach those courses. They cited the time it took to learn new technology and new teaching skills, yet even here, the majority of those actually conducting the classes were positive about the outcomes.

By 2008 the Sloan Consortium found that 3.9 million students were taking at least one course online (Allen and Seaman, 2008). The percentage of those who were graduate students remained approximately the same as before. Interestingly, the only major academic discipline to not make extensive use of the Internet for course delivery was engineering. Chief academic officers interviewed by the researchers cited both the economy and the rising fuel costs as highly favoring a focus on distance learning. In fact, over 70 percent of chief academic officers stated that distance education is "critical" for their institution's long-term strategy and survival.

The most recent Sloan Consortium report symbolized the fifth generation of distance education in its title: *Learning On Demand* (Allen & Seaman, 2009). The fifth generation exploits all of the advantages of the previous four generations and capitalizes on the features of the Internet. Computer conferencing not only allows for the thoughtful reflection of text-based, asynchronous communications, according to Taylor it re-humanizes distance education and therefore represents a qualitative shift which may well also impact conventional educational systems (Taylor, 2001).

As in each of the six Sloan Consortium prior studies, the researchers found that the growth in online programs far exceeded the growth in on-campus education. They surveyed 4,494 institutions, and received responses from 2,590 of them. This is approximately the same

response rate as the 2006, 2007, and 2008 studies, and more than double the response rate from the first survey in 2003. The most recent figures show 4.6 million students are taking at least one course online, a 17 percent increase from 3.9 million of the previous year, and the most recent data shows no sign of this growth slowing. At least one in four higher education students is now taking at least one course online. Two big news stories of 2009 played significantly in the growth of online education, according to the authors. First, the bad economy, which traditionally tends to bring more students to higher education, had a much greater positive impact on online courses than on in-classroom courses. Fifty-four percent of the institutions surveyed reported that the economic downturn had increased the demand for existing courses. Yet 66 percent of these institutions reported a demand for new online courses, and 73 percent reported increased demand for existing online courses. Second, the H1N1 flu epidemic drove more students toward an online environment, according to the authors. Interestingly, despite all of this growth, faculty acceptance of distance education remains approximately the same as it was two years ago (Allen & Seaman, 2009).

Though distance learning, especially online learning, is not yet the dominant way that higher education happens in the United States, it has shown remarkable and consistent growth over the years – from a total of 10,000 involved in the 24 years of the first correspondence school to 4.6 million involved in online higher education in 2009 alone, not counting other forms or modalities of distance education. Further, as the next section of this dissertation shows, educational researchers have begun to make a serious study of this now major player on the higher education scene. The question is, even though millions are involved in online education each year, are they getting at least the same quality as they would if they were sitting in a classroom?

Equivalency of Distance Education and In-Classroom Education.

Several of the published research articles on the effectiveness of using distance education have focused on the kindergarten through 12th grade schools (e.g., Cavanaugh, 2001), but since the focus of this study is on graduate education, I have chosen to ignore this body of literature on the field.

Many of the published articles on adult and higher-education distance education did follow Cavenaugh's pattern, that is, they were meta-analyses of various research sources, some published and some not (e.g., unpublished dissertations). For example, Machtmes and Asher (2000) published a meta-analysis of the effectiveness of telecourses in distance education. By "telecourses" the authors meant using video and either one-way or two-way audio. Generally, they found that the more interactive the distance education, the more satisfied the learners were with the experience and the more effective the programs were. Even though this study was published in 2000, before the use of two-way video became easily available to most users, the positive impact of the levels of interactivity is still significant.

Swan (2003) began her review and analysis of research data by stating, "If we can't learn as well online as we can in traditional classrooms, then online education itself is suspect, and other clearly critical issues, such as access, student and faculty satisfaction, and (dare we say it) cost effectiveness are largely irrelevant" (p. 13). She examined the claims that there is no significant difference for the learning in the virtual classroom of distance learning versus the physical classroom of traditional learning, and found that the evidence is "good and ample" that students do learn as well in the virtual classroom as the physical one. As Machtmes and Asher had previously found, the level of interactivity between faculty and student was a significant factor in both the student's satisfaction and the learning effectiveness.

Yet Swan also drew two other very interesting, and significant, conclusions from the data. The first of these is that asynchronous learning is not necessarily inferior to synchronous. It is the level of interactivity which is crucial, not the temporal synchronicity which is most relevant. The second finding fits with the first. Social presence, i.e., the ability to emotionally connect with the instructor and the classmates, is a critical variable. Low bandwidth media, such as text-based media, require different means of facilitating social presence than high bandwidth media, such as two-way video. In either media, there is some degree of leveling of the power structures, so that instructors become more facilitators of discussion rather than leaders of discussion. Students assume greater autonomy and therefore greater responsibility. Swan's data substantiates the contention that teaching in a distance learning environment requires different skills than teaching in a physical classroom, and the various distance learning media require further adaptation. Still, the research is "good and ample," as Swan wrote, that distance learning is an effective way to learn.

Bernard, Abrami, Lou, et. al. (2004) examined 232 studies published between 1985 and 2002 on the effectiveness of distance education. They found that many of the distance programs outperformed their classroom counterparts while others did not match quite as well. Confounding their statistical analysis was the wide variability they found in quantitative analyses in many of the articles. Even so, they too, concluded that distance learning is at least as effective at traditional classroom learning.

Neuhauser (2002) added two interesting bits of new information to the previous studies. She, too, found that distance learning is as effective as physical classroom learning. In her study, 95 percent of the students actually preferred the online environment. This was a facet that other studies suggested and stated, but did not quantify as she did. A second facet had to do with

learning style. She found that 66 percent of the online students and 60 percent of the in-classroom students were visual learners, while only three students from the entire population chose auditory as their preferred learning style. In the online classroom, just as in the physical classroom, material which appeals to a visual learning style is most likely to be effective.

The studies cited are representative of literature on the effectiveness of distance education. With near unanimous voice, the published research strongly suggests that distance learning is at least as effective as in-classroom learning. The next logical question, then, is, how does one do distance education effectively? So far, there has been little research in that field other than some meta-analyses of published articles and papers. Gaytan and McEwen (2007) produced one exception to that general rule, and their research did provide some clear guidelines for quality distance education. The top three elements of quality online instruction they found were, in rank order:

- Requiring continual, immediate, and detailed feedback regarding student understanding of course materials;
- Online course materials are at least as rigorous as the conventional courses; and
- Email is used appropriately to aid the instructional process.

This study supports some of the concerns reported by faculty interviewed by the Sloan Consortium researchers, namely that there are some unique educational strategies required for successfully conducting courses online. It also supports the studies already cited in this review of the literature. Prime among the unique educational strategies to make distance education effective is the ability to manage communication both synchronously and asynchronously.

More such studies will be needed to establish “best practices” for the virtual classroom as there have been for the physical classroom. Indeed, these are already beginning to be published

(e.g., Boulous, Maramba, & Wheeler, 2006). Until these are forthcoming, instructors in distance learning environments will need to make maximum use of the two primary advantages of distance learning: increased flexibility for the student and the ability for self-directed learning (Howard, Schenk, & Discenza, 2004; Monolescu, Schifter, & Greenwood, 2004).

Distance Education in Mental Health Fields.

There has been a real lack of published research on using distance supervision in marriage and family therapy, despite the positive articles about the subject cited in Chapter 1 (e.g., Ambrose, 2000). Using ProQuest Psychology and keywords "supervision" and "distance" or "online", I examined all editions of *Family Process, Journal of Marital and Family Therapy*, and *Journal of Systemic Therapies* available in the database and found no articles on supervision at a distance. This lack further supports the need for this study.

Counseling has been a bit more interested in distance education. Clingerman and Bernard (2004) investigated the use of email as a tool of supervision. Their research supported other, earlier, research they cited which found that the use of email produces a greater intimacy than face-to-face interactions. They did concede that there was no control group, so the comparison may not be methodologically solid. Even so, Clingerman and Bernard concluded, just as Bernard said in her textbook on supervision (Bernard & Goodyear, 2004), that e-mail is an effective adjunct to clinical supervision. "Because communicating by email allows time and psychological space to respond, it may serve to assist students who are relatively passive in group supervision or who find the intensity of individual supervision to be a barrier to growth (Clingerman & Bernard, 2004, p. 93).

Cook and Doyle (2002) investigated online therapy. While that is a somewhat different focus than this study, given the strong belief in the isomorphic nature of supervision and therapy

(Liddle, Bruenlin, & Schwartz, 1988; Todd & Storm, 1997)), I believe it is important to cite their work here. Cook and Doyle found that an empathic relationship could be established whether the relationship were formed online or face-to-face. In their study, the empathic relationships established online were just as effective for the therapeutic alliance as those formed in person.

Lahey's dissertation (2008) supported the application of Cook and Doyle's findings to supervisory relationships formed online. She examined 46 supervisor-trainee relationship pairs. All of these were involved in a master's level training program. Of these, 34 were what she called "traditional," that is, they met in the same room. In many cases, the faculty advisor was also the clinical supervisor. Fourteen relationship pairs were what she called "distant," that is, students did their clinical work at some distance from the university, and they frequently had a site supervisor who was different from their university supervisor. Interestingly, in her study online supervisors reported a significantly stronger working alliance with their trainees than traditional supervisors ($p<.05$). Perhaps this is simply an artifact of the demographic reality that the online supervisors had significantly more (almost twice as much) supervisory experience than the traditional supervisors did. Lahey noted but did not fully address this finding in her discussion. Whatever may be the case, it is clear from this study that supervising via Internet is indeed quite compatible with forming working relationships between supervisor and trainee, relationships which are at least as good as in traditional settings.

Another dissertation which I found applicable to this study was Thurber's 2005 investigation of supervisory modalities. Thurber discovered that direct intervention by supervisors was positively associated with changes in trainee behavior, which was, in turn, positively associated with sustained changes in client behavior. What is most germane for this present study is that Thurber found that both phone-in and "bug-in-the-ear" supervision, two

technologies commonly used in many traditional training programs, are the least effective means of producing change in trainee behavior. Computer Assisted feedback, where the supervisor types in a text message to the trainee and the trainee reads it on the screen while in session, was the most effective form of supervisory feedback. Scherl and Haley (2000) found similar ability of computer assisted supervision to produce and sustain positive change in therapist behaviors.

Thurber's results fit nicely with some of the research on distance education. Most learners are visual learners, so being able to see the feedback, rather than simply hear it, fits most closely most learner's preferred learning styles (e.g., Neuhausser, 2002; Gaytan & McEwen, 2007). Further, it suggests that computer-mediated supervision, even in traditional settings, is a very effective way to modify trainee behavior and thus to assist the trainee's clients.

The field of psychiatry has significantly contributed to the use of fourth generation technology in mental health services. While this is not precisely the same as clinical supervision, there are some similarities. A group of psychiatrists in the United States investigated whether text-based, Internet-delivered continuing medical education (CME) could lead to good, evidence-based decisions on the part of the participants. The researchers in this study found that there was no significant difference in the quality of decisions reached between those who had taken the CME in a traditional classroom versus those who had taken it via Internet (Medscape, 2008). Though this study did involve post-degree CME, it seems reasonable to assume that the findings can be generalized to clinical education within a graduate academic setting.

Another important contribution from psychiatry deals not with education per se but with the delivery of clinical services. Psychiatrists in Canada conducted a study to see if telepsychiatry, by which they meant psychiatric services delivered via Internet video or satellite video to patients who were some distance from the psychiatrist's office, would result in

acceptable standards of patient care. The researchers did indeed find just that, that there was no significant difference between the care provided to patients via telepsychiatry compared to the patients seen in the office (O'Reilly, Bishop, Maddox, Huchinson, Fisman, & Takar, 2007). The effectiveness of telepsychiatry has been so conclusively proven that the American Psychiatric Association website now declares that telepsychiatry is "one of the most effective ways to increase access to psychiatric care for individuals living in underserved areas" (retrieved 9 May 2009 from http://www.psych.org/Departments/HSF/UnderservedClearinghouse/Linkeddocuments/telepsychiatry.aspx). Again, though this does not directly relate to distance education, this support for doing psychiatric clinical work via Internet or satellite does provide indirect support for the concept of providing clinical education via Internet.

In addition to the research, there are others who have written to provide strong support for the concept of using third and fourth generation technology for online supervision. Coursol (2004) writes about "cybersupervision" in the same terms employed in this study – the use of videoconferencing technology via Internet to conduct supervision. She cited several advantages to this technology, including one not mentioned in any other source I consulted – the ability of the faculty member to conduct site visits with trainees in real time. The technology also makes it possible for trainees to consult with faculty members in real time on difficult cases, furthering the connection between the practicum student and the clinical faculty member(s). Based on her survey of the literature, she concluded that cybersupervision is a viable way to conduct supervision with benefits for both the practicum student and for the faculty member. She did caution that some ethical concerns need to be addressed, however. While all of the concerns have very close parallels in more traditional in-the-same-room supervision, the use of technology does

introduce several important variations that need to be addressed through training, and perhaps through changes in ethical standards, according to Coursol (2004).

Greenwalt (2001) covers all the same ethical issues as Coursol, with the sole exception of the emergency response procedures she highlights, and does so in more detail. One of the main issues that arises in my conversations with other supervisors is the issue of confidentiality. While Internet traffic is subject to "hacking" and other forms of interception, it is quite possible to take some simple steps to guard client confidentiality. Prime among these, in keeping with Coursol's emphasis on training for both faculty and students, is simply making that possibility a constant emphasis, so that everyone takes all reasonable precautions to protect client confidentiality. Other issues Greenwalt highlights include establishing means for the supervisor to fulfill his or her ethical obligation to oversee all of the trainee's cases, beneficence (i.e., the obligation to ensure that the client benefits), and non-malfeasance (i.e., the obligation to ensure that the client is not harmed). Both Greenwalt and Coursol conclude that these ethical concerns are very real, just as they are and have been in more traditional therapy, but they are no more insurmountable in cybersupervision than they are in "in-the-room" therapy or supervision.

Storm, McDowell, and Long (2003) are no less positive about cybersupervision (which they call "virtual supervision") than Coursol or Ambrose (2000) or any of the other sources previously cited. They go so far as to state, "In our opinion, virtual supervision will become an integral part of most supervisors' practice in the future…" (p. 442). One of the unique benefits of virtual supervision for trainees is the increased self-reflection such supervision offers, according to these authors. That conclusion fits with a similar contention by Ambrose (2000), Fialkov and colleagues (2001), Kanz (2001), and Bernard and Goodyear (2004).

More recently, Bacigalupe (2010) wrote strongly favoring what he calls “e-supervision.” He stated that traditional supervision is just as challenged as e-supervision when it comes to showing that the supervision actually makes a difference in what happens to clients. Further, he makes a point that those of us who are “digital immigrants” (his term for those who began using computers in adulthood) may mistakenly assume that that e-supervision is devoid of the personal touch found in in-person supervision. By contrast, he states, “digital natives” (his term for those who have grown up with computers) find it just as easy to construct relationships in a virtual world as in a physical world. The research already cited suggests (though Bacigalupe does not say so) that it may actually be more easy in the online world, at least for some people. Given that his writing is the most current reviewed on the subject, it is not surprising that he is more aware of and at home with fourth generation technology than previous writers. In harmony with many other proponents of distance education, he concludes that e-supervision may actually inform practices of traditional supervision, just as others have suggested that distance learning may inform practices for in-classroom education.

Supervision in Marriage and Family Therapy and in Counseling

A classic text in the field of family therapy supervision stated,

> Today the training and supervision subsystem has become vital to the family therapy field because it transmits the field's values, body of knowledge, professional roles, and skills to the new clinician. Training and supervision are also primary vehicles through which a field evolves. They prepare future generations to be the representatives and developers of the field's viewpoint, with the hope that they will move beyond their mentors in conceptual, therapeutic, and professional development (Liddle, Breunlin, & Schwartz, 1988, p. 4).

This definition of the purpose of supervision, to transmit knowledge, values and skills, has formed the field in many ways. For example, the AAMFT standards for Approved Supervisor status require the supervisor candidate to complete a 30 hour course in supervision covering

these subject areas. Fifteen of these hours must be interactive, that is, the class participants must learn experientially (AAMFT, 2007). The next logical question comes, what is the best way to achieve this purpose?

General Theories of Supervision.

Competence-Based Theories. The theories of the purpose of supervision appear to fall into two major camps, competence-based theories and transaction-based theories. Liddle (1991) cites five questions, which he calls "classic" and which he claims apply regardless of the supervisor's theoretical approach:

- Who should teach and be taught family therapy?
- What should the content of training be? How should this be translated into corresponding skills?
- What should our training methods be?
- How does the training influence the setting and the setting influence the training?
- How should training be assessed?

Competence-based theories of the purpose of supervision attempt to answer these five questions by defining, in various categorical terms, the "competence" on the part of the trainee which is to be the product of good supervision. The one who should teach family therapy is the one who is already "competent." The content of the training should be tasks and behaviors that are defined as "competent." Training should be assessed against skill or task lists which define "competence."

Mede (1990) exemplifies this model. He defines the purpose of supervision as seeing that no harm comes to the client and increasing the therapist's skill in delivering treatment to the client. The supervisor accomplishes this by changing "the behavior of trainees to resemble behavior of an experienced expert therapist" (p. 4). Mede cites several studies that suggest that trainees do prefer supervisors they perceive as experts. The supervisor models "expert" or competent behavior, and the trainee learns by observing and copying the modeled behavior.

Felander and Shafranske (2004) focus more on the competencies needed to be a good supervisor. Competence, they claim, "reflects *sufficiency of a broad spectrum of personal and professional abilities relative to a given requirement*" (p. 5, italics in original). The advantage of using a competence-based approach, according to the authors, is that competencies are linked to real world requirements, and it is these real-world requirements that drive supervision. One example of linking supervisory expectation to real-world requirements would be the Basic Skills Evaluation Device (Nelson, 1999). Another, still not-yet fully accepted, example would be the Core Competencies list developed under the auspices of AAMFT (2004).

Bernard and Goodyear (2004) have many similarities with Felander and Shafrankse, so much so that Felander and Shafrankse cite their work in several places. Bernard and Goodyear define supervision as:

> an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is:
> - evaluative,
> - extends over time, and
> - has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession (p. 8).

They make explicit that this is a competence-based approach by suggesting several likert-type scales for providing assessment and feedback to trainees. To buttress their argument, they cite the American Psychological Association's Council on Professional Education in Psychology, which states that there must be "some" educational competencies in the supervisory process.

Wampold (2001) takes a slightly different bent. Wampold studied various therapy-outcome research products and concluded that, based on the evidence, "what works best" is an illusory goal. The vast majority of the treatment approaches achieve approximately equal results. This conclusion produced a search for some common factors. Obviously, then, "competence"

should focus on these common factors, an approach explicitly taken by Stoltenberg (2008) at his plenary presentation to the International Interdisciplinary Conference on Clinical Supervision. Though he stated that he favors a developmental understanding of the process of supervision, Stoltenberg agreed with Bernard and Goodyear that the research support for developmental understandings is weak at best. Trainee development may be a component in the process of achieving competence, but it is not, according to the evidence, sufficient to account for what happens in supervision.

Other researchers have defined these common factors suggested by Wampold (Bergin & Garfield, 1994; Hubble, Miller & Duncan, 1998). They identified:

- Extratherapeutic factors, such as the client and the client's view of therapy, the client's cognitive style, and the client's expectations of what makes change happen. These extratherapeutic factors accounted for 40 percent of the change in successful therapy.
- Core elements of the therapeutic relationship, such as the therapist's displaying empathy and the therapist's ability to join with the client, accounted for another 30 percent of the change.
- The placebo effect, that is the expectation on the part of both the client and the therapist that change would actually occur, accounted for a further 15 percent of the change in successful therapy. Clearly, the therapist's belief that he or she is competent in this particular situation has a positive effect on the outcome.
- The structure or the model of therapy employed accounted for the final 15 percent of the change.

The contribution of this common-factors approach to supervision is broadening the definition of competence. As Stoltenberg stated during his presentation, the outcomes research does support that some models of therapy do provide a better "fit" between the client, the client's presenting problem, and the therapist. It is just that an exclusive focus on the therapy, no matter how competently performed, will produce only relatively small amounts of change. Competence must include the ability to identify and effectively use the extratherapeutic factors present, good relational skills, and the ability to engender hope in one's self and in one's client.

The competence-based approaches do have a solid appeal. Once "competence" has been defined, assessing the trainee becomes a relatively straight-forward process. Likewise, structuring therapy becomes relatively straight-forward. The supervisor merely ensures that the trainee is performing the "right" behaviors (as defined by the particular model of competence) with the trainee's clients, and that the "right" behavior continues and improves over time. Regulatory bodies, such as state license boards, like this approach (Schwallie, 2005). They have a legal mandate to ensure that persons who are to be licensed will be, at a minimum, not harmful to the public, and having objective standards of "competence" helps these boards have some basis for stating that they are meeting that mandate.

Transaction-Based Theories. One difficulty for this study with the competence-based theories concerning the purpose of supervision is that most, if not all, are based in a modernist epistemology. In other words, they assume that there is some objective reality "out there" which can be known, defined, and measured. Knowledge, then, proceeds from those who have it to those who do not have it. It becomes an inevitably hierarchical process. Yet increasingly within the therapeutic community, a more postmodern epistemology is gaining favor. Though there are many variations on the theme, essentially postmodernism believes that reality, and therefore knowledge, is socially constructed (Gergen, 1999). Since knowledge is socially constructed, in this epistemology the relationship between supervisor and trainee becomes more equalitarian, with less emphasis on content and far more emphasis on process (Behan, 2003).

The transactional-based theories of the purpose of supervision are grounded fundamentally in both this postmodern epistemology and in the multi-cultural work of Green (1999). Green states that most work in understanding ethnicity has been grounded in a categorical understanding. That is, theories of ethnicity have tried to define the categories that

belong to this ethnic tradition and not to that one. This understanding assumes both a high degree of homogeneity within ethnic groups, and a high level of conformity within ethnic groups. The problem with this, according to Green, is that the one who defines the categories has the power. Furthermore, this usual understanding does not allow for the reality of differences within ethnicities. The answer, according to Green, is a more transactional understanding. The transactional understanding of ethnicity is a more fluid, socially constructed understanding. Rather than emphasizing the content within groups, the transactional approach emphasizes how the boundaries of belonging are constructed. This allows for both complexity within groups and differences within groups.

Flemons, Green and Rambo (1996) apply this social constructionist, transactional approach directly to supervision. They state that because we are inevitably embedded in a relationship with our trainees, there is no possible way to provide objective evaluation of our trainees. "Ethical decisions, therefore, are neither subjective nor objective, but *relational* – they have to do with taking a clear stand and, in so doing, defining a relationship between self and other" (p. 45). They cite Anderson and Goolishian's (1988) collaborative language system's approach in contending that supervision, like therapy, is one kind of meaning-generating or language system. Therefore, to provide a "grammar" for the relationship, they provided a list of 32 qualitatively developed criteria for assessing therapeutic relationships. They found that the doctoral students with whom they were using this outline actually started using the list proactively, as a means to structuring their own learning. They also found that this provided a common language for conversations between supervisor and supervisee.

British medical researchers (Kilminster & Jolly, 2001) found that the supervisory relationship is the single most important factor in the effectiveness of psychotherapy supervision.

The key elements of that supervisory relationship are, according to their study, clear feedback, and the supervisee having some control over and input into the supervisory process. An older study (Holloway and Neufeldt, 1995), this one focusing on supervision by psychologists for psychologist, found similar results. What makes this 1995 study worthy of note here is that Holloway and Neufeldt found that supervision can be an effective way of changing supervisee's values and beliefs, as well as their skills. The change in values, beliefs, and skills fits with the definition of professional identity used in this study, and therefore supports both the effectiveness of supervision in general and the use of professional identity, as defined here, as an indicator of the effectiveness of the university program under investigation. Worthen and McNeil (1996) reported similar results.

McNamee (2004) argues for more "promiscuity" in family therapy. Rather than trying to decide which is the "right" approach, as though there were only one "right" answer, she argues that theories, techniques, and models are fluid and flexible resources for therapeutic conversation. In this sense, she is proposing to work in a similar fashion to Flemons, Green, and Rambo (1996).

Lowe (2000) contends that a primary goal of supervision to equip the trainee for self-supervision, that is, to enable the therapist to supervise his or her own work. The most appropriate means to this end, Lowe contents, is to follow a more constructionist, transactional approach in formal supervision. By experiencing self-supervision within the context of formal supervision, such as in a university or post-graduate supervision experience, the trainee is better equipped when the formal supervision ends, Lowe believes.

Behan (2003) claims that a transactional, narrative approach to supervision is not antithetical to having some clear standards. He states that the inevitable power differential

between supervisor and supervisee must be openly acknowledged and faced. Thus, Behan (2003), Unger (2006), and Selicoff (2006) would maintain that transactional model of supervision does not imply there are no standards and no hierarchy. The transaction-based models differ primarily from the competence-based models in who gets to define "competence." In the transactional models, both supervisee and supervisor are active participants in that relationship, while in the competence-based models, the supervisee primarily receives and is evaluated by criteria handed down by the supervisor, who, in turn, receives the criteria from others.

Current Issues in Supervision.

Examining the journals available through the ProQuest Psychology database, there were two primary issues that appeared more often than others: multicultural training and defining "effective" supervision. This is not to say that other issues are not present, just that these were the two most common themes. For the purpose of this dissertation, I defined "current" as meaning the last six years, i.e., since 1 January 2004.

Multicultural issues. Dickson and Jepsen (2007) conducted a national survey of master's level supervisees regarding their experiences of multicultural training, and their experiences of multicultural counseling. Perhaps not surprisingly, their regression analysis of student scores on a multicultural awareness test indicated that multicultural knowledge and awareness came primarily through didactic programs, but multicultural competence came from the university's "ambience" (the researchers' term) and from the student's clinical training experience. Clearly, this study suggests, the ability to practice comfortably in a multicultural setting must be modeled and practiced, as well as taught. Though his study falls outside the operational definition of "current," Baker (1999) found similar results even when working with mandated clients.

Marshall and Wieling (2003) investigated students' phenomenological experiences of multicultural supervision. Specifically, they examined the students' experiences of having been supervised by someone who was culturally different from themselves. The investigators found that the students proclaimed such experiences were very valuable and the students highly desired more such experiences. This was as true for ethnic minority students as it was for ethnic majority students. The supervisor's style was a major theme in all of these reports. All of the students seemed to prefer an "open and collaborative" style of supervision. Several participants listed the supervisor's gender and country of origin as important variables. Interestingly, in this study the students' "bad" supervisory experiences did not appear to be tied to race, gender or culture. "Bad experiences" tended to be tied more to the supervisor's style, theory, and philosophy. However, good supervisory experiences were often tied to gender, race or culture.

Inman (2006) performed a similar investigation. Inman looked at the direct and indirect effects of the trainee's perceptions of their supervisors' multicultural competence. This research supported previous findings that the supervisor-supervisee working relationship is an important mediating variable. Even so, the supervisee's perceptions of the supervisor's multicultural competence is positively associated with developing a strong working alliance within supervision. Specifically, the supervisor's awareness of and willingness to discuss race, gender, and cultural issues in supervision had a positive effect on the trainee's perceptions of the supervisor and the supervisory relationship. This study, too, found that the ability to comfortably deal with multicultural issues in supervision is positively related to the supervisee's perceptions of their own multicultural competence.

Other articles provided guidance on developing multicultural competence within the supervisory context. For example, Ober, Granello and Henfeld (2009) proposed a model which is

grounded in a particular developmental theory of trainee development. Fine (2003) highlighted the importance of attending to power issues inherent in the supervisor-supervisee, or teacher-student, relationship. Mittal and Wieland (2006) found that international doctoral students often have difficulty adjusting to the United States, and they provided suggestions for doctoral program faculty to assist this transition. These are a representative sample of the kinds of articles that have focused on multicultural issues within supervision.

Supervision effectiveness. One of the gaps in the literature is that there are no studies that conclusively show that supervision in person is or is not comparable to supervision by distance. In other words, there may or may not be an automatic carryover from one venue to another. Even so, these studies do provide context for discourse on the focus of this current research.

Earlier in this chapter I cited Kilminster and Jolly (2001), Holloway and Neufeldt (1995), and Worhen and McNeil (1996) for their research showing that the supervisory relationship is the primary factor in the effectiveness of the supervision. Falender and Shafranske (2007) prefer a more competence-based approach to measuring supervision effectiveness. Yet they acknowledge that one of the inherent difficulties in defining such an approach is empirically defining the essential competencies to be assessed and acquired. Interestingly, they do include values and beliefs as well as skills in their list of essential areas of competence. They also explicitly acknowledge that the process of defining essential competencies is fundamentally a culture-laden and value-laden process. Therefore, Falender and Shafranske recommend that the supervisor collaborate with the supervisee to facilitate the formation of a working alliance, and that the supervisor and supervisee apply the competencies as a template for continual professional development.

In the profession of marriage and family therapy, discussion of competencies often centers on the AAMFT Core Competencies. Miller, Todhal, and Platt (2010) investigated this movement in light of experiences with similar competence-based approaches in other disciplines, including law and medicine. They echoed many of the dilemmas that Falender and Shafrankse found, and concluded that defining core competencies is an area needing more study.

Bartle-Haring, Silverthorn, Meyer and Toviessi (2009) reported a quantitative analysis of supervisory interventions to see if live supervision makes a difference. Their results were somewhat mixed. Trainees reported that the live supervision made a difference in their functioning. Yet clients were not as positive about the supervision's having made a difference in their progress toward resolving their problem(s).

Morgan and Sprenkle (2007) examined the research on a variety of models of supervision and found that each model has its strengths and its limitations. Based on their research, they proposed a common-factors approach to supervision, which they defined as "a structured relationship between a supervisor and supervisee with the goal to help the supervisee develop the attitudes, skills, and knowledge needed to become a responsible therapist" (p. 7). Once again, although they do not use the term "professional identity," their definition of supervision fits very well with this study's definition of professional identity. Indeed, they placed clinical competence and professional competence as poles along a single continuum. Some supervision activities may focus more toward one pole or the other, but the ultimate goal is to encompass both. This synthesis of research into a common-factors approach provides one potential bridge over the either/or of the competence-based and transaction-based focus.

Aggett (2004) pointed to the extensive literature on the importance of learning styles in the general field of adult education, and then suggested that effective supervision will make use

of the supervisee's learning style. Specifically, Aggett was focusing on group supervision, and so suggested that an awareness of different learning styles as well as the trainee's personal narratives would facilitate the trainee's self-reflectivity.

Edwards and Patterson (2006) focus on training marriage and family therapists to function within a medical setting. While many of their specific suggestions are not germane to this study, their basic guidelines do seem to fit. Effective supervision requires that the supervisor is aware of the supervisee's context and is able to use that context in supervision. Effective supervision also requires a focus on self-of-therapist (Aponte, 1994) issues.

One of the problems with much of the research on supervision effectiveness is that it tends to lack methodological rigor (Milne & James, 2000). That is, many of the studies focus on changed behavior on the part of the therapist without connecting that changed behavior to anything more lasting like client change as Thurber does. This current study seeks to fill that gap by focusing on change in trainee professional identity, which includes what the therapist does and also other relevant variables. I include more about this in the professional identity section of this review of the literature.

Research in Supervision

To investigate the beliefs and practices of current clinical supervisors regarding the purpose of supervision, I employed a focus group (Piercy & Hertlein, 2005). One of several legitimate ways to employ a focus group, according to these authors, is to generate theories and explanations. That was indeed the purpose of this particular focus group. I am including the explanation of the methodology for this investigation here, rather than in the Methodology chapter, because this was actually part of the search of the "literature," except that in this specific instance the "literature" is the lived narratives of those actually doing supervision.

The membership in this focus group consisted of all participants at a February 2009 Supervisor Refresher course sponsored by the Alabama Association for Marriage and Family Therapy. In my institutional review board (IRB) application to conduct this focus group study, I called this a "modified Delphi approach" because I anticipated, accurately as it turned out, that many of those participating would be very experienced, some with more than 20 years experience as MFT supervisors (see Appendix C for the IRB application and approval documents). I met with this panel of experts following their lunch break, which made for a logical flow with the rest of the course material in their five contact hour course. The full text of the interviews can be found in Appendix A of this document.

Since the purpose of using this group was to generate theories and explanations about how practicing supervisors actually view the purpose of supervision, I employed a grounded theory methodology to analyze the conversation, specifically the more constructionist version proposed by Chamaz as cited in Creswell (2007). After transcribing from the recording into a text document, I read the text document several times to get a feel of the entire flow. I also listened to the audio recording twice more during this process to be sure I had not missed anything, including any possible subtle nuances of meaning. Once I was satisfied that I understood what had been said and that my script accurately reflected what had been said, I began the process of open coding. The coding worksheet is included in Appendix B of this document. To avoid imposing any preconceived ideas of my own, I employed symbols found in the Microsoft Word Symbols tools as markers for the open coding. Based on the open coding, I then constructed the axial coding, also found in Appendix B. Finally, the selective coding came in the form of visually relating the various concepts found through the axial coding.

The axial coding produced seven themes:

- Good Executive Skills (6 instances)
- Application of theory to practice (3 instances)
- Ethical behavior (1 instance)
- Growing in skill proficiency (2 instances)
- Producing change in the client (2 instances)
- Able to use process as well as content (2 instances)
- Intuitive awareness (2 instances)

Of these, the "Application of theory to practice" seemed to be the central idea, with the others forming supporting or explanatory concepts. In other words, the focus group believed that the primary purpose of supervision is to help the trainee relate theory to practice. While the language used by the practicing supervisors differs from the formal, academic language employed by Liddle and his co-authors (1988), there appears to be sufficient similarity between the two definitions to assume that the classic definition has indeed permeated into the field and forms at least part of the narrative by which practicing supervisors, at least in Alabama, function with their trainees. Figure 2-1, below, graphically depicts these results.

This grounded definition contains both didactic and experiential components. For example, there were two statements by supervisors that they would just intuitively know that the trainee was growing. Such intuitive knowledge would imply direct, experiential contact with the trainee and, by extension, at least some direct contact with the trainee's clients. The supervisor's having some direct access to the trainee's work with clients fits with the expectations of the AAMFT approved supervisor (AAMFT, 2007). Another of the supporting concepts, "Producing change in the client," also implies having sufficient access to the trainee's clinical work to be able to make accurate judgments about the trainee's ability. Many of the other concepts imply more didactic focus, such as knowing and applying "Ethical behavior" and being able to distinguish between process and content.

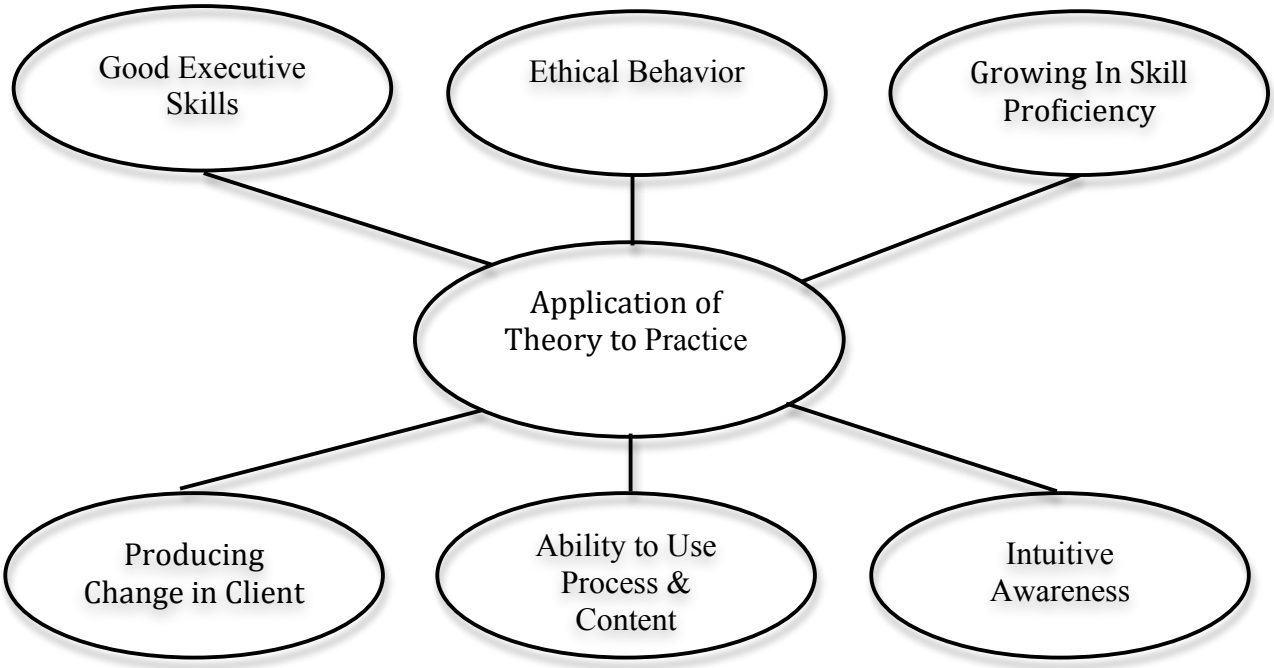


Figure 2-1 – Grounded Theory Results

This focus group's responses suggest that currently practicing supervisors, at least as represented by this focus group, are generally aware of the literature in the field and do tend to both structure their supervision and evaluate the effectiveness of their supervision according to what the literature suggests. There seems to be evidence here for both competence-based and transaction-based approaches, though the competence-based does appear to predominate in this particular group. Whether that would be true in other, similar, focus groups remains an open question. What is evident is that both this focus group and several articles in the literature suggest that a blended competence/transaction approach, rather than a more strict either/or, will be more reflective of the way supervisors are actually practicing.

Professional Identity

General Literature on Personal and Professional Identity.

One of the classic works on how one's personal identity develops is Erikson's *Childhood and society* (1950). According to Erikson, one's identity develops through a series of what he

called psychosocial crises, the resolution of each influencing the future choices of the individual. Specifically, he identified the crisis of adolescence as "identity versus identity confusion." Erikson further developed that concept in his book *Identity: Youth and crisis* (1968). In this volume, Erikson developed the idea that identity enables one to experience a continuity with one's living past and with one's anticipated future. He applied the concept to racial identity as well as more general applications of identity development in adolescents.

Perhaps because of Erikson's influence many of the articles I discovered on personal identity focused on identity development as an adolescent (e.g., Meeus, Ledema, & Vollenberg, 1999; Bosma & Kunnen, 2001; and Houle, Brewer, and Kluck (2010)) , or ethic/racial identity (e.g., Mana, Orr, & Mana, 2009; Dien, 2000 [this one explicitly employs Erikson's model]; and Kiang, Witkow, Baldelomar, & Fuligni (2010)). However, since this study focuses on graduate students, I have chosen to restrict the review of the literature to articles and studies which would be more appropriate for that demographic.

One of the variables in adult identity formation investigated in several studies (Anthis & LaVole, 2006; Tesch & Cameron, 2006) was openness to change. The more one is open to and ready for change, the more easily that person moves from adolescence to adulthood, according to these studies. Further, these studies suggest that an openness to change is positively associated with a willingness to explore various options before settling on an identity.

Amstey and Whitbourne (1981) used Erikson's psychosocial stages to investigate sex-role identification with adult women. Their research supported the existence of the psychosocial stages of development, and suggested that the identity crisis may well continue into young adulthood. Significant for this study, they also found that among women involved returning to college in midlife, the intensity of the identity crisis increased as they neared graduation. This

suggests that for adults, taking on new educational experiences may stimulate a return to the identity versus identity confusion crisis well past Erikson's postulated stage of adolescence.

Lang and Byrd (2002) found a similar relationship between educational experiences and adult identity. They investigated first-year university students, comparing their current identity development with their estimates of their success in an introductory psychology course. They found, in keeping with other research, that those who were more secure in their identity as adults did in fact do better in that introductory psychology course, while those who had not completely formed an adult identity were much more inaccurate in their estimates.

Côté (2002) offers one possible explanation as well as a second variable for adult development: identity capital. By identity capital, Côté means a sense of agency, a willingness to invest one's self in the work. Though Côté does not make the connection, the concept does appear to be similar to Bandura's (1977) concept of self-efficacy. In Côté's research, identity capital was a better predictor of successful transition to adulthood than structural factors, such as social class. The more one is invested in one's self, and has identity capital (i.e., resources) to invest, the more likely one is to be successful.

Other uni-focused models are available in the literature, but the more recent trend toward seeing identity construction as the function of multiple, correlated constructs (e.g., Schwartz, 2007; Luyckx, Schwartz, Soenens, Vansteenkiste, & Goossens, 2010). Abes, Jones & McEwen (2007) take the multifactoral model even further. They conceptualize personal identity as comprised of multiple dimensions, such as gender, sexual orientation, religious, socioeconomic status, etc. These dimensions are socially constructed and interrelated, so that one dimension cannot be understood apart from its interaction with the others. The various contextual influences to these dimensions (peers, family, stereotypes, sociopolitical conditions) get filtered through

increasingly complex meaning-making structures. The more complex the meaning-making ability, the more smoothly and completely the various identity dimensions are integrated.

This more complex, interrelated, and socially constructed model suggests that there is no real discontinuity between one's personal identity and one's professional identity. Indeed, Wilson & Deaney (2010) found just such a continuity between personal and professional identity. They followed one person moving from a career in science to a career in teaching. Among the key factors they found in making this mid-life transition easier were a strong sense of self-efficacy and assistance in socially constructing the new identity, versus remaining fixed on preconceived archetypal images of what the new profession "ought" to be like.

Another study on teacher identity development explicitly states that the personal identity must be a factor in any investigations of professional identity (Beijaard, Meijer, & Verloop, 2004). They cited several studies suggesting that the two identities are related and both are socially constructed, which, according to these authors, means that identity construction is an ongoing process. One factor they highlight in most of the studies they reviewed is the self-reflection of the teacher as a key modality through which both personal and professional identity are constructed.

These studies cumulatively suggest that professional identity is dynamic. It changes over time as an individual interacts with significant others (e.g., mentors, supervisors, etc.), events (e.g., education, clinical training, etc.), and experiences. It is socially constructed through the individual bringing his or her personal identity into conversation with the relevant features of the profession, such as codes of ethics, standards of behavior, etc.

Representative Literature on Professional Identity in the Mental Health Fields.

There is a large body of literature on developmental theories of professional identity in the mental health field, though many of them do not explicitly use that term. One that does is the classic by Friedman and Kaslow (1986). They proposed a six stage model of professional identity development that is often cited (Google Scholar found 58 citations) but seldom quoted. Stoltenberg, Pierce, and McNeill (1987) proposed eight domains of professional functioning in which the trainee will develop. Though Stoltenberg is best known for his competence-based developmental work, this early work laid the groundwork for his later Integrated Developmental Model (Stoltenberg, McNeill, & Delworth, 1997). Both the earlier and the later versions of his model are based in the trainee's increased ability to handle cognitive complexity. That is, while not strictly a stage theory, the Integrated Developmental Model does provide a framework for how trainees change over time, and how various supervisory environment and supervisory interventions can enhance or detract from the trainee's professional competence. The reader should note that Stoltenberg operationally defines professional competence in much the same terms in which this study defines professional identity, except that Stoltenberg does place more emphasis on the skills component of professional competence.

In the field of marriage and family therapy, one model which has gained some acceptance in training programs is the Basic Skills Evaluation Device (Nelson, 1999). This model defines trainee development in terms of the number of hours of client contact the trainee has accumulated: the Basic (0 to about 50 hours), Intermediate (about 50 to about 300 hours) and Advanced (more than 300 hours). The "about" is there because the model allows for variations between trainees and trainee experiences. As the trainee gains more experience doing "professional" things, she or he is assumed to show greater ability to integrate theory and

practice through each of the five dimensions of the model: Cognitive, Perceptual, Executive, Professional, and [Self-]Evaluation.

Ronnestad and Skovholt (2003) proposed an eight stage model that is interesting for two reasons. First, it is based on their qualitative research of practicing therapists. Second, unlike most models, it covers the entire spectrum from beginning the journey of professional identity development through becoming a "Senior Professional," one with more than 20 years of experience. Their model is quite compatible with other, more general, research which shows that personal and professional identity are both socially constructed and dynamically developed.

Nelson and Jackson (2003) point out that the CACREP standards call the development of a professional identity one of the central themes of counselor education. They used a qualitative, phenomenological approach to investigate how this professional identity develops in Hispanic graduate students. Their group consisted of eight students. Based on their analysis of the interviews, Nelson and Jackson elicited seven themes which were critical to these Hispanic students' professional identity: knowledge, personal growth, experiential learning, relationships, accomplishment, costs (i.e., the personal sacrifices they were making to achieve their professional identity), and perceptions of the counseling profession. There are enough similarities between the Nelson and Jackson study and this current study to support the validity of the research design and focus. There are enough differences (e.g., this was in an in-classroom setting) to justify the need for this study as a contribution to the literature.

Overall, the competence-based theories of professional development and identity would emphasize the content, the tasks to be performed and expect a great degree of homogeneity among "competent" therapists. By contrast, the transaction-based theories of professional development and identity would emphasize the way "belonging" is constructed. That places the

power firmly in the transaction, the relationship, since all parties to the transaction have the power to work out the differences between themselves (Green, 1999).

As a group, the transactional theories would answer Liddle's "classic" questions (1991) by saying that the content of supervision should be a focus on relationship – the therapist-client relationships, and the supervisor-therapists relationships. The training methods should, therefore, be more equalitarian and focused on enabling the therapist-trainee both experience and construct helpful relationships. It follows that assessment should be mutual, and in the form of a conversation, rather than in the form of a monolog. The trainee's evaluation of the supervisor is just as critically important as the supervisor's evaluation of the trainee.

Narrative therapy theorists have been in the forefront of explicating this understanding. Winslade (2003; Winslade, Crocket, Monk & Dewey, 2000) claims that the task of supervision is co-authoring with the trainee a story of professional identity development. He acknowledges that this identity will come from learning and practicing certain skills, as the competency-based theories would claim, and additionally it will come from certain thinking in relationship to current theoretical conversations, and to forming relationships within the community of therapists of which the trainee hopes to become a part. In the relationship envisioned by Winslade, the power differential between supervisor and trainee is openly acknowledged and accepted. Assessments are handled in a dialogical, rather than in a monological (i.e., supervisor to trainee only) manner.

Lowe (2000) makes a similar assertion. Lowe believes that the supervisor's work can best be described as "expert wonderings" about the overlapping narratives inherent in the case material the trainee is presenting. Lowe identifies three of these overlapping narratives in every case consultation. The first of these is, of course, the case story. This is usually the focus of the

case consultation, and contains the story of the therapist's work with the particular client. Embedded within the case story is the client's story or stories. The second narrative thread is the therapist's story. The therapist brings his or her personal and professional stories to the table, and they form a legitimate part of the work of supervision. The third narrative is the supervision story, that is, the therapist's story about her or his experience in supervision. In practice, the supervisor's focus shifts back and forth between these various narratives through a process that Lowe calls "constructive inquiry." The purpose of the supervisor's questions is to create a sort of parallel process, by which the supervisor's curiosity about the strengths the trainee employs parallels the therapist's curiosity about the client's strengths.

Behan (2003) joins with Winslade in accepting the power differential between supervisor and trainee. Behan, too, says the supervisor should take power in the relationship without controlling. Instead, the supervisor works collaboratively with the trainee to help the trainee recognize, deconstruct, and reconstruct the positions of discourse in which they find themselves. For example, instead of teaching or coaching the trainee what to do in a given situation, the supervisor may encourage the trainee to interview the supervisor about tools or techniques that the supervisor finds helpful in the supervisor's own clinical work. Another way of accomplishing this goal might be for the trainee to assume the role of the client in question, and the supervisor would interview the "client" about what the client found most helpful in therapy. This taking a different discourse position opens new possibilities for the trainee to construct a new, and potentially more helpful, narrative about the case story. Whatever the specific techniques employed, the end goal is for the trainee to become more proficient in using stories within therapy by copying the supervisor. However, in keeping with the transactional theories and in contrast to the competency theories, this copying is not simply the supervisor making a clone of

himself or herself. Rather, this is what White calls, "the copying that originates" (1992, p. 93). The trainee copies the supervisor, and then adds to the copy the trainee's own personal and professional narratives, making the new story truly the trainee's own.

Sax (2006) defines the purpose of supervision as enabling the trainees to become "reflective practitioners." Therapists become "reflective practitioners" by learning processes to think through their theories and then putting espoused theories into practice. Sax states that there are five narrative practices which, taken together, help accomplish this goal. The first of these is reauthoring conversations, that is, paying attention to neglected parts of the client's, or therapist's, story through time which can help form the basis of an alternative story which has a more desired outcome than the current one. The second practice is particularly relevant to this dissertation, and that is maintaining an intentional understanding of identity. For Sax, as for most postmodern thinkers, identity is not something that is fixed, but rather is something that is constantly evolving. The question for trainee and client alike is, "Who am I today and who do I want to become?" The third narrative practice listed by Sax is double listening, that is, listening to both the overt content and to the "absent but implicit" experiences which guide people through their lives. The fourth narrative practice is "re-membering" family members, friends, and mentors who contributed to the person being who he or she is. By explicitly attending to these relational connections, clients or trainees have the opportunity to contemplate how this connection has shaped or could potentially shape who they are. The final narrative practice is the definitional ceremony. This involves a ritual or ceremony that defines who I am. In this sense, the various transitions (e.g., from practicum student to intern to associate member to licensed therapist) may be very important rituals in developing the trainee's professional identity, and the supervisor can potentially make very good use of them.

Ungar (2006) presents a theory based on intrapersonal transactions as well as interpersonal transactions. Ungar claims that each supervisor develops and employs six roles in his or her work with trainees: supporter, supervisor, case consultant, trainer or teacher, colleague, and advocate. Each of these roles is socially constructed and is therefore constantly reinterpreted as the supervisor employs them over time with various trainees. It is the way the supervisor negotiates these various roles and yet keeps them integrated within the supervisor's professional identity (i.e., a sense that this is still "me" regardless of which role I am playing at a given moment) that is most beneficial for the trainee. From the trainee's observation and experience of the supervisor negotiating the supervisor's various roles, the trainee learns to negotiate and integrate the various roles the trainee must play. One example might be the way the supervisor handles the role of expert. As a good postmodern supervisor, Ungar wants to avoid wearing that role and instead keep the focus on helping the therapist/trainee construct his or her own knowledge. Yet the trainee might just as likely want the supervisor to assume that role. The way the supervisor is able to negotiate that tension can be more instructive for the trainee about negotiating times when clients ask, "Tell me what to do" (i.e., play the expert role for me) than any lectures on how to handle those situations. In other words, according to Ungar, modeling by the supervisor is critical to effective postmodern supervision, further supporting the contention previously cited by White (1992).

Storm, Todd, Sprenkle, and Morgan (2001) examined the gaps between supervision theory and what actually happens in supervision. Among their recommendations for supervisors was a return to the "common factors" approach included under the competence-based theories in this paper, with a special emphasis on the supervisory, and by extension therapist-client, relationship, since relationship accounts for at least 30 percent of the change in therapy. This

emphasis places their recommendations more in line with the transactional theories. Furthermore, the ability of the supervisor to accurately assess the therapist/trainee's cognitive style, beliefs about how change happens, trainee's life story, etc., should account for a further 40 percent of the change in supervision, if the same common factors hold true. Thus, the emphasis on competence, as defined by skills, is not misplaced, it is merely inadequate, since it accounts for only 15 percent of change, again if the common factors hold true for supervision.

While there has been no direct evidence this common-factors approach holds for supervision as it does for therapy, Bischoff, Barton, Thober and Hawley (2002) provided indirect evidence. These authors conducted a qualitative study of first-year practicum students to see what events and experiences were most influential in developing the practicum students' clinical self-confidence. They found that volatility in self-confidence during this first year was very common, with the self-confidence rising and falling with almost every client contact. One powerful modulating factor was the supervisor's expressed confidence in the student. This finding supports the assumption that the ability of the therapist to engender hope in the client is analogous to the ability of the supervisor to engender hope in the trainee. Further, these authors found that the ability of the supervisor to hone in on specific in-session behaviors and to highlight them in terms that made sense to the trainee was a very positive factor for trainees. As important as the relationship with the supervisor was for these practicum students, relationships with peers was at least as important. Contact with peers tended to normalize the volatility of their confidence, making it less frightening. Indeed, contact with more advanced peers tended to decrease the volatility and increase the perceived self-confidence. The trainees that the authors interviewed listed personal factors (e.g., illness, pregnancy, a relationship breakup, etc.) as major distractions from clinical self-confidence. This finding, too, parallels the importance of

"extratherapeutic factors" for therapy. Interestingly, none of the trainees in this study mentioned the importance of the supervisor's theoretical model as a factor in their developing clinical self-confidence. That, too, parallels the relative unimportance of every technically skillful application of a therapeutic theory to the actual outcome of therapy. Overall, then, this study would appear to support the transactional models, with their emphasis on relationship factors, and specifically the applicability of the "common factors" approach to supervision. Morgan and Sprenkle (2007) support that conclusion in much the same language.

Qualitative Research in Marriage and Family Therapy and In Counseling

Hawley, Bailey and Pennick (2000) published a content analysis of 195 research articles from three marriage and family therapy journals. The three journals they selected were the *American Journal of Family Therapy, The Journal of Marital and Family Therapy,* and *Family Process*. They limited themselves to "empirical articles" from 1994 to 1998. They found that overwhelmingly, the articles were quantitative in their methodology. For example, 98 percent of the articles published by psychologists were quantitative, while 85 percent of other researchers in university settings used quantitative methodology. Marriage and family therapy researches had the lowest percentage of articles using quantitative methodology (70 percent), and even so, it was still very much in the majority. By simple math, approximately 59 of the 195 articles would have been qualitative (or "descriptive" as they labeled them).

The following year, Gehart, Ratliff, and Lyle (2001) focused specifically on qualitative research. They used PsychLit and PsychInfo databases to find 24 qualitative research articles published through early 1999. The searched literature included all indexed literature in those databases since 1979. They used "qualitative research" and "ethnography" as the key words, looking in "family" and in "couple/marital" therapy. The majority of the articles in this study

were based in a phenomenological and/or social constructionist epistemology (nine of the 24). Methodologically, seven of the studies used ethnography as their method, followed by content analysis (3 studies) and phenomenological interview (2 studies). There was only one instance of each of the seven other qualitative methodologies. The authors concluded that the growing interest in qualitative research signified a "common interest in deepening the theoretical and practical understanding of family therapy and its usefulness in the 'real' world" (p. 267).

In 2002, Faulkner, Klock and Gayle published a different look at qualitative research in family therapy. They stated there is "a growing trend" in interest in qualitative research and sought to specifically build on the Gehart, Ratliff, and Lyle article (2001) by looking at the trends over the last 20 years, rather than just the methodologies. Faulkner, Klock, and Gayle looked at every issue from 1980 to 1999 of four family therapy journals: *American Journal of Family Therapy, Contemporary Family Therapy, Family Process,* and *Journal of Marital and Family Therapy*. What they discovered was that both qualitative and mixed methodologies articles doubled over the selected time period. Both *Family Process* and *Journal of Marital and Family Therapy* actually tripled the number of qualitative articles they published. Across all four journals, there were more qualitative articles than there were mixed methods articles. Finally, the authors noted that there was a sharp increase in the qualitative research articles published in the 1990s versus the 1980s, suggesting the trend towards accepting qualitative research was accelerating. They also noted that in the 1990s there were a number of articles "about" qualitative research which were not actually empirical articles, and therefore did not enter into the count.

Another, more indirect, indication of the continuation of this trend is Sprenkle's respected textbook *Research methods in family therapy*. In the first edition (Sprenkle & Moon, 1996), only

six of the 22 chapters were on qualitative methods. By the time Sprenkle published the second edition (Sprenkle & Piercy, 2005), nine of the 21 chapters were on qualitative methods, and an additional four chapters focused on mixed methods.

Perhaps we have come to a time which Larner (2004) dubbed "paramodern," transcending the dichotomy between modern and postmodern. Family therapy is an ecological invention which does not translate easily into step-by-step instructions. There is both art and science in the profession, and therefore we have come to a time, Larner contends, when the "politics of evidence" must privilege both "evidence based practice" (i.e., quantitative methodologies) and "practice based evidence" (i.e., qualitative methodologies). Though this study is solidly in the current trend toward qualitative research, this author agrees with Larner that other, quantitative, investigations could certainly be beneficial.

My Personal Experience With Distance Education

Distance education has a long history in the United States, and my personal experience illustrates major themes in that history. In 1960, when I was twelve years old, I joined my father in taking a correspondence course in radio and television repair [first generation technology (Taylor, 2001)]. We sent in assignments via surface mail and received graded comments by surface mail. Later that same year, while I was studying to become a licensed amateur radio ("ham") operator, I took classes in Morse Code and electronic theory by watching broadcasts targeted to prospective "hams" on Alabama Public Television [second generation technology (Taylor, 2001)]. Though these television classes were not offered for academic credit, they did beyond question help me earn not one but two "ham" radio operator licenses. At this early stage, I had no opportunity for interaction with the instructors . The instructors were not able to give or receive feedback. They had no way of knowing if I were studying the concepts and skills, if I

took the required tests, or if I passed the tests. Communication was strictly from the instructor to the student via the televised broadcast.

By the time I began my first doctoral work in the mid-1970s, an early form of distance education was well established in higher education. At that time, faculty from Emory University traveled to a central location some distance from the campus, a "cluster" location, and students met with them at these cluster locations [also second generation technology]. The time actually spent on the Emory campus was significantly less than required by the "traditional" model. Several years later, I experienced a similar model during my time in the United States Air Force. Most mid-level Air Force officers who took professional military education did so using the "cluster" model of distance education. My last experience with this "cluster" model came in 1989, when I graduated from the USAF Air War College.

As indicated in the previous chapter, it was not until the end of the 20th Century that technology advanced to the point that "distance education" did not necessarily have to mean that faculty must physically travel to a location distant from the campus, or have to correspond via surface mail with the days of delay that implies. Technology had begun to shrink the world.

When I began teaching at Amridge University (then known as Southern Christian University) in 1996, Amridge was among the first universities to make use of video tape to shrink the distance [third generation technology (Taylor, 2001)]. Each week, the on-campus classes were recorded onto VHS tapes, and these tapes were surface-mailed to students in the program. Students would then view the tapes and complete the assignments just as the on campus students did. Interactivity came through email exchanges between instructor and student. While this worked well enough for the didactic classes, the significantly asynchronous nature of the interactions made this much less than desirable for clinical education, in my experience. Still,

it was the best technology could offer at the time and it made possible at least a rudimentary form of clinical training by distance.

In 2005 Amridge University made the next big technological leap forward and started using Internet-based telephone to provide almost instantaneous communication (there was about a 10 second delay) between instructor and students. Students were able to see the instructor in real-time using streaming Internet video, but the instructor was only able to hear the students. Still, using this third generation technology, we were getting closer to making Internet-based clinical training isomorphic, or nearly so, with traditional "in the same room" supervision.

The year 2006 saw another technological shift for Amridge University. In that year, Amridge started using an Internet-based video conferencing system that Amridge dubbed "Summit Point 2." For the first time, instructor and student could see each other while discussing the case material, and the communication delay was down to four seconds or less. We were now using fourth generation technology (Taylor, 2001). Group discussion became possible by the university clinical training instructor calling on one person at a time, and whoever was speaking could also have their image on the screen if they had a webcam active. This growing similarity with what I had experienced for years as a supervisor in "in the room" supervision enabled me to make several innovations and improvements in the process. We were getting closer yet to isomorphism with "in the room" supervision.

Since 2006, the technology for providing Internet-based video conferencing has continued to evolve and improve. Our current technology allows us to have up to six students on screen simultaneously (the primary limiting factor being available bandwidth), and we can send students to virtual breakout rooms for group discussion of case material. The communication is

near instantaneous, and allows for multiple modes of presentation simultaneously (e.g., audio, video, and slides of text or images on the whiteboard).

In my years as a student and as a faculty member, I have personally experienced the first four generations of distance learning. I am aware of the benefits and limitations of each. It is this phenomenological base that drives my interest in this study and excites me about the possibilities of the fifth generation.

Summary Analysis of the Review of the Literature

There were two main questions for this review of the literature: is distance education an effective way of doing graduate education, and what is the purpose of supervision. The evidence seems to strongly support the view that providing didactic material by distance technology, both synchronous and asynchronous, is at least as effective as in-classroom education. While the literature does suggest that online learning does require some different teaching skills, and while the best-practices for online instruction are still evolving, there is every reason to believe that this shift in paradigm from "classroom" as only physical space to "classroom" as either physical or virtual space will positively impact both styles of teaching-learning interaction.

The second question, what is the purpose of supervision, goes right to the core of this study. We must know what "supervision" is in its traditional sense before we can know if that purpose can also be achieved via online technology. The competence-based theories have their contribution. As Schwallie's article (2005) clearly pointed out, license boards do tend to like these definitions. The definitions provided by the focus group further supported the impact of competence-based theories. Most, though not all, of what the focus group offered could easily be subsumed under this general heading.

Even many of the transaction-based theories granted that an emphasis on competent performance of skills is a necessary part of supervision. These theories merely state that helping the trainee to demonstrate competent performance of therapy skills is only part of the equation. The majority of the emphasis in the transaction-based theories is on the quality of relationships.

This is particularly important for this study because Abes and colleagues (2007) contend that repeating enactments of identity creates identity. In other words, if I learn to repeatedly relate to others and to myself as a therapist, I create an identity of myself as a therapist. The key word in that sentence is "relate." Abes and colleagues place themselves within the social constructionist understanding, and therefore the relationship implies a reciprocal confirmation and acceptance on the part of others with whom I am relating.

This conclusion receives further support from Nelson and Jackson (2003). They cite the 2001 CACREP standards, the same ones that Amridge University employs for our professional counseling students, in saying that developing a professional identity is a "central theme of counselor education" (p. 4). Similar to Abes and colleagues, Nelson and Jackson emphasize that trainees construct their professional identity by repeatedly "storying" their activities within the profession. The emphasis I am placing on professional identity in this dissertation clearly has support in the literature.

The mentoring of the trainee by the supervisor implied in many of the transactional models appears to fit with the frame offered by Bandura (1977). Bandura claims that our actions are guided by prospective visions of the outcome of our efforts. This belief that our actions will have beneficial outcomes is what he calls self-efficacy. This self-efficacy has a number of sources, prime among them personal experiences of mastery in the past and vicarious experiences of mastery – i.e., watching others whom you consider "similar" having experiences

of mastery. In terms of this study, Bandura's theory would suggest that the supervisor's highlighting trainee successes and the trainee observing other trainees doing well both contribute to the trainee's growing identity as a professional.

In summary, the literature, especially the transactional theories of the purpose of supervision, appears to both support the conceptualization of this study, and suggest that the use of the Internet to provide clinical training may in fact be an effective way to help practicum and intern students construct their professional identity. The question remains, does that actually happen? Answering that question is the focus of the remainder of the dissertation.

Chapter 3 – Research Methodology

Qualitative research always takes place from a certain context and from a certain frame of reference (Creswell, 2007; Dahl & Boss, 2005). There are two primary streams of influence that have come together to give me the frame from which I approach this study. These streams are not presented chronologically or in order of importance. Both are equally important and both form essential background for understanding how I designed the study and how I will analyze the data.

The first stream of experience is my background in Adlerian therapy. I was introduced to Adlerian thought in my practicum. At the time (1971), my supervisors presented Adlerian therapy as very traditionally individually-focused and psychodynamically oriented. Even so, there were a few key concepts which really connected with me. The first was Adler's emphasis on the uniqueness of each person. That is why Adler named his school of thought "Individual Psychology" – each person approaches the world from an idiosyncratic point of view and must be understood as an individual (Sweeney, 1989). Yet the name "Individual Psychology" is in some senses a misnomer, since Adler's theory places a very high premium on social interactions. Indeed, one of the two innate psychological drives he listed was *Gemeinschaftsgefühl*, an untranslatable German term usually rendered "Social Interest" or "Social Cooperation." Adler held that we humans are incurably social animals, and we can only be understood in our social context. Montagu (1955), an Adlerian therapist, held, "life is social and man is born to be social, that is cooperative – an interdependent part of a whole" (p. 185). Later, Montagu (1981) stated the issue even more powerfully: "The child is born not only with the need to be loved, but with the need to love others" (p. 131).

It follows that another prime Adlerian concept is mutual respect (Sweeney, 1989). The truly healthy person, according to Adler, is one who can strive for his or her own superiority (as idiosyncratically defined – the drive for superiority is the other innate psychological drive Adler posited) while at the same time doing so in a way that is considerate of the person's web of relationships. In other words, my growth cannot come at anyone else's expense if I am truly healthy. I will grow in my unique way and you will grow in your unique way and we will together form relationships which are mutually respectful and supportive.

Later in my clinical training, when I discovered systems thinking, it was a very short intellectual jump to embrace systems though because of this strong Adlerian emphasis on the primacy of relationships. This transition was made even easier through books such as *Systems of family therapy: An Adlerian integration* (Sherman & Dinkmeyer, 1987), which detailed how many core family therapy theories connect well with Adlerian thought. In more recent times, other Adlerian authors have claimed that Adler is the unrecognized intellectual father of both Solution-Focused Therapy and Narrative Therapy (Wood, 2003; Watts & Pietrzak, 2000; Bitter, 2007). So the first stream of experience comes from Adlerian psychology as reinterpreted in the last two decades by systems thinking.

The second stream of experience comes from my theological training. Like most, if not all, theologians, I studied hermeneutics. However, in both my master of divinity and in my doctor of ministry degrees, my primary focus was pastoral counseling. That field is heavily influenced by Anton Boisen, a man who is widely regarded in pastoral theology circles as the father of hospital chaplaincy, clinical pastoral education, and pastoral counseling (Miller-McLemore, 2005). Both my master's level supervisor of pastoral counseling and my doctoral level supervisor of pastoral counseling had worked with and studied under Boisen, so they were,

naturally, profoundly influenced by his work. In fact, my doctoral supervisor, C.V. Gerkin, wrote a book some years after I completed my doctoral studies with him that captured one of Boisen's major themes as its title: *The living human document: Revisioning pastoral counseling in a hermeneutical mode* (1984). According to this tradition of pastoral theology, human life is a "text" to be approached with the same care as a Scriptural text, and to be interpreted with the same care. This second stream of experience parallels nicely for me with the Adlerian and family systems stream, especially with Adler's emphasis on "private logic" and teleology as the drivers behind behavior (McCurdy, 2006). While I will not rely on any of the traditional theological categories or concepts to interpret the results, the hermeneutical approach to the data, the "living human document" of my research participants' lives, will be very prominent.

In summary, these streams of experience give me a frame of reference where I am most interested in interpreting the unique constructions of reality which are formed through social interaction. I will tend to approach this task of understanding from a hermeneutical frame.

The Focus of the Inquiry

According to Maxwell (2005), qualitative research is about process (i.e., the process by which X interacts with Y), while quantitative research is about variance (i.e., the extent to which variance in X causes variance in Y). That distinction gives focus to this project. As a qualitative research piece, the focus is on process not on variance.

Specifically, the focus of this research is the process by which the Amridge University clinical training program fosters growth in professional identity among our students. As I stated in Chapter 1, one of the operating assumptions of the Amridge University clinical training program is that students will experience multiple theories of therapy at work with clients, and based on this experience select a personal theory of therapy which best "fits" the student as their

core theory. This selection of a personal theory is but one aspect of a more fundamental process, the development of a professional identity.

Abes, Jones, and McEwen (2007) review several theories of how personal identity develops, and they conclude, based on multiple studies from multiple theoretical frameworks, that identity comes from the capacity to make meaning of one's lived experiences. Winslade (2003) provides a similar concept, except that Winslade frames it in terms of creating new stories, new narratives, which guide and define new actions. The primary question, then, is, just how does this new identity, this new meaning, this new self-narrative develop? This focus undergirds all three of the research questions spelled out in detail in Chapter 1:

- What is the phenomenological experience of students engaged in the clinical training experience at Amridge University?
- What is the phenomenological experience of the site supervisors involved with student interns at Amridge University?
- What phenomenological evidences of growth in professional identity are evident as a result of this process?

Fit of the Paradigm to the Focus

The research paradigm in this study is phenomenology, which is usually traced to the work of German philosopher Edmund Husserl and French phenomenologist Michelle Merleau-Ponty (Gergen, 1999). Husserl's passion was to get to the core of experience, to the lived experience of the moment (Singer, 2005). For Husserl, that core was always relational. It is what he called the "intentional" nature of experience. In other words, all experience is directed toward some pattern (some person or object) in the external world. My experience thus requires "you" for my experience to have any content, and you exist for me only to the extent that I bring my

experience to bear on you. From this frame of reference, knowledge is inevitably relational and socially constructed (Gergen, 1999).

Since phenomenology believes that knowledge is socially constructed, it follows that everyday life is a fruitful arena of research, and common moments are at least as valid, and perhaps more so, than experiences created or enacted in a laboratory. Furthermore, objects and events can mean a variety of things to different people. To truly understand a phenomenon, you must hear multiple voices. Each of these voices will have its part to contribute. Furthermore, since knowledge is socially constructed, the researcher's experience is a valid part of the consideration (Dahl and Boss, 2005).

This method of qualitative inquiry fits the focus of the study quite well. The three questions all ask about the lived experience of the participants. True to the phenomenological method, the questions seek to solicit commonalities of experience, while still leaving room for unique or idiosyncratic constructions of meaning from the experience (Creswell, 2007). Specifically, this study will proceed along the lines of hermeneutical phenomenology, since I as researcher will not only attempt to capture the lived experience of the participants, but I will also attempt to apply some interpretation of the "text." This is appropriate, because phenomenological questions are questions about meaning (Dahl and Boss, 2005).

Specifically, the meaning I am studying involves the meaning by which the activities of clinical training become authored into an emerging professional identity. That is, I am interested in the transformation that each student experiences in the move from "these are things that I do" to "this is who I am." As Carlsen (2006, p. 146) says, "We are what we do, and how we talk and think about what we do." Phenomenology seems to be a method very well suited for capturing that meaning-making process.

Fit of the Inquiry Paradigm to the Substantive Theory

As already indicated, there is an exceptionally good fit between Adlerian theory ("Individual Psychology") and phenomenology. Adlerian theory is quite compatible with what Carlsen (2006) calls "retrospective teleology", that is, selecting events in the past, charging them with identity status (i.e., "this is what I do and therefore who I am"), and then using them to actively shape our future practice. In Adlerian language, I construct the private fiction which guides my life from the things that have happened to me, and then, based on my private fiction, I select the things that I will do.

The Adlerian term "private fiction" points to another connection with phenomenology. Each person constructs a "fiction," a guiding story, from that person's past experiences which guides that person. Adler called it a private fiction because is developed by that unique individual and is therefore as unique as the person who developed it. And Adler called it a private fiction because it does not matter if it is objectively true or not. The person will live as though it were true. The private fiction is an authored meaning derived from the individual's phenomenological experience.

The third research question, the question regarding growth in professional identity, fits well with Adlerian emphasis on superiority. Superiority to an Adlerian connotes a drive for self-improvement, not necessarily a comparison with others (Sweeney, 1989). In other words, it is a drive to become a more "superior" me than I was previously. Totally in keeping with phenomenology, "superiority" is socially constructed and idiosyncratically defined.

Adlerian psychology focuses on the client's phenomenology (Lemberger & Dollarhide, 2006). In Adlerian language, this is called the client's style of life (also called life style). The clients' style of life is the way the client actually lives, and understanding just what that

phenomena looks like is a core part of Adlerian therapy. Isomorphically, Adlerian supervision focuses on the supervisee's phenomenology. Specifically, the Adlerian supervisor is interested in the trainee's therapy style of life. The supervisee forms goals consistent with the supervisee's point of view. These goals in turn influence the context in which supervision takes place. Supervision involves deconstructing old beliefs (old "private fictions") and reconstructing new beliefs more appropriate for the new and evolving context in which the supervisee lives. This study proposed to look at the process by which a part of that deconstruction and reconstruction takes place, as defined from both the supervisee's (trainee's) subjective point of view, and from the site supervisor's subjective point of view.

One key Adlerian concept not previously mentioned in this document should be mentioned at this point. The concept of the drive for superiority has its complementary concept, "organ inferiority" (Sweeney, 1989). By this Adler meant that no one is able to be truly superior in every area of life, no matter how hard they try. There are some biological limits to our strivings, hence the name "organ inferiority." The healthy response to meeting these limits is to appropriately compensate and place superiority efforts in areas where one can truly become superior. For example, a child may not have the physique or interests to play competitive sports, but this same child could become skilled as a musician or an artist. My more than 30 years' experience as a therapist and nearly 20 years experience as a supervisor tell me that the clinical training students are inevitably going to find limits to their superiority in their contact with their clients during their clinical training. Hopefully, this study will uncover, along with other experiences, the student interns' phenomenological experience of these limits and how they were able to author some appropriate compensatory skills so that they can truly become superior in areas where that is possible, while letting go of areas where superiority in therapy is less likely.

For example, a trainee may find that Narrative Therapy simply does not fit her context or her professional style of life, but Structural Therapy makes wonderful sense to her and her clients do well working with her this way. This part of Adlerian therapy, too, fits with the research paradigm.

Before moving to the next section, it may be useful to graphically depict the multiple interactions discussed in this section. To do so, I am adapting the model suggested by Maxwell (2005).

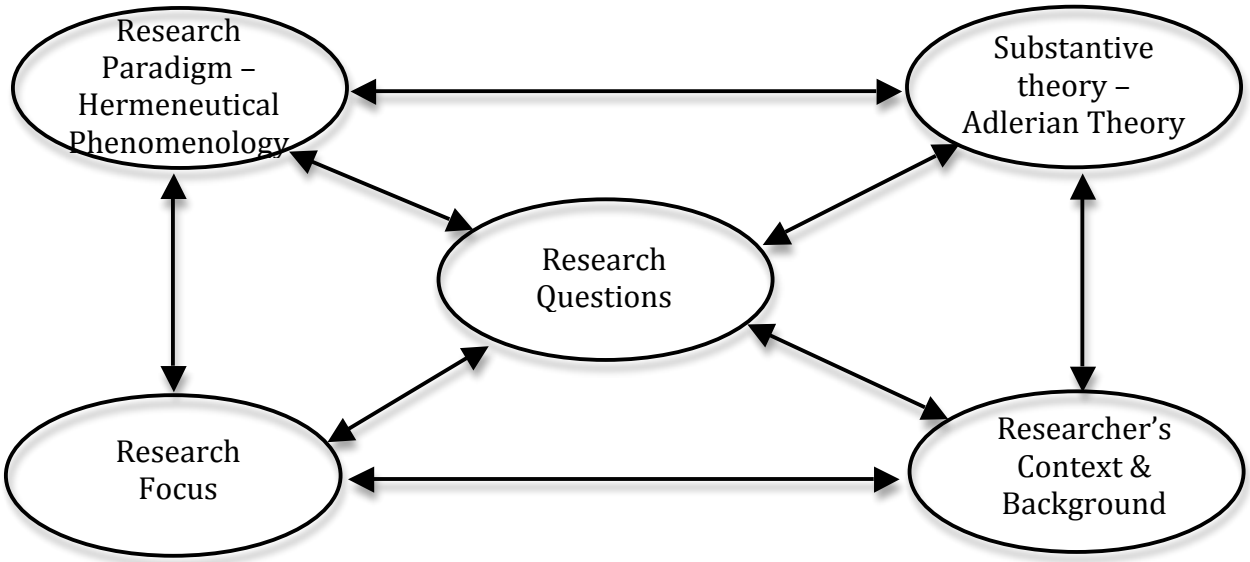


Figure 3-1 – The Interaction of Focus, Paradigm, Theory and Research

Source of Data Collection

The first source of data collection was described in Chapter 2. This was a modified Delphi study of current, practicing marriage and family therapy supervisors' conceptions of the purpose of supervision. This preliminary study consisted of a single interview of an assembled group of all eighteen supervisors attending a supervisor workshop at the Alabama Division of the American Association of Marriage and Family Therapy annual meeting. I selected this group

because (a) I expected, accurately as it turned out, that this would be a group of very experienced supervisors who would have both practical and theoretical expertise which would be valuable in defining the purpose of supervision; and (b) I expected that few, if any, of these would be involved in the main study and therefore their participation in this preliminary study would not bias the results of the main study. I describe what happened with that data in the next section of this chapter.

The phases of data collection for the main study follow the outline suggested by Creswell (2007). The first phase, selecting a site and individuals, flows naturally from the nature of this study. Since the focus is the clinical training program at Amridge University, students currently in the clinical training program at Amridge became the natural choice for participants. Similarly, since the vast majority of the current (Fall [August – December] 2009) Amridge University clinical training students live some distance from the physical campus, the site for the research naturally came as telephonic interviews. I selected telephone rather than video conferencing, a technology all of the Amridge students use every week, because (a) not all of the supervisors may have used this before and therefore I did not want to introduce a technology variable into the study, and (b) I assumed that the participant's being able to see as well as talk with me could introduce some level of intimacy that simply being a voice on a telephone would not. I based this assumption on my experience of having used both telephone and video conferencing technology both at Amridge and in my personal clinical work. The telephone interview provides for real-time interaction, while still providing the participant a bit of emotional distance from the interviewer.

The Amridge University Institutional Review Board (IRB) protocols provide for exemption if, among other conditions, the research is being conducted within an established

educational institution. I applied for and received an exemption from full IRB review. The application letter and the approval for the exemption from the Chair of the Amridge IRB are located in Appendix C of this document.

The second phase will come at the end of the Fall 2009 semester and will follow the process delineated in the IRB approval – gaining access and establishing rapport. At the end of the Fall 2009 semester, I will solicit volunteer participants from students who will be continuing on to either Clinical II or Clinical III in the Spring 2010 [January – April 2010] semester. I will solicit from this particular group because, by definition, they will have had at least three semesters' experience in the Amridge University clinical training program by the time of the interview and therefore should, if the research hypothesis is supported, have experienced some growth in their professional identity. Even if the research hypothesis is not supported, they should have had sufficient experience from which to draw in the interview. A second criteria for selection will be that their site supervisor must also agree to participate. I will solicit site supervisor participation by sending an email to the supervisor of students who agree to participate. Since I routinely collect site supervisor email addresses as a normal function of my role as clinical programs director at Amridge, gaining access to this information will be no problem at all. Similarly, gaining access to the volunteer participants' telephone numbers will be no problem, since I routinely collect this data as a part of the Amridge University clinical training program. In keeping with Principle 5.3 of the AAMFT Code of Ethics, my email contacts will explicitly remind students and supervisors that they have the right to decline participation with no repercussions or prejudice to the students, and that students who choose to participate will receive no special benefits from doing so, other than knowing they furthered the sum of human knowledge about the supervisor process.

This brings up the third phase, purposeful sampling. There are nineteen students who could potentially serve as participants in this study. This is the group that will receive the invitation to participate. My hope is that of this number, ten will volunteer and have their site supervisor volunteer. Both criteria hopefully will be met for each participant selected. This means that the study will have approximately twenty interviews, each of which should last approximately 30 minutes. Each subsample, the students and the site supervisors, will have their unique phenomenological experience to contribute to answering the research questions.

Some may question whether this sample size of approximately 20 is sufficient for this investigation. Dahl and Boss (2005) explicitly state that phenomenological research lends itself to small-N studies. How small? Creswell (2007) states that the sample could include "one or more individuals who have stories or life experiences to tell" (p. 55). He goes on to suggest that a sample size ranging from five to 15 would be adequate in most cases. Since the proposed sample size for this study will be eight to ten students plus eight to ten supervisors (a total n of 16 to 20), the proposed sample size is well within those parameters. Indeed, a brief review of published phenomenological research supports both Creswell's guideline and the current study's sample size. Giorgi (1985) examined the psychological phenomena of verbal learning using a group of 27 students. Anastoos (1985) used only five skilled chess players to phenomenologically examine how these chess players think during a match. Fischer (1985) used a sample of 13 graduate students in a psychology class to examine the phenomena of self-deception. Friman, Nyberg and Norlander (2004) interviewed seven soccer coaches for their experience of threats of and acts of violence from soccer fans. Norlander, Blom, and Archer interviewed six high school teachers about their experience of teaching psychology at a high school level. This is merely a

representative sample, and not an exhaustive review of literature at all. Clearly, this sample size fits with what many others have done in their published research.

The fourth phase is data collection. This will take place during the Spring 2010 [January – April] semester. I will again contact those who volunteered to ensure their continued desire to participate, and solicit again those who may have previously declined but now want to volunteer. I expect the sample to be firm by the third week of the Spring 2010 semester and the telephone interviews to begin shortly after that. I will establish a mutually convenient time for these interviews in advance of each. The questions I will use during the interviews are contained in the letter to the IRB, which is found in Appendix C.

For the student participants, the main questions are as follows. While the nature of phenomenological inquiry is such that I will likely amplify the questions, depending on the student participant's response, I will not go into any areas other than these:

1. Just for the record, how old are you? What occupation were you in when you entered the master's program at Amridge?
2. I want you to think back as best you can to when you first started Practicum. How clear would you say you were in your identity as a marriage and family therapist/ professional counselor? What experiences up to that point helped you get to where you were in your new identity as a marriage and family therapist/professional counselor?
3. How comfortable with your identity would you say you are now? What experiences in your clinical training have helped you come to where you are now? What experiences did you find most helpful? What experiences did you find least helpful?
4. If you had the opportunity to talk with students from other university programs, how do you think your preparation as an intern compares with these other students?
5. One of the benefits we claim is that our program allows our students to experience a much wider variety of clinical issues and settings than they could if they only experienced their own clinical site. Did you find this helpful to you in your comfort with your own clinical work?
6. According to our definition [on the BSED], you are now either a senior Intermediate or an Advanced intern. How confident are you that you are adequately prepared for your future profession once you graduate?

The questions for the site supervisors are similar. Here, too, I may amplify an area, depending on the participant's response, but I will not go into any area other than these:

1. If you think back to when you first met your student intern, how well prepared did he/she appear to be compared to other similar students you have known in your career? What impressed you the most? What concerned you the most? How have those impressions changed over the course of your work with your intern?
2. How helpful has your connection with Amridge University been? Given the limitations of distance, what would you like to see improved?
3. Now that your intern is nearing the end of his/her master's work, how well prepared do you perceive your intern to be to assume the professional role? How comfortable are you with being associated with him/her in his/her future work?
4. What was your impression of clinical training by distance education prior to beginning your work with your Amridge intern? What is your impression now? To what do you attribute this change?

With each participant's knowledge and consent, each interview will be recorded and stored as a digital file on my computer for later analysis. The computer is password protected to prevent unauthorized access to these files.

The fifth phase of Creswell's data collection process is recording information. During this phase, which will take place during the middle of the Spring 2010 semester, the digital files of the interviews will be transcribed into an accurate Microsoft Word text for analysis. I will be assisted in this phase by Dr. Christopher Perry. Dr. Perry is familiar with qualitative analysis, having won a major award for a piece of qualitative research he did at Asbury Theological Seminary. While he is not an expert in the subject matter, he is familiar enough with qualitative research to understand the critical importance of an accurate typescript. He has also agreed to keep all of the interviews absolutely confidential. Both of us will listen to the digital recordings and read the typescript to be as sure as possible that the typed text is an accurate representation of the digital recording.

The sixth phase of the data collection process is resolving field issues. This phase should occur late in the Spring 2010 semester. I will contact each of the participants and review with them the initial coding of their comments to make sure I have accurately understood what they had to say. Should any questions arise about what was actually said (e.g., words which were not clear on the recording), I will ask those questions at the same time, and make any corrections or changes to the data on the spot. If necessary, I will make additional phone calls until this "member checking" (Murphy & Wright, 2005; Lincoln & Guba, 1985) shows that the data accurately reflects the lived experience of the person reporting the experience.

The final phase of data collection is data storage. Following successful completion of the "member checking" phase, the data, including the original digital voice recordings, the Word typescripts, the initial coding, and any memos (Creswell, 2007) generated during this process, will be stored in an external 1 terabyte (1,000 gigabytes, or 10^{12} bytes) hard drive. This hard drive is also password protected to ensure against unauthorized access. Storing duplicate copies of all data in an external hard drive ensures against data loss should anything happen to my primary computer. The original data will be stored in this safe location to be available even after this study is published for further analysis and possible future publications.

Phases of the Inquiry

So far, I have delineated the initial phases of the inquiry. The two phases that have not been delineated so far are the data analysis and publication of the results (Berg, 2004). Data analysis will begin concurrently with data collection (Dahl & Boss, 2005). However, the full, formal phenomenological analysis will take place during the Summer 2010 [April – August 2010] semester. I will describe the process I will use in the next section of this chapter.

The final phase is dissemination of the results. The publication of this dissertation will be the first step in making results available to others. After the dissertation is accepted as final and complete, I will attempt to publicize the results in peer-reviewed journals and at appropriate professional workshops so that other supervisors can benefit from this research.

The graphic below depicts the entire process, along with timelines for each phase of the process.

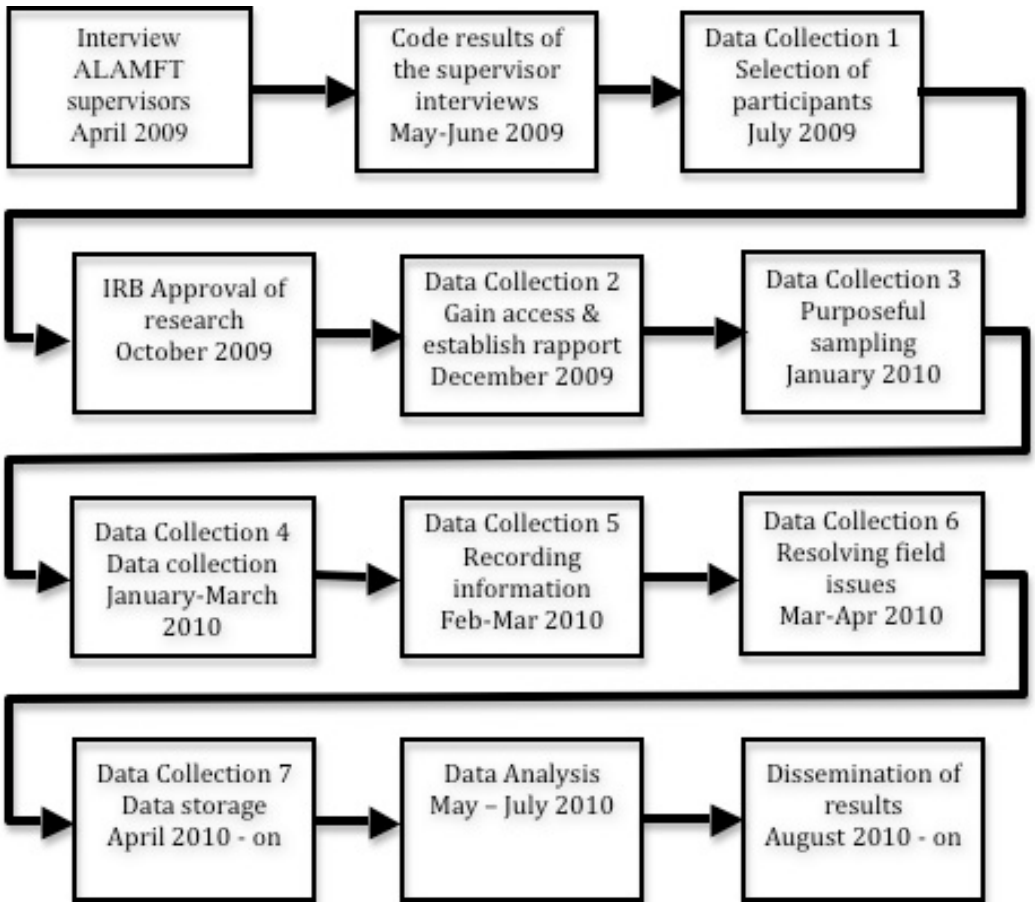


Figure 3-2 – Phases of the Inquiry

Data Analysis Procedure

The data analysis procedure in this investigation follows the classic standard for phenomenological research published by Giorgi (1985). The first step in the process is to "sense the whole," that is, to read the entire document through many times. Dr. Christopher Perry and I will perform this first part of the process concurrently with my conducting the interviews and

prior to doing any of the initial coding. Each of us will read the documents independently and make memos about impressions that emerge for our later use. This part of the process should be complete by March 2010.

The initial coding is the second step in the process. This is what Giorgi calls the "discrimination of the meaning units." Dr. Christopher Perry and I will independently code each interview and then discuss each interview to try to come to some shared understanding about what the participant is actually saying. At this point, each interview is treated independently. We are making no attempt yet to relate the various interviews.

To avoid imposing any meaning of our own on the data during the initial coding, we will use a form of "bracketing" of the data (Creswell, 2007). We will independently assign an arbitrary symbol to each statement that appears relevant to the investigation, without any attempt to name the meaning unit that the symbol represents. Other statements which appear similar will receive the same symbol, while statements that appear different will receive a new arbitrary symbol. Once the entire interview has been coded, then we will go back through and again independently group the similar symbols together to allow the statements grouped by symbol to name the various meaning units. As Dahl and Boss (2005) state, far from being problematic, the use of intuition in selecting which statement goes with which symbol is an asset for phenomenological research. The shared discussions about the meaning units come after the independent coding. If there are differences, we will again sort the data as necessary to allow new, and more comprehensive, meaning units to arise from the data.

Once this step is complete for a given interview, I will contact the participant for the "member check" to make sure that we heard the participant accurately and that the meaning units

we discovered do accurately reflect the participant's lived experience. This step should be complete by April 2010.

Once the initial member check is complete and we are confident that each individual coding is an accurate reflection of the participant's experience, we can begin step three in the process, which is the transformation of the participant's everyday experience into language which reflects a more general reality. This is Giorgi's third step. Once again, Dr. Christopher Perry and I will work together to allow the meaning units from the various interviews to suggest, via new arbitrary symbols, larger groupings. Once again, we will allow the larger groupings to name themselves, and once we have completed our individual data analysis, we will meet to discuss and resolve differences. As we did during the second step, we will allow the raw data to challenge each grouping until we are both satisfied that the general groupings account for all of the data.

The final step in the process is the synthesis of the results from the second coding into consistent statements of the structure of our learning. In other words, the final step provides answers to the research questions. While I will be the author of this synthesis, Dr. Christopher Perry will review my work to make sure it is indeed an accurate reflection of the entire learning, including any experiences which may not fit easily with the major themes. Only after we are both satisfied that the synthesis statements are accurate to the whole will I publish the results.

Trustworthiness

Trustworthiness in this study comes from multiple sources. First, my assistant and I will independently code the material for both the initial and the secondary coding. Meanings which arise will come from our independent analysis of the data, and from our joint discussions of our

results. The final coding at each stage will come from these joint discussions, and therefore will represent a socially constructed understanding of the experience of those I am interviewing.

A second source is the use of arbitrary symbols to "bracket" the data. By allowing the meaning units to name themselves, rather than naming a unit and then looking for "similar" units, we are taking steps to avoid imposing any meaning of our own. While our subjectivity will, of course, be part of the coding process, this should not unfairly bias the results. Using the arbitrary symbols helps ensure that is true.

A further trustworthiness source is the "member check" I will perform after the initial coding. Each participant must agree that the representation of his or her statements is accurate before we can use that coding for further analysis. If there are any disagreements, the participant's voice gets more highly privileged than our voices. It is, after all, the participant's experience, and he or she is the expert in his or her experience.

Yet another source of trustworthiness is our allowing the data to challenge our groupings and our meanings at each stage. Each meaning unit, both in the initial coding and in the final coding, will be subjected to the data as a whole to make sure it accurately reflects the whole. In this way we will be sure that the meaning units account for all of the data, especially those which appear unique and do not easily fit into other, more broad categories.

A final course of trustworthiness is the consensual agreement required for the final synthesis of learning statements. Throughout the entire process, there are at least two sets of eyes looking at all of the meanings and conclusions. This makes it more reasonable to believe that the conclusions are in fact an accurate representation of the participants in the study.

Figure 3-3, below, gives a graphic representation of the flow of the trustworthiness process in this study.

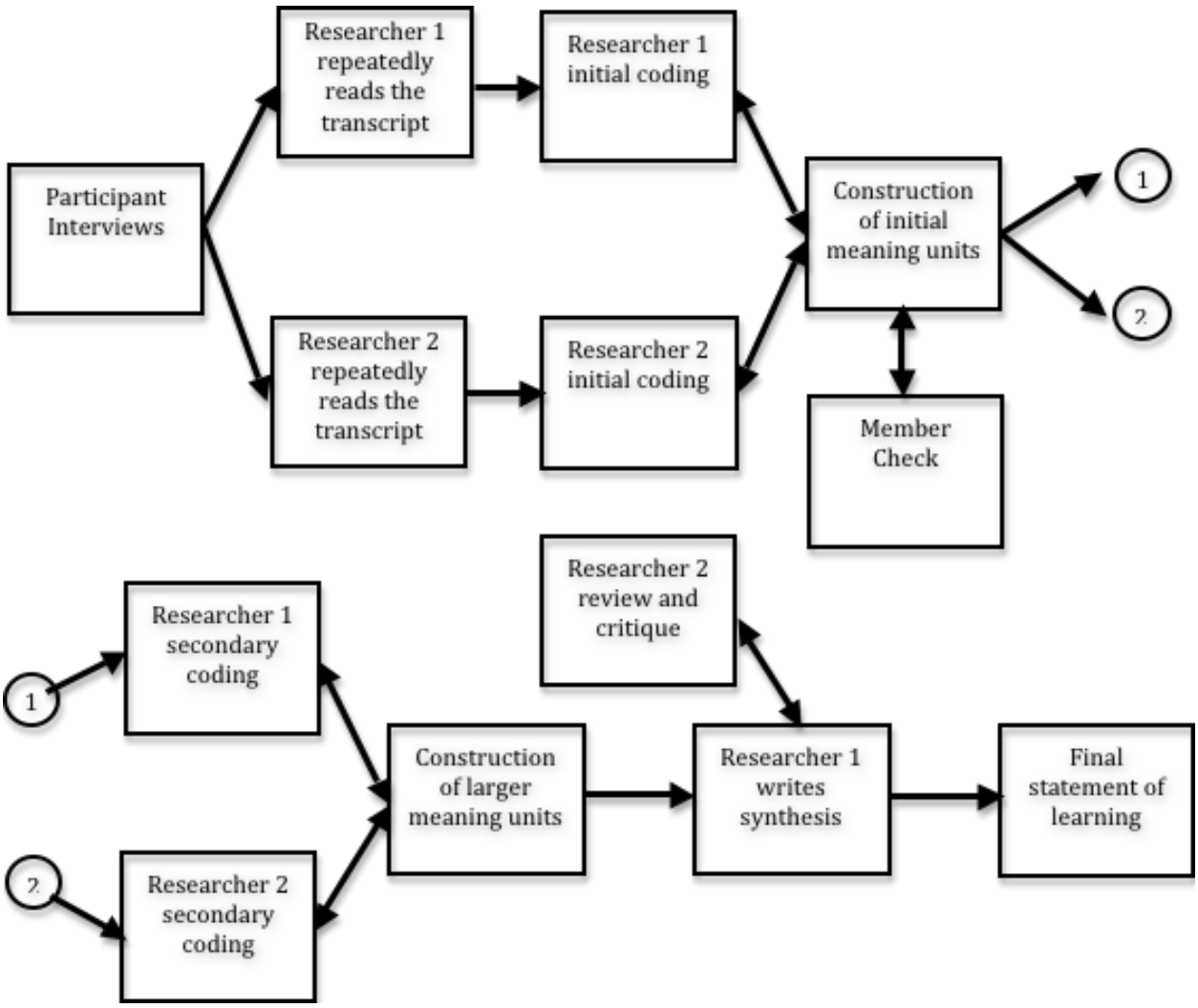


Figure 3-3 – Trustworthiness Process Employed

Chapter 4 – Results

The research plan presented in Chapter 3 did not work out quite as smoothly as I had originally hoped. Several of the students I anticipated would be available as potential participants did not, for various reasons, sign up for clinical training in the Spring 2010 semester. On the other hand, all of the students in that semester who met the defined criteria did in fact volunteer. The total number of student participants was nine. Two of the nine site supervisors were not able to participate in the interviews. One was on maternity leave, and her replacement did not feel comfortable commenting on the student's growth because he, the replacement supervisor, had not known the student long enough. The other supervisor said she was too busy to participate. I elected to go without these two supervisors, leaving me a total of seven supervisor interviews, and a grand total of 16 participants on which to base the results. This is well within the general guidelines given by Creswell (2007) of between five and 25 participants.

As it turned out, the seven supervisor interviews appeared to be sufficient, because by the seventh interview, I appeared to have reached "saturation" (Echevarria-Doan & Tubbs, 2005). That is, no new data were emerging from the supervisor interviews. Though the concept of "saturation" comes from Grounded Theory, the phenomenon seems to apply here, and therefore I do have confidence that the supervisor data accurately reflect the shared experience of the Amridge University site supervisors.

The rest of the process went exactly as described in Chapter 3. Each interview was recorded and then transcribed for analysis. After the initial analysis, I conducted member-check interviews to make sure I had accurately understood what the participants had to say. As a further measure to ensure trustworthiness, I submitted the raw transcribed data to Dr. Christopher

Perry for his analysis and we compared themes, just as planned. The results presented here come from that detailed process.

Brief Description of the Participants

To ensure the confidentiality of each participant, immediately after my initial interview I randomly assigned them an alphabetical identifier. I randomly assigned students to letters A through I, inclusive, and I randomly assigned supervisors to letters M through S, inclusive. The letter assigned has no connection with the person's name.

Students. There were three males and six females in the student group. They ranged in age from 26 to 61, with an average age of 34.8 years. Eight of the nine students were employed full time; only one person was a full time student. Subjectively, I would say this group is perhaps a little younger overall than many others with whom I have worked in the past, but the pattern of the majority being employed full time fits my subjective impression of the vast majority of master's degree students at Amridge University. All but one of the students fit the criteria for an Advanced student on the Basic Skills Evaluation Device (BSED), a rating scale devised by Thorena Nelson, Ph.D., and others, and used by many graduate programs in marriage and family therapy (Nelson, 1999). According to the BSED, to be an Advanced student the individual must have amassed at least 350 hours of client contact. The one student who did not meet those criteria was a senior Intermediate student (150 to 350 hours of client contact).

Student A is a 26 year old female from Alabama. Prior to entering Amridge University she had been a case manager for a community mental health agency and she continued to work as a case manager there while doing her clinical training. The same career pattern fit Student B, a 27 year old female, who is a children's case manager from Mississippi. Student C is also 27 and also female. She is from Alabama and has worked as a bachelor's level substance abuse

counselor for several years. Student D is a minister from West Virginia, the only minister in our clinical training cohort. He is 33. Student E is from Alabama and is one of the few to not work in a field related to behavioral sciences. She is 43 and works as a manager for a city public transportation agency. Similarly Student F works as a supervisor for United Parcel Service (UPS). He is 34 and lives in Alabama. Student G is the one person who has never been employed full time. She is 32, lives in Pennsylvania, and considers herself a full time student. She is the only person in this cohort to go from bachelor's degree to master's degree with no break in between. She is also the only person who came to Amridge University after completing the majority of her didactic work in another university. Student H is our third case manager. She is 30 and lives in Kentucky. She started doing her clinical work at the same homeless shelter where she was a case manager, but very quickly shifted to a different facility to keep the job responsibilities more clear. Finally, Student I is a 61 year old male school teacher from Georgia. He has taught high school for most of his adult life.

The following table summarizes the student participants:

Background of Amridge Clinical Training Students Participating in Research			
Student	Age	Gender	Prior Occupation
A	26	F	Case manager
B	27	F	Case manager
C	27	F	Substance abuse counselor
D	33	M	Minister
E	43	F	Manager, Public transportation
F	34	M	UPS supervisor
G	32	F	Full time student (never employed)
H	30	F	Case manager
I	61	M	School teacher

Table 4-1 – Students Participating in Research

Supervisors. The site supervisors of the Amridge clinical training students are, from my subjective impression, typical of the supervisors we have employed in the past. In keeping with

the requirements of many license boards, we insist that all of our site supervisors have at least 5 years of experience as a licensed mental health professional in order to supervise our students. This floor of experience is one way we attempt to ensure quality for our students. In this particular cohort, our supervisors ranged in years of licensed clinical experience from 5, the bare minimum we accept, to 30, with a mean of 17.1 years of clinical experience. When it came to experience as a supervisor, one had no prior experience. The most senior supervisor had 20 years experience as a supervisor. As a group, the site supervisors averaged 12.3 years of experience as a site supervisor. Four of the supervisors were licensed as professional counselors, two were licensed as marriage and family therapists, and one was licensed as a psychologist.

To keep the identities as confidential as possible, I will not give the state of residence of the supervisors, as that would allow a relatively easy match with the respective student. Suffice it to say that each supervisor lives in the same state and in the same general area of that state as the student he or she supervises. Table 4-2 summarizes the supervisor data.

Background of Amridge Clinical Training Supervisors			
Supervisor	Yrs. Clinical Experience.	Yrs. Supervision Experience.	License
M	30	25	LPC
N	5	0	LPC
O	10	15	LPC
P	25	20	LMFT
Q	20	11	Psyc.
R	15	7	LMFT
S	15	8	LPC

Table 4-2 – Supervisors Participating in Research

Themes That Emerged From Interviews

Prior to doing any analysis, I listed to the audio recordings of the interviews several times to get familiar with both the overt content and the potential meta-messages which could be conveyed by tone of voice. Following this, Dr. Christopher Perry and I independently engaged in

a thick reading (Giorgi, 1985) of the transcribed interviews. Satisfied I was familiar with what was actually said, I began coding the interviews according to the process outlined in Chapter 3. That is, I assigned random symbols to each statement which appeared to represent a significant phenomenon for the student or supervisor. Within each interview I allowed these symbols to name themselves. Dr. Christopher Perry independently followed the same process. We then met to compare our results and work out any differences. We found very few differences in the phenomena we coded. Only after we resolved these and were satisfied we had identified the meaning units within each interview did we, again independently, use a coding process to transform the meaning units into a consistent statement of our learning. We once again compared notes and found very few differences. After resolving those few, we arrived at the results presented here. In all of the exemplars I present below, I inserted bracketed words or phrases to either replace potentially identifying material and thus maintain confidentiality, or to make the person's statement more clear by giving a little context.

Student Meaning Units. One source of professional identity (i.e., one meaning unit) for students came from their background. Each of the persons interviewed talked about how their background had impacted them. For some this was a positive impact. Others found it was a negative impact, while still others found their background presented a mixed impact, both positive and negative. One example of the mixed impact was Student G, who said:

> …what I was able to bring to the table most at that time [at the start of Practicum] was the fact that I had had my own counseling and I thought that had taught me a lot. But, I can't say that my [prior academic] program did a very good job in preparing me to be a counselor.

Student G also listed her undergraduate program as an asset that helped her construct her professional identity. Student F had a similar experience. In fact, for him it was his experience of

having been in personal therapy that prompted his desire to become a marriage and family therapist.

> On a scale of 1 to 10, with 10 being I was totally comfortable, I'd say I was about a 2 or a 3 [when I started Practicum].
> Previous counseling experience, as the counselee, not the counselor. Kind of knowing what the setting was. Understanding a little about the structure. Just knowing the…going through…talking to people at church, having a few people bring you a problem. Just life experience. Mostly previous counseling experience…going through the whole experience. Had I not done that I probably would have been about a 0.

Others found their background a more positive impact on their clinical work. For example, Student B stated:

> I think it was pretty clear because the job I had already been working in. So, when I switched over to professional counselor I already had some type of background.

Student I, like Student E, found one major source of positive impact in his work in his local church:

> I decided to do marriage and family as opposed to LP [professional counseling] because we get a lot of calls at church from families who come in with different problems. ….So I really wanted to be a family therapist because I feel that's the background of our society. So I had a pretty good idea of what I did…what I wanted to do and what I wanted to try to do when I came into practicum.

On the other hand, others found their background got in the way of their current clinical work. Student E, who had no prior experience in the counseling field, said:

> Not clear at all. . I don't know how to explain it other than I was not sure how I would fit into the counseling realm.

Student H had worked in the field as a case manager and found that prior experience got in the way of her new learning.

> When I first started, that was kind of hard for me to conceptualize, I think. So, now I find myself talking a lot more…actually I find myself listening a lot more and using a lot of reflection and treating the person as if they…treating

> them with dignity and respect and using that as my model of therapy instead of trying to fix something or find a solution. And that seems a lot more fitting to me so I feel more comfortable. But I also see more the difference in me as a therapist and me as a case manager. When I started none of that really made sense to me.

A second meaning unit came from two students – the necessity of clinical exposure. Although several students implied that clinical exposure is necessary, only Students A and B stated so explicitly. Student A said:

> I still have limited hours…very limited experience with performing that identity so it's really kind of hindering that development.
> It's a slow process with the restraints I have on being able to get my hours, not the exposure to it that I would like to have…the constant exposure…but every day, every session I've had I've gotten a little more confident.

As she implies, Student A is the one student who is still a senior Intermediate student according to the BSED standards. Student B, an Advanced student (according to the BSED), stated:

> I think the most helpful is the experience in the room…with the face-to-face client contact. The pressure of that has molded me the most.

All of the students agreed that the site supervisor, and specifically their relationship with the site supervisor, is an essential part of their growing identity. This is the third meaning unit. Student C stated:

> And also I've really enjoyed working with my site supervisor because during my practicum, I didn't have that much contact with LPCs…. So, actually, working with LPCs, you know, someone who has really been trained and has the proper credentials, has really helped me out a lot.

Student D credited not only the site supervisor but also the entire staff at the facility:

> The staff here treats me very well. They've been very educational, helped me with numerous confidences and personal growth, and how to handle various situations. They have not treated me like an intern. They've treated me like they were training me for something.

Student F was even more explicit about the importance of the supervisor. He rated his growth in professional identity from "a 2 or 3" [on a 10 point scale] at the beginning of Practicum to his current "8. Maybe 8 ½" as coming primarily from his site supervisor.

> I would say the dominant factor would be [my site supervisor] and my experience there at the counseling center. …knowing that he's [my supervisor] got my back, being in session and being able to call on him when I get stuck. I'd say the structure of the therapy was probably the practicum. I couldn't get much help [before practicum] with how to set up the room, confidentiality, things like that. That what I was scared of the most. How to structure the whole thing.

The importance of the clinical training class itself formed a fourth meaning unit. This is significant since this is the distinctly distance-learning part of the clinical training process. As described in Chapter 1, the work at the clinical site and with the site supervisor are very traditional, that is, requires the kind of in-the-same-room contact which has always been the norm since the days of Freud. Students found the class itself helpful in several ways. Some students found that the class added breadth and depth to the relationship they had already established with their site supervisor. For example, Student B stated:

> Really, I think the presentations [in class] helped me and just having other people give thoughts on how they interpreted my work with the clients was going and then also giving me different notes on how to do things. Like my supervisor would tell me…she would provide me with different ways to do things and it helped getting other outside information. I really think the presentations and feedback from you and other people in the class helped.

Student C echoed that sentiment:

> I enjoyed [clinical training] class because we did the one-on-one and got the private feedback from you as well as the classmates in class…. I'm planning to move out of state and knowing what other programs, how other people work and their requirements and stuff…it has been helpful [to me] because I have talked to a lot of classmates that have lived out of state and it's a wonderful experience at Amridge.

Student E expressed special appreciation for the multicultural emphasis that is always implicit and often explicit in the variety of student presentations.

> I believe that I would not have known so much how tribal counseling…or dealing with Indian cultures is different, or Hispanic, if I had not had those folks doing those things in class with me. I really don't think you'd get that in [my city] for sure because we don't have such a big cultural interaction with other cultures so much here.

Student F especially appreciated the freedom to explore and develop his identity in ways that best fit him, rather than having to conform to outside constraints.

> The best part of the clinicals, the practicum, was, to me, the freedom to explore. The best example, to me, would be like a securely attached child who wanders about the room exploring his environment versus an insecure child who stands by his mother because he's afraid. I feel like now I'm not afraid at all. I could walk into any setting. We had that freedom to kind of reach out there and no body was telling us this is what we had to do. It gave me the flexibility to do something that I was comfortable with and then also the flexibility to shift, mid-stream.

Student G expressed a similar appreciation, and she went on to state, along with Student I, an appreciation for the ability to interact with professors both in and outside of the clinical training class.

> I would say the most helpful is the fact that this course has been kind of self-directed in terms of creating the learning goals. That's been really, really motivating to me. It's helped me feel like instead of I was being watched I could challenge myself more. And it really just motivated me to do lots of reading and research…to learn how to apply things more….
> And then I would say, second to that would be…just…certainly a lot of the things you…your availability to be able to answer questions and things like that…that I had as I was going through that process. That was really, helpful because I felt that you were able to answer some questions that my site supervisor...it's not necessarily that he couldn't but you were able to answer them in a different way. That was really helpful to me. And then I really appreciated the fact that we were able to read other students' verbatims which worked from…a lot of them were from very different places or contexts compared to where I'm counseling at. So that has been very helpful and eye opening as well.

While all of the students affirmed the clinical training class was important, and all expressed a desire for more interaction with their fellow students, two students, D and I, did express one concern. Both said they were at times frustrated when their fellow students were not as well prepared as they were, or when their fellow students only appeared to be trying to impress the professor. For example, Student I said:

> When it's pretty obvious that either they [Student I classmates] are not prepared or poorly prepared…when we're in the second or third presentation and they still haven't figured out…[how to follow the prescribed class format].

Student D was a little more cautious in his criticism.

> …if I had to put one [thing as] least [helpful], and that does not mean that this was a negative experience or anything like that, I think sometimes in our clinical class we have a mixture of students, some who come with personal confidence and some who lack it…I think at times there are occasionally opportunities for students to…to take advantage of the situation…to try to…almost impress the professor while taking advantage or manipulating another student. Almost like, let me show the professor how much knowledge I have, and I've found that to be a little discouraging.

A fifth meaning unit was the importance of clinical skills. While all of the students implied this in their interviews, a few made that source of meaning explicit. Student I said:

> It was really…what I had a theory was real good until I started putting it into practice. It became a whole new ballgame…. But I'm learning how to work the different theories and put them into practice. I will work more than one theory because I know from experience that one size never fits everybody.

Student A phrased her experience this way:

> [Cases in the clinical class] lets you know from folks doing this that your cases aren't the strangest out there, that other people are dealing with the same type stuff, and other ones who are new at this are dealing with it as well.

Student C, who had experience as a substance abuse counselor prior to starting her Practicum at Amridge, said:

> It has been a tremendous help going through practicum and clinicals. I've been able to use different therapies with the guys and see what works best in the field of counseling…solution focused therapy was the only therapy I could use with them [prior to practicum] but now I'm beginning to use more therapies, more therapies with the guys…. It has been a tremendous help.

Student D was even more explicit:

> The clinical class has helped me to fine tune what I need to be doing, who I am, what my role is. Interacting with the other students has also helped me. I think we've discussed before…I know we have…my difficulties in focusing in on what specific therapy and not drifting out of that therapy. I kind of thought I was the only one having this problem. Then my interaction with peers outside of the classroom and inside the classroom during our clinical Monday nights has really helped me to hone myself and focus on what's really important.

For all of these, it was the actual doing of the clinical work, in a context which allowed the student to experience others doing a similar but not identical work that was most formative.

Finally, the sixth meaning unit was the clear guidelines. Students found that having clear expectations helped them know if they were on track or not. Student C talked about her experience helping a Practicum student from a different university program:

> Amridge has it all laid out and others are on their own…. [I had to help a friend in another program] try to figure out what all would go here, what would go there.

Student D reported compliments from his site supervisor and others at his site:

> Based on what my supervisor and others have told me, they would rate it, in their own words, as a superior education. They have been very impressed with the way I was prepared to be a professional, to conduct myself in a professional manner, the knowledge and understand I have of the various therapies….. Most people I have talked to have recognized the quality that I received at Amridge.

In summary, the nine student interviews produced six meaning units, and there was a great deal of similarity of experienced reported. Table 4-3, below, summarizes these meaning units.

Meaning Unit	Subheading	Students Affirming This Meaning Unit
Student Background	Mixed bag	A, G, H
	An asset	B, I
	Didactic work necessary preparation	C, D, E, F, G, H
	No prior experience in the field a minus	E
	Own personal therapy a plus	F, G
Clinical exposure	Necessary for growth in identity	A, B
Importance of the site supervisor		A, B, C, D, E, F, G, H, I
Importance of the clinical training class	Adds depth & breadth to relationship with supervisor	A, B, C, D, E, F, G, H, I
	A minus when other students are not well prepared	D, I
	Multicultural emphasis	D, E, G
	Freedom to find what fits	F, G
	Ability to interact with professors in and out of class	G, I
Importance of clinical skills	Practical focus of the program	A, G, I
	Working with others of same license	C

Table 4-3 – Student Meaning Units

As planned, I conducted the member check interviews with the students. In doing so, I emailed them the quotes I planned to use from their conversation and the meaning units I saw in those quotes prior to the conversation. They only saw the information on their particular interview. Then at the appointed time, I telephoned them and discussed the findings. The students' responses ranged from "you're right on" to "amazingly accurate" to "that's it. That's what I said." Despite my probes, none of the students offered any corrections or changes to the data. A few offered amplification of their points, but nothing that changed or contradicted my findings in any way. Thus, the member check interviews gave good confidence in the trustworthiness of my findings.

Supervisor Meaning Units. Understandably, the supervisors had a slightly different construction of reality than the students. One of the areas of basic agreement was the importance of good didactic preparation for clinical work. This was the first of the supervisors' meaning units. Supervisor M stated that his student's "development has tracked right along where it should be." This is significant because this supervisor has supervised interns from two very traditional programs in the Southeast. Supervisor N was even more complimentary of her intern. She stated:

> Well, I guess what impressed me most is his knowledge base of counseling already…his education as far as theory and knowledge of what techniques were, as far as defining them and tell me what things were. Not necessarily show me what they were yet, but being knowledgeable and educated about the counseling profession and mental health in general.

Supervisor P expressed a similar experience.

> But, but one of the things that I have been impressed with with the Amridge Students…and even [one of my co-workers] has said the same thing with the students he's supervised…that you guys get some really sharp folks. They're very intelligent. They've got a lot of book learning. They have a good foundation.

Supervisor R framed his opinions in terms of his own personal preparation for licensure:

> So I would say, based on my comparison, I know they [Amridge student interns] are average, and they are probably a little above where I was. I consider myself average so I'd say Amridge is better at preparing students.

It seems reasonable to say from this meaning unit that supervisors were expecting to find a certain level of academic background, and their standard of comparison was either their own personal preparation or students they had supervised from other universities. Either way, the supervisors interviewed found the Amridge students met the expectations in that area.

The second meaning unit for the supervisors was the importance of the clinical skills. Three of the supervisors expressed concerns about where students were in their practical skills

prior to beginning clinical training. Yet they also expressed confidence in the students' growth during the time they were in clinical training. For example, Supervisor P said:

> When you begin to frame yourself as a therapist you're taking on a different persona, so to speak, and I think he struggled with that. But I think he's turned around a whole lot and he's very professional…. He's having to learn his role as a therapist and what that means. And I think he's really made some great strides in that. I'm really impressed with him…his growth in that area.

Supervisor Q stated about his intern:

> I think what's been helpful for her, that we wanted to see, is that's she's a bit more conscientious and deliberate in terms of thinking about the why behind the what of what she does…. With [my intern], the fact that she has had to write out for herself her theoretical constructs that informed her treatment of patients [for the class presentations]. Justification for her diagnostic impressions. There are things that in group supervision and in individual supervision, we do talk about in the group as well…I think having to write that out for herself and in terms of the related reading and research in treating of patients I think have been helpful. I think the fact that she has to prepare materials to present to her classmates or supervisor in her online course, I think have contributed…. I think the very part of having to present her materials to peers forces her to take some ownership of that at a more conscientious level.

Supervisor N framed this in terms of the variety of clinical experiences that Amridge students have because of their clinical classes. Like all of the supervisors, Supervisor N had not discussed this at any length with her student, so she only knew a little about what happens in the class. Even so, she stated:

> I was just thinking how wonderful an experience that would be to say…I'm not originally from [this state]. I grew up outside of Philadelphia, and so that culture and that experience that I had there…when I came to [this state], which is rural, helped me understand a little bit and then give my perception of more of a city kind of perspective. And I thought that would be kind of neat to be in class and discuss [Student D]'s experience of rural poverty, with some poverty, a lot of poverty, with somebody who maybe is doing their clinical experience in, like, either a suburb of a city, that's more wealthy.

The third meaning unit was closely related – the advantage of using standardized forms and guidelines. Supervisor M was supervising an intern toward becoming a professional counselor, and expressed appreciation for finding the CACREP standards in the Amridge clinical training handbook. He specifically stated his appreciation for the BSED to help him know what skills to look for, and to be able to objectively rate his intern's growth. Other supervisors expressed similar appreciation for Amridge University's use of the BSED. For example, Supervisor N said:

> The one thing I do have to say—that evaluation system that you have for him…my mind is blank, I can't remember exactly the name of it. (WP: The BSED?) Yes. That is fantastic and I have not seen that before. And I am just thrilled that that has become a part of how I evaluate him. Because that, to me, I think should be standard for evaluations for students. I think that's just wonderful.

This leads to a fourth meaning unit – the importance of interpersonal relationships. Supervisor O expressed a sentiment that several other supervisors expressed:

> The disadvantage [of distance learning] is that you go by the…you're not able to talk with a person face-to-face and the real feel for what it is they are saying and meaning as opposed to sitting in a classroom and…you don't have the exposure of the other peoples' feedback, like you would like to even though you're going to the little chat rooms and discuss that.

Supervisor O, like others expressing the same idea, appears to assume that "online" still means text-based and seemed unaware that our students do in fact see each other and the professor via webcam each class period.

Even those who were aware of the changes in technology still stressed the importance of interpersonal relationships. Supervisor Q expressed a desire for more relationships with other supervisors:

> Conceivably, there could be perhaps a week or a time wherein when possible maybe supervisors could interact in a forum format. Perhaps share ideas or talk about what they have learned or talk so we can form those relationships.

> …to me there's a larger community of supervisors out there and so in theory I think the benefits of a running conversation with other supervisors would be helpful so you learn more about other trainees in different settings and I guess it builds community.

Supervisor R expressed a similar wish, as did Supervisor S:

> A phone call, connecting…I value the face-to-face, sit down and talk about what's going on. In lieu of that, a phone call. Hey, thanks for being a site supervisor. What can we do to help you as a site supervisor? What can we do to help you get on board with what we want to do at Amridge? Maybe a phone conversation so we could have the dialog, come to an understanding…maybe then it would occur to me to think about Amridge as being a support system for the work that I'm doing as a supervisor.

All of the supervisors expressed the importance of staying connected with the university. Most of them agreed that the communication with Amridge has been good, but it could be better. Supervisor N made that very explicit:

> Your emails have been very straight forward and very open: "Please email me if you have any questions or comments." Which is helpful. I don't get that from the other site supervisors, necessarily. The one thing that do kind of wish that we did have is some time actually to talk on the phone briefly about how he's doing. Or, maybe once or twice during the experience the three of us sit down and talk on the phone or somehow connect with the three of us and share a little bit about the experience or any questions he may have, or the student may have. Just a little bit more contact.

Supervisor R took some personal responsibility for making the communication with the university better. He said the communication from the university "I would rate as good. It could be better by my own initiative." Yet all of the supervisors who expressed this desire for better contact with the university also acknowledged the already-present demands on their time, and therefore the difficulty of finding a time to participate in such conversations if they were available. Supervisor M and R both used nearly identical words in expressing this tension: "For me, and at the same time it would be rather inconvenient, I interact better face-to-face." Supervisor S expressed a similar concern. He said:

> I guess things are done through emails, and maybe for all the people that works well. For me, it doesn't. A phone call, connecting…I value the face-to-face, sit down and talk about what's going on. In lieu of that, a phone call…. setting up a meeting schedule, it's one thing to add to the schedule. It's one more thing for me to forget. It's just…I don't do very well with those thing. But, to call and talk like this…this works very well.

Interestingly, none of the supervisors talked about their relationship with their trainee as being significant to the trainee. I could speculate possible reasons for that, but for now, I can only note that as an interesting omission from the conversation.

Perhaps the closest they came to talking about their impact on the student was the fifth meaning unit. This was what has traditionally been called "self-of-therapist" work (Aponte, 1994). Two of the supervisors explicitly stated that this was a major focus in their supervision of their interns. For example, speaking of his intern, Supervisor S said,

> However, she didn't…she didn't value what she knew. That was my sense when we began and that has been part of my work with her. Helping her to value what it is she's bringing to the process out of her own experience and not just in terms of what she's read about what other people have said about how to do counseling but what she brings to the process out of her own experience and to find a way to express…to value, to appreciate, to honor, to express what she knows from her own experience and background in the work that she's been doing.

Supervisor R expressed the same basic concern:

> Some things that, I guess, concerned me that may be applicable to the research you're doing…There doesn't seem to be as much self-care with [my supervisee] as someone I would expect to see who is attending school through an institution—missing the camaraderie, the support, the interaction with other students. And it concerns me about her individual self care…just the need for daily encouragement.

Supervisor P described some spontaneous enactments (to use the Structural Therapy language in which Supervisor P is well versed) of events at the counseling center to help his intern consciously develop a more professional attitude. Other supervisors were more indirect in

expressing the importance of who the intern is. Supervisor O talked about her intern's professionalism and desire to learn:

> …in comparison to others….She had more of an eagerness to learn more about the field and what it detailed.... Her personality is that of a professional, anyway. She's very professional and she's bringing with her from her own repertoire, her own professionalism, and she's learned over the years how to be a professional, how to approach people, and how to identify with and connect to people…so her own personal identity which she has developed over the course of a lifetime is exhibited in her own behaviors.

Supervisor Q talked about his intern's "mindfulness" as it showed in relationships with clients:

> …I think there are certainly no demerits in what [my intern] has done going through your training. In many ways she's certainly a more ambitious, more conscientious, more mindful…I don't know if I like the word mindful, but she's a bit more in the moment and conscientious with her patients and I think that's obviously partly from what this experience has given to her.

This emphasis on the "self-of-the-therapist" certainly fits with the dominant paradigm of this dissertation. I will make that connection more explicit in Chapter 5.

In summary, there were five major meaning units from the interviews with supervisors. Table 4-4 shows the meaning units, along with the supervisors whose interview supported that meaning unit.

Meaning Unit	Subheading	Supervisors Affirming Meaning Unit
Importance of good didactic background		M, N, P, Q, R
Importance of clinical skills	A primary focus of supervision	M, N
	Concerns about skill levels prior to beginning Practicum	P, Q, R
Importance of using standardized forms		M, N
Importance of interpersonal relationships	Necessity of in-person contact during supervision	O, S
	Desire for more contact with other supervisors	M, N, O, Q, R, S
	Desire for better contact with the university	M, N, O, Q, R, S

Meaning Unit	Subheading	Supervisors Affirming Meaning Unit
Importance of "self-of-therapist" work	A major direct focus of supervision	R, S
	Important component in the supervision	O, P, Q

Table 4-4 – Supervisors' Meaning Units

The Structure of the Learning.

The final step in the phenomenological analysis process is to state the structure of the learning in everyday terms (Giorgi, 1985). I will save an analysis of how these learning statements respond to the research questions for Chapter 5 of this document. For now, there are three primary lessons learned from this research.

The first lesson is that professional identity is constructed from peer relationships. Based on the interviews, this is true for both students and for supervisors. Both groups talked about the importance of interacting with peers. Both groups expressed a desire to do so more than they are currently able to do. Given the time demands on both groups, this is a significant statement. Despite the difficulties both groups acknowledged, they value interaction with others. One of the significant differences in the two groups is the way they are able to use the Internet to construct those peer relationships. While I will reserve a more detailed analysis of this fact for Chapter 5, for now it is worth noting that the students, at least, are able to construct relationships via Internet resources and are very creative in doing so. Even supervisors, however, strongly and consistently expressed a desire for more contact with their supervisor peers. This finding supports the social constructionist and Adlerian philosophical underpinnings of this research.

The second lesson is that professional identity is constructed through relationships with significant others. Again, this applies to both students and supervisors, though the "significant others" differs between the groups. Students by a very wide margin found the "significant other"

was the site supervisor. Overwhelmingly, the students cited the site supervisor as the single most significant factor in their developing professional identity. There were multiple facets to this relationship for the students. For some it was the direct mentoring in skills. For others, it was the more indirect mentoring of actually working with someone who already does for a living what the student was training to do. Less frequently cited, the "significant other" was also the clinical class instructor. Students saw this relationship as expanding and broadening the relationship they defined as primary, the relationship with their site supervisor. Nevertheless, this relationship with the clinical training instructor was a vital part of a significant number of the students' construction of their professional identity.

For supervisors, the "significant other" was the university. Supervisors repeatedly talked about how important the emails and other communications the university had with them were to them. Several expressed appreciation for the website dedicated specifically for the site supervisors. Most expressed regret that they had not done a better job of taking advantage of the resources that the university has provided. All expressed a desire for even more connection with the university, usually through a phone call rather than an online conference, though a few were open to that web-based option. Several supervisors explicitly stated that the connection with the university helped them to not feel isolated. They were part of something, not just an individual doing what they always do, and that was important to their identity as a site supervisor for Amridge University.

This second learning once again supports the social constructionist and Adlerian underpinnings of this research. The process by which professional identity is constructed in a distance learning environment includes constructing meaningful relationships with peers and with significant others.

The third learning is that professional identity is constructed from doing professional things. Students and supervisors alike cited the importance of actually doing clinical work, as opposed to just taking didactic courses, for forming their identity as a professional. Both students and supervisors talked about their work. Obviously, their roles in the process of clinical training are different, but both found doing their role a significant source of their identity. At the same time, both students and supervisors acknowledged that the student's background forms a noteworthy variable in the students' ability to do clinical work. Identity is not constructed in a vacuum. For some students, their background was an asset, and their supervisors acknowledged it as such. For other students, their background was a deficit, and their supervisors also pointed that out. Several of the supervisors were so convinced of the importance of the student's background as a variable that they explicitly focused on "self-of-therapist" work with their trainee. Student interns of those supervisors commented on that focus with appreciation. For both supervisors and students, however, the focus of this learning was always on more effectively doing clinical work, i.e., professional things.

Only one student directly commented on the importance of the staff of the clinical training facility, but that is also worth noting. This student unambiguously cited the staff's including him in staff meetings, professional development activities, and other aspects of the site's daily activities as important. Thus, while therapy skills was a primary focus of all of the conversations about "professional things," at least one person found that being included in other professional activities was also central to his constructing his professional identity.

The findings here supported several of the criteria for effective postmodern supervision cited by Ungar (2006). Relationships are a primary vehicle for identity construction, just as he proposed. Secondly, the multicultural emphasis available uniquely through a distance learning

environment is vital and appreciated by both students and supervisors. Two of the students overtly cited the questioning style of both the clinical training instructor and their respective site supervisors as helpful to their constructing their own meaning. Other students explicitly cited their freedom to construct their own learning goals in the class and to explore their own "best" way as vital to their professional identity. What remains is a detailed analysis of what all of this means in terms of the goals of this research.

Chapter 5 – Analysis and Conclusions

Through the review of the literature and the examination of the phenomenological material, this document has presented a multiplicity of data regarding the construction of a professional identity in an online program for marriage and family therapy, and professional counseling interns. This chapter will attempt to pull all of these elements together into a coherent statement of learning.

Data Analysis

The research presented here began with three research questions (see Chapter 1):

- Research Question One: What is the phenomenological experience of the students involved in the clinical training process at Amridge University? Do the students engaged in the process find it helpful? Do they find that the purported benefits translate into actual benefits in their, the students', own experience? How well prepared and trained do they feel compared to other student interns they encounter?
- Research Question Two: What is the phenomenological experience of the site supervisors of students involved with student interns at Amridge University? How well prepared do these supervisors perceive the Amridge students compared to other student interns these supervisors have known and/or supervised? How helpful do the supervisors perceive the connections with Amridge University to be, especially given the issues of distance and even time zones?
- Research Question Three: What phenomenological evidences of growth in professional identity are evident as a result of this process? To what degree do student interns perceive themselves as more competent, more "at home", in their chosen profession? To what degree do they attribute the Amridge University clinical training process a help to that

growth? To what degree do supervisors perceive their student interns have grown in their identity as mental health professionals?

Research Question One. The data suggest that the answer to Research Question One is that the students at Amridge University experience the clinical training class to be a very helpful way of constructing their growing identity as either a marriage and family therapist or a professional counselor. Despite the fact that most of these students have never been in the same physical classroom with each other, they report experiencing a connection with their classmates and with their clinical training professor, and this connection is one of the primary vehicles for constructing their professional identity. In other words, they experience their identity as being socially constructed, with multiple components of that social construction. In fact, it is the very multifactoral nature of the experience that students report as being so helpful.

A prime example of that multifactoral nature is the variety of placements in which Amridge students do their clinical training, with the resulting diversity in the demographic and diagnostic data for the clients with whom students work. This "practical multiculturalism," as I frequently label it in the clinical training classes, is one of the advantages the Amridge University clinical training program has alleged for its way of doing clinical training since its inception. The students' experience now validates that contention. Though the students are clear that interactions at their specific site are highly significant for them, they also claim the vicarious clinical experience through case presentations in the clinical training class to be very helpful in their identity as a competent mental health professional.

This is significant because most of the students interviewed reported having friends attending more traditional degree programs in other universities. When the Amridge students compared themselves and their experience with those in the more traditional, in-the-classroom,

students they knew, universally they experienced themselves as at least as well prepared as the other students they knew. Several of the Amridge students even reported experiencing their clinical training as superior to what other students received at more traditional programs. Whether this is objectively true or not, and if so if there is any sort of statistical significance between clinical training as provided online at Amridge University and as provided in more traditional programs, are questions which will have to await a different study. For the purposes of this current study, the clear answer to Research Question One is that Amridge University students perceive themselves as receiving at least as good a clinical training and having at least as solid a professional identity as students they know at other, more traditional universities.

Research Question Two. Of course, Amridge University students, like students at any other university, have only a small base of practical knowledge from which to analyze their experience. That is why the phenomenological assessment of the supervisors is so important. As shown in Chapter 4, the site supervisors in this study averaged 17.1 years of clinical experience, and 12.3 years of supervisory experience. All but one, the one for whom being a supervisor was a new role, reported having worked with students from other universities, as well as graduates from other universities who were working toward licensure. It seems reasonable to conclude from these facts that they would have a broader base from which to understand and compare their work with the Amridge University clinical training program.

Given that conclusion, it is significant that all seven of the supervisors experienced the Amridge University students as at least as competent and well-prepared as other students with whom they have worked. In other words, there was a high degree of similarity between the self-assessment of the students involved in clinical training and the assessment of their respective site supervisors. That is all the more significant because the nine students who participated were

from six different states, and only two of the nine were from the same city. Supervisors looking at students in different sites in different states came up with a very similar kind of phenomenological assessment. While the supervisors did express a few questions and even fewer reservations about the process, none of the supervisors experienced the Amridge University student with whom they were working as being in any way at a disadvantage due to receiving their didactic and clinical training through a distance learning format.

The questions the supervisors had were about "distance education" in general, and not about their particular experience with this particular sample of a product of distance education. Most of the questions appeared to come from an outdated understanding of what distance education involves (i.e., assuming it is purely asynchronous and/or purely text-based). Some came from a basic discomfort with the technology and a preference for in-person meeting. I will spend more time offering a possible interpretation of these questions in the next section of this chapter. It is interesting, however, that even Supervisor O, the one who was most negative toward distance learning as an educational delivery system, was very positive about her experience of her trainee from Amridge University. So, when supervisors considered their phenomenological experience of working with an Amridge University student and Amridge University's distance learning format, they were convinced that their trainee was at least on par with other students from other, more traditional clinical training programs. It was only when they started thinking in the more abstract, conceptual terms that their questions about "distance learning" appeared.

A few of the concerns of the supervisors were well taken. Even though they did not know that technology currently allows us to do precisely what they were suggesting, they did suggest that we offer more role plays and more practice therapy sessions before the student

actually enters practicum. Supervisor P, for example, reflecting on his own experience as a student, stated he was more comfortable at the start of his Practicum than he experienced the two Amridge University students he has supervised as a result of his having role plays on doing therapy, conducting intake interviews, etc., in his didactic classes. While he readily agreed that the Amridge students not only caught up with but actually surpassed students he has worked with from other universities, he believed that allowing pre-practicum hands-on practice would allow for not so steep a learning curve. Given the state of the Internet and the webcam-based interface that many universities currently use, Supervisor P's suggestion could be easily implemented in many of the didactic classes.

Another concern can also be easily addressed. While the supervisors all experienced the degree of contact they had with Amridge University's clinical training director as helpful, they all expressed desire for even more. Many of them wanted a personal phone call at least once a semester in addition to the several emails they receive. That change to the program can be easily implemented. It is also technically possible, if appropriate approvals can be obtained, to offer periodic face-to-face meetings for the supervisors via webcam. As the supervisors said, some are not comfortable enough with technology to take advantage of this offering and some would perhaps have scheduling problems, but it is at least one potential way to address their expressed need for more connection with their peers and with the university.

In summary, the supervisors, like the students, experienced the clinical training program as being an effective way of helping students construct their professional identity. While there are many things Amridge University appears to be doing right, in the supervisors' opinions, there are also a few opportunities for improvement to make what they experience as a good process even better.

Research Question Three. Both supervisors and students report phenomenological evidence of growth in professional identity through the process of clinical training. Most of the students experienced themselves as very unsure and uncomfortable when they entered practicum. Even the few who felt confident on entering practicum because of their work background found during the first semester that they had much to learn. Yet by the time they had become an Advanced student, as defined on the BSED which Amridge University uses, they reported feeling very confident in their ability and very ready to take on the next step of their professional growth – post-degree supervision toward licensure. The supervisors concurred with this assessment. Though the supervisors focused more on the students' ability to do accurate self-of-therapist work and/or clinical skills, rather than the subjective experience of comfort, the end result was the same. There was phenomenological evidence of growth through clinical training.

For the students, the primary vehicle of this growth was their relationships with their supervisor and with their classmates and with the clinical training director, in that approximate order. The comfort with using the therapy techniques they reported was, for the students, a direct result of these relationships. In other words, they experienced their growth as socially constructed. For the supervisors, the primary vehicle for the growth was the clinical work itself, i.e., being in the room with real clients trying to apply the theories and techniques they, the students, had learned in their previous course work. I will offer an interpretation of these differing constructions of the reality in the next section of this chapter. What is significant for the research question is that both students and supervisors phenomenologically experienced the process of clinical training as leading to the students' growth in professional identity and thus in competence in professional functioning.

This study was not designed to offer data on which of the factors was most significant. Perhaps a future study will offer a factor analysis or other statistical analysis of a much larger sample to suggest the various weights of importance of the factors. What the current data does allow is a conclusion that the students were very clear that there was nothing in the process of clinical training, as they experienced it, which hindered their growth or development as mental health professionals, and supervisors concurred.

In Chapter 2, I reported the results of a focus group of currently practicing MFT supervisors in Alabama to help define the purpose of clinical supervision. From the grounded theory analysis of these supervisors' statements, I derived "application of theory to practice" as the central idea, with six other supporting, explanatory ideas surrounding that idea (see Figure 2-1 for a graphic depiction of the results). Both supervisors and students in this current study reported they, too, experienced "application of theory to practice" as a primary purpose of, and result of, the clinical training they received through Amridge University. In fact, growth in this ability was one of the primary measures by which both supervisors and students rated the students' progress. Several of the students reported entering practicum with a good grasp of the theories, but with much less idea of how to actually apply those theories with real clients. Others reported beginning practicum knowing how to apply only one or two theories. All of the students reported a much greater ability to apply theory to practice now that they were Advanced (as rated on the BSED) students. The supervisors concurred. From this data it seems reasonable to conclude that the Amridge University clinical training program is an effective way of achieving the primary purpose of clinical training as defined by the focus group – the application of theory to practice.

Interpretations

There were some differences in how comfortable the students were with using the Internet to form a community versus how comfortable the supervisors were. While some of that may be due to experience – by this point the students all had had at least two years' experience using online classes – the literature would suggest that there is a broader and deeper explanation. In 1991 Straus & Howe published a study of generational differences since the American Revolution entitled *Generations* (Straus & Howe, 1991). Significant to this current study is their data on what is generally known as Generation X, or more simply and typically Gen X. These are people born between 1964 and 1981. They are quite different in many respects from their parents, the Baby Boomers (born 1946 to 1964). Of relevance here is their experience with technology. The Baby Boomers grew up with evolving technology, from no television (for the oldest segment) to black & white television to color television. Personal computers did not appear until their early adult lives, and the Internet was not generally accessible until well into their work lives. By contrast, the Gen Xers grew up with video games and with the Internet (McMullin, Comeau, & Jovic, 2007). Perhaps for this reason, the Pearson Education database Infoplease (2009) states that 82% of the Gen Xers regularly use the Internet, while only 72% of the Baby Boomers do so.

All of the supervisors in the study, including those in the focus group cited in Chapter 2, were of the Baby Boom generation ("digital immigrants" to use Bacigalupe's (2010) term). By contrast, all but one of the students were Gen Xers ("digital natives" to use Bacigalupe's term). As digital natives, the Gen Xers grew up with a digital reality. They have practiced since childhood how to make it work for them. The same sources already cited all suggest that the next generation, the Millennials, who are just now entering the work force, will be even more adept at

creating community out of a virtual environment (Pearson Education, 2009; McMullin, Comeau, & Jovic, 2007). The Millennials will find a very different work place than the Gen Xers did, because the Gen Xers are already leading the charge for business and other organizations to accept and adopt a more collaborative use of technology. Gen X employees are the fastest growing demographic in Facebook and are the ones getting management to accept technology as more than a fad (Walling, 2009). Baby Boomer supervisors will have to adapt to supervisees who are increasingly willing and able to accept an online community as at least as useful as a physical community for building relationships.

Before leaving the generational differences issue, there is one more aspect to add to the consideration. Swan (2003) cites studies that support the contention previously made in this document, that is, that there is no significant difference between online education's effectiveness and traditional education's effectiveness for graduate students. However, Swan goes on to say that "no significant difference" obscures one issue – that online education, and especially asynchronous online education – taps into different learning styles than the more traditional in-classroom learning style. While I know of no studies which have specifically correlated learning style to generational data, it does seem reasonable to conclude, based on the evidence we do have, that part of what makes an online environment more comfortable and useful for the Gen X students than it is for the Baby Boomer ("digital immigrant") supervisors is that the Gen X students have learned how to learn this way. If this is true, it is also reasonable to conclude that the Millennials, sometimes known as "Gen Y" students, will be even more adept at learning how to learn in an online environment. Perhaps this is because, as Swan contends (page 11), online education is optimized for social learning:

> "Socio-cognitive theories of learning maintain that all learning is social in nature and that knowledge is constructed through social interactions [65]. Online

> education seems particularly well constructed to support such social learning because of the unique nature of asynchronous course discussions [106]. To begin with, all students have a voice and no student can dominate the conversation. The asynchronous nature of the discussion makes it impossible for even an instructor to control. “

Both of these elements, the equalitarian nature of the discussion and the social learning nature, are present even in the synchronous case discussions of the clinical training classes, and these are universally rated among the students as their favorite parts of the class.

From the experiences of both the students and the supervisors, professional identity is clearly socially constructed, and one’s background is a part of that process. This reported experience substantiates the soundness of the philosophical basis on which the clinical training program is constructed. Whether the student viewed his or her background as helpful or not, it was a factor for them. Thus, self-of-therapist or style-of-life work seems highly indicated. Indeed, Adlerian supervision places a high value on the supervisee examining his or her style of life (Lemberger & Dollarhide, 2006). Part of this will inevitably involve deconstructing old beliefs (“private logic” in Adlerian language) and reconstructing new, more helpful beliefs. The core assumption behind both Aponte’s version of self-of-therapist work, as enunciated and practiced by the site supervisors involved in this study, and Adlerian style-of-life analysis in supervision is that the better the trainee knows him or her self, the more effectively he or she can function in the therapy room. The clinical training instructor conducts this kind of work in the clinical training class in very much the same way a supervisor in a more traditional, in-the-same-room setting would conduct group supervision. The clinical training class is, in effect, group supervision. The results suggest that the style-of-life analysis ought to be an even more prominent part of the in-class time for the students.

Group supervision, whether in the same physical room or in a virtual classroom, accurately reflects the essential embeddedness of human existence (McMahon & Fall, 2006). Especially in an online environment, group supervision encourages the student to develop a voice. In class each week I hear students who are about to present expressing the same sort of anxieties I felt during my supervision in my own internship. I experience a sense of connection with them. Yet one factor that makes the online environment different from what I experienced all those years ago is that when my words were spoken, they were gone, vanished into memory. These students' words and actions are recorded and can be reviewed again and again, even years from now, and they know it. Yet that is a very real advantage of online clinical education. "As one supervisor told a supervisee, 'If you can't be comfortable with being imperfect, don't expect your clients to be comfortable with it, either'"(McMahon & Fall, 2006, p. 127).

Identity is just as socially constructed for the supervisors as it is for the students, according to the results we have here. They value being part of the university's work of helping to form the next generation of counselors and therapists. However, part of the learning from this study is that the Amridge University clinical training program cannot rely on web-based resources to reach out to these supervisors. They report needing and wanting a feeling of connection with the university, but they also report discomfort with the virtual world. One of the keys to success of an online distance education clinical training program is taking the differing constructions of reality into account. By and large, for at least the next several years the supervisors will be Baby Boomers who construct reality based on in-person, or at least telephone, contact. The students, as Gen Xers (and soon Millennials), can and do construct reality from the digital world of cyberspace. Clinical training program directors will have to put

much more of their effort into telephonic contact with supervisors and less into asynchronous, web-based resources such as recorded class sessions, printed handouts, or discussion boards.

Based on the data from the study, part of the future conversations with site supervisors will cover what actually happens in the clinical training class. I was honestly not surprised that the students found the class so helpful, but I was very surprised that the supervisors reported knowing almost nothing about how class works. They had no idea that their student was conversing with students from all over the United States and from a multitude of different clinical environments. When they learned about this during the interviews for this research project, they were impressed and expressed appreciation for what was happening. The learning here is that I, as clinical training director, need to be more intentional about telling supervisors what we do and how during telephone conversations with them, so that they, in turn, can ask about the broader context during their individual supervisory sessions with the student and can feel more personally connected to what we are doing at the university.

Suggestions for Further Study

This study is only a first step. It is a pioneering work. Much more needs to be done, including replications of this study to support the transferability of the phenomenological experience of Amridge University students and site supervisors to other locations. Another, similar, kind of follow up study could be a grounded theory examination of the process by which students are able to construct their professional identity in a virtual environment.

Grounded theory also might provide useful data on what supervisors do that is really helpful to the students. A study of this sort could enable clinical training program directors to more effectively work with the program's site supervisors and help them work even more

effectively in this environment. Given the generational differences and resulting differing constructions of reality suggested in this study, these data could be particularly useful.

Of course, as already proposed in this chapter, some quantitative work could also be useful. One quantitative study that could be beneficial would be a comparison of the Amridge University, and similar, distance education clinical training programs with more traditional, in-person clinical training programs. This would involve creating some effective outcome measures tools which can provide valid and reliable outcome data on the results of clinical training. That would be particularly useful because this study provides the phenomenological data of students' and supervisors' experience of the Amridge program as at least as effective as traditional programs. A quantitative study could provide data on the extent to which these experiential data can be verified numerically.

Another potentially useful study would be a factor analysis of distance education clinical training programs similar to the Amridge University clinical training program. The phenomenological data answered the research questions affirmatively, that is, forming one's professional identity in an online community is one effective way to do so. However, what is missing from the current study by its design is an examination of the various factors embedded in the clinical training program and the extent to which each factor contributes to the perceived growth in clinical competence and professional identity on the part of the students.

An ethnographic study of license boards would be most helpful. As indicated in Chapter 1 of this document, only a few license boards accept the validity of supervision provided by distance education. Even the American Association for Marriage and Family Therapy insists that supervision for the Approved Supervisor designation be given in the same room (AAMFT, 2007). The majority of the license boards currently insist that "face to face" means being in the

same room. The ethnographic study could provide data on what kinds of data the license boards would need for them to make the political decisions to revise their rules and allow at least some of the supervision during internship and supervision toward licensure to take place via webcam and/or other Internet technologies. The potential advantage of this move for the license boards is that those working toward licensure could seek supervision from the best qualified supervisor in the state, not necessarily the one most geographically accessible. As license boards change the culture of the profession, the professional organizations might begin to change as well.

Conclusions

This study has shown that the Internet generally and distance education in specific have tremendously changed the way Americans think of themselves. Both of these forces are, according to the sources cited, democratizing processes, giving more people free access to information and interaction than was previously possible. Popular magazines like Delta Airlines *Sky* tout the benefits of distance learning; one particular edition devoted twelve pages to articles on the topic (May 2010 edition, pp. 120-132). While this is a popular rather than a scholarly source, it does show that Delta believes its customers would have an interest in distance education. According to the Sloan Consortium (Allen & Seaman, 2008), 95 percent of America's public institutions offer at least some course work by distance learning, so that belief seems well grounded. However, clinical training in the United States has been very slow to adopt this cultural shift. Based on the review of the literature, most supervision is still conducted in much the same way it has been since the days of Freud.

The study provides phenomenological data to show that modern Internet technology has provided a means by which the traditional goals of supervision can be met in an online community. There were three primary learnings.

- Professional identity as a marriage and family therapist or as a professional counselor is socially constructed. Specifically, professional identity is constructed through peer relationships, and relationships formed in an online environment is a phenomenologically useful means of constructing those relationships.
- Professional identity as a marriage and family therapist or as a professional counselor is grounded in doing "professional" things. Even this part is socially constructed, since the professions, through the site supervisors and the clinical training course requirements, help students define what these professional skills are and to what level of competence they are to be performed. Supervisors and students alike report having a widely used tool like the BSED as very helpful defining "professional" developmentally. This is the piece of clinical training which does, from reports of both students and supervisors, require a physical presence of the supervisor. The vicarious learning in the virtual classroom serves primarily to broaden and deepen this learning which takes place in the physical interaction between supervisor and supervisee (student) in the clinical training site.
- Professional identity as a marriage and family therapist or as a professional counselor is constructed from relating to significant others. How the "significant others" gets constructed differs for students and for supervisors, but both groups report needing this connection.

Technology is opening many challenges and many opportunities. As we learn more of what constitutes effective clinical training, perhaps we can learn even better how to do that in a virtual environment. This study is a first step in that direction.

References

Aanstoos, C.M. (1985). The structure of thinking in chess. In Giorgi, A. (Ed.). *Phenomenology and psychological research* (pp. 86-117). Pittsburg: Duquesne University Press.

Abes, E.S., Jones, S.R., and McEwen, M.K. (2007). Reconceptualizing the model of multiple dimensions of identity: The role of meaning-making capacity in the construction of multiple identities. *Journal of College Student Development, 48*(1), 1-22.

Aggett, P. (2004). Learning narratives in group supervision: Enhancing collaborative learning. *Journal of Systemic Therapies, 23*, 36-50.

Allen, I.E., and Seaman, J. (2005). *Growing by degrees: Online education in the United States, 2005*. Needham, MA: Sloan Consortium.

Allen, I.E., and Seaman, J. (2006). *Making the grade: Online education in the United States, 2006*. Needham, MA: Sloan Consortium.

Allen, I.E., and Seaman, J. (2008). *Staying the course: Online education in the United States, 2008*. Needham, MA: Sloan Consortium.

Allen, I.E., and Seaman, J. (2009). *Learning on demand: Online education in the United States, 2009*. Needham, MA: Sloan Consortium.

Ambrose, H. (2000). Therapy and supervision in the age of the internet. In American Association for Marriage and Family Therapy [AAMFT], *Readings in family therapy supervision: Selected articles from the AAMFT Supervision Bulletin* (pp. 124-126). Washington, DC: Author.

American Association for Marriage and Family Therapy (2004). *Marriage and Family Therapy Core Competencies*. Alexandria, VA: Author.

American Association for Marriage and Family Therapy (2007). *Approved Supervisor Designation Standards and Responsibilities Handbook*. Alexandria, VA: Author.

Amstey, F.H., & Whitbourne, S.K. (1981). Continuing education, identity, sex role, and psychosocial development in adult women. *Sex Roles, 7*(1), 49-58.

Anderson, H., & Goolishian, H.A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27*, 371-393.

Aponte, H. (1994). How personal can training get? *Journal of Marital and Family Therapy, 20*, 3-15.

Anthis, K., & LaVole, J.C. (2006). Readiness to change: A longitudinal study of changes in adult identity. *Journal of Research in Personality, 40*(2), 209-219.

Bacigalupe, G. (2010). Supervision 2.0: E-supervision a decade later. *Family Therapy Magazine*, 9(1), 38-41.

Baker, K.A. (1999). The importance of cultural sensitivity and therapist self-awareness when working with mandatory clients. *Family Process, 38*(1), 55-67.

Bandura, A.J. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Bartle-Haring, S., Silverthorn, B.C., Meyer, K., & Toviessi, P. (2009). Does live supervision make a difference? A multilevel analysis. *Journal of Marital and Family Therapy, 35*(4), 406-414.

Behan, C.P. (2003). Some ground to stand on: Narrative supervision. *Journal of Systemic Therapies, 22*(4), 29-42.

Berg, B.L. (2004). *Qualitative research methods* (5th Ed.). Boston: Pearson Books.

Bergin, A. & Garfield, S. (Eds.) (1994). *Handbook of psychotherapy and behavior change* (4th Ed.). New York: Wiley.

Bernard, J.M., and Goodyear, R.K. (2004). *Fundamentals of clinical supervision* (3rd Edition). Boston: Pearson Education, Inc.

Bernard, R.M., Abrami, P.C., Lou, Y., Borokhovski, E., Wade, A, Wozney, L., Wallet, P.A., Fiset, M., & Huang, B. How does distance education compare with classroom instruction? A meta-analysis of the empirical literature. *Review of Educational Research, 74*(3), 379-439.

Bischoff, R.J., Barton, M., Thober, J. & Hawley, R. (2002). Events and experiences impacting the development of clinical self-confidence: A study of the first year of client contact. *Journal of Marital and Family Therapy, 28*(3), 371-382.

Bitter, J.R. (2007). Am I an Adlerian? *Journal of Individual Psychology, 63*(1), 3-31.

Bloom, J.W., & Walz, G.R. (Eds.)(2000). *Cybercounseling and cyberlearning: Strategies and resources for the millennium*. Alexandria, VA: American Counseling Association.

Boulous, M.N.K., Maramba, I., & Wheeler, S. (2006). Wikis, blogs and podcasts: a new generation of web-based tools for virtual collaborative clinical practice and education. *BMC Medical Education,6*(42). Retrieved 13 July 2010 from http://www.biomedcentral.com/1472-6920/6/41.

Bosma, H.A., and Kunnen, E.S. (2001). Determinants and mechanisms in ego identity development: A review and synthesis. *Developmental Review, 21*(1), 39-66.

Carlsen, A. (2006). Organizational becoming as dialogic imagination of practice: The case of the indomitable Gauls. *Organization Science, 17*(1), pp. 132-149.

Cavanaugh, C.S. (2001). The effectiveness of interactive distance education technologies in K-12 Learning: A meta-analysis. *International Journal of Educational Telecommunications, 7*(1), 73-88.

Clingerman, T.L., & Bernard, J.M. (2004). An investigation of the use of e-mail as a supplemental modality for clinical supervision. *Counselor Education and Supervision, 44*(2), 82-95.

Commission on Accreditation for Marriage and Family Therapy Education (2002). *Manual on accreditation* (Version 10.1). Alexandria, VA: AAMFT.

Cook, J.E., & Doyle, C. (2002). Working alliance in online therapy as compared to face-to-face therapy: Preliminary results. *Cyberpsychology and Behavior, 5*, 95-105.

Côté, J.E. (2002). The role of identity capital in the transition to adulthood: The individuation thesis examined. *Journal of Youth Studies, 5*(2), 117-134.

Coursol, D. (2004). Cybersupervision: Conducting supervision on the information superhighway (ERIC Document Reproduction Service No. ED478221).

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd Ed.). Thousand Oaks, CA: Sage Publications.

Dhal, C.H., and Boss, P. (2005). The use of phenomenology for family therapy research. In Sprenkle, D.H., & Piercy, F.P. (Eds.). *Research methods in family therapy* (2nd Ed.) (pp. 63-84). New York: Guilford Press.

Dickson, G.L. and Jepsen, D.A. (2007). Multicultural training experiences as predictors of multicultural competence: Students' perspectives. *Counselor Education and Supervision, 47*(2), 76-95.

Dien, D.S. (2000). The evolving nature of self-identity across four-levels of history. *Human Development, 43*, 1-18.

Echevarria-Doan, S., and Tubbs, C.Y. (2005). Let's get grounded: Family therapy research and grounded theory. In Sprenkle, D.H., & Piercy, F.P. (Eds.). *Research methods in family therapy* (2nd Ed.) (pp. 41-62). New York: Guilford Press.

Edwards, T., & Patterson, J. (2006). Supervising family therapy trainees in primary care medical settings: Context matters. *Journal of Marital and Family Therapy, 32*, 33-43.

Erikson, E. H. (1950). *Childhood and society*. New York: W. W. Norton & Company.

Erikson, E.H. (1968). *Identity: Youth and crisis*. New York: W.W. Norton & Company.

Fialkov, C., Haddad, D., & Gagliardi, J. (2001, Summer). Face to face on the line: An invitation to learn from online supervision. *AAMFT Supervision Bulletin*, 1-3.

Falender, C.A., and Shafranske, E.P. (2004). *Clinical supervision: A competency based approach*. Washington, D.C.: American Psychological Association.

Falender, C.A., and Shafranske, E.P. (2007). Competence in competence-based supervision practice: Construct and application. *Professional Psychology: Research and Practice, 38*(3), 232-240.

Fine, M. (2003). Reflections on the intersection of power and competition in reflecting teams as applied in academic settings. *Journal of Marital and Family therapy, 29*(3), 339-51.

Flemons, D.G., Green, S.K., & Rambo, A.H. (1996). Evaluating therapists' practices in a post-modern world: A discussion and a scheme. *Family Process, 35*, 43-56.

Frick, T. (1991). *Restructuring education through technology*. Bloomington, IN: Phi Delta Kappa Educational Foundation.

Friedman, D., & Kaslow, N.J. (1986). The development of professional identity in psychotherapists: Six stages in the supervision process. *The Clinical Supervisor, 4*(1), 29-50.

Friman, M., Nyberg, C., and Norlander, T. (2004). Threats and aggression directed at soccer referees: An empirical phenomenological psychological study. *The Qualitative Report, 9*(4), 652-672.

Fischer, W.F. (1985). Self-deception: An empirical-phenomenological inquiry into its essential meaning. In Giorgi, A. (Ed.). *Phenomenology and psychological research* (pp. 118-154). Pittsburg: Duquesne University Press.

Garrison, D. R. & Anderson, T. (2003). *E-learning in the 21st century: A framework for research and practice*. New York: Routledge.

Gaytan, J., & McEwen, B.C. (2007). Effective online instructional and assessment strategies. *The American Journal of Distance Education, 21*(3), 117-132.

Gehart, D.R., Ratliff, D.A., & Lyle, R.R. (2001). Qualitative research in family therapy: A substantive and methodological review. *Journal of Marital and Family Therapy, 27*(2), 261-274.

General Accounting Office (2004). *Distance education: Improved data on program costs and guidelines on quality assessments needed to inform Federal policy* [GAO Publication GAO-04-279]. Washington, DC: Author.

Gergen, K.J. (1999). *An invitation to social construction*. Thousand Oaks, CA: Sage Publications.

Gerkin, C.V. (1984). *Living human document: Revisioning pastoral counseling in a hermeneutical mode*. Nashville: Abingdon Press.

Giorgi, A. (Ed.)(1985). *Phenomenology and psychological research*. Pittsburg: Duquesne University Press.

Green, J.W. (1999). *Cultural awareness in the human services: A multi-ethnic approach* (3rd. Ed.). Boston: Allyn & Bacon.

Greenwalt, B.C. (2001, Summer). Cybersupervision: Some ethical issues. *AAMFT Supervision Bulletin*, 12-14.

Hansen, B.G. (1995). *General systems theory beginning with wholes*. Washington, DC: Taylor & Francis.

Hawley, D.R., Bailey, C.E., & Pennick, K.A. (2000). A content analysis of research in family therapy journals. *Journal of Marital and Family Therapy, 26*(1), 9-16.

Holloway, E.L., & Neufeldt, S.A. (1995). Supervision: Its contribution to treatment efficacy. *Journal of Consulting and Clinical Psychology, 63*(2), 207-213.

Howard, C.; Schenk, K;, & Discenza, R. (Eds.) (2004). *Distance learning and university effectiveness: Changing educational paradigms for online learning*. Hershey, PA: The Idea Group.

Houle, J., Brewer, B., & Kluck, A.. (2010). Developmental Trends in Athletic Identity: A Two-Part Retrospective Study. *Journal of Sport Behavior, 33*(2), 146-159.

Hubble, M., Miller, S., & Duncan, B. (Eds.) (1998). *The heart and soul of change: What works in therapy*. San Francisco: Josey-Bass.

Inman, A.G. (2006). Supervisor multicultural competence and its relation to supervisory process and outcome. Journal of Marital and Family Therapy, 32(1), 73-85.

Internet World Stats (2009). *Internet usage and population in North America*. Retrieved 23 April 2009 from http://www.internetworldstats.com/stats14.htm.

Jeffries, M. (1995). Research in distance education. In *Indiana Partnership for Statewide Education: Faculty handbook,* ed. K.H. Bonnell, 12-20. Indianapolis, IN: Indiana College Network. Retrieved September 11, 2008, from www.digitalschool.net/edu/DL_history_mJeffries.html.

Kanz, J.E.(2001). Clinical supervison.com: Issues in the provision of online supervision. *Professional Psychology: Research and Practice, 32*(4), 415-420.

Kiang, L., Witkow, M., Baldelomar, O., & Fuligni, A.. (2010). Change in Ethnic Identity Across the High School Years Among Adolescents with Latin American, Asian, and European Backgrounds. *Journal of Youth and Adolescence, 39*(6), 683-693. Retrieved July 30, 2010, from ProQuest Psychology Journals. (Document ID: 2030451271).

Kilminster, S.M., & Jolly, B.C. (2001). Effective supervision in clinical practice settings: A literature review. *Medical Education, 34*(10), 827-840.

Lahey, S. (2008). A quantitative examination of distance and traditional counselor education supervision modalities. *Dissertation Abstracts International, 69*(06A), 2157. (UMI No. 3319385).

Lang, C., & Byrd, M. (2002). Differences between students' estimated and attained grades in a first-year introductory psychology course as a function of identity development. *Adolescence, 37*(145), 93-105.

Larner, G. (2004). Family therapy and the politics of evidence. *Journal of Family Therapy, 26*, 17-39.

Lemberger, M.E. and Dollarhide, C.T. (2006). "Encouraging the supervisee's style of counseling: An Adlerian model for counseling supervision." *Journal of Individual Psychology, 62*(2), 106-125.

Lewis, J., Whitaker, J., & Julian, J. (1995). Distance education for the 21st century; The future of national and international telecomputing networks in distance educational. In Berge, Z. and Collins, M. (Eds.),*Computer Mediated communication and online classroom*, 13-39. Cresskill, NJ: Hampton Press.

Liddle, H.A. (1991). Training and supervision in family therapy: A comprehensive and critical analysis. In Gurman, A.S., & Kniskern, D.P. (Eds.)(1991). *Handbook of family therapy*, Vol. 2. (pp. 638-697). New York: Brunner/Mazel.

Liddle, H.A., Breunlin, D.C., & Schwartz, R.C. (Eds.)(1988). *Handbook of family therapy training & supervision*. New York: Guilford Press.

Lin, C., & Atkins, D.J. (2007). *Communication technology and social change: Theory and implications*. Mahwah, NJ: Lawrence Erlbaum Associates.

Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry*. Newberry Park, CA: Sage Publications.

Lowe, R. (2000). Supervising self-supervision: Constructive inquiry and embedded narratives in case consultation. *Journal of Marital and Family Therapy, 26*(4), 511-521.

Luyckx, K., Schwartz, S.J., Soenens, B., Vansteenkiste, M., & Goossens, L. (2010). The path from identity commitments to adjustment: Motivational underpinnings and mediating mechanisms. *Journal of Counseling and Development, 88*(1), 52-88.

Machtmes, K., and Asher, J.W. (2000). A meta-analysis of the effectiveness of telecourses in distance education. *American Journal of Distance Education, 14*(1), 27-46.

MacKenzie, O., Christensen, E.L., & Rigby, P.H. (1968). *Correspondence instruction in the United States*. New York: McGraw Hill.

Maniacci, M.P. (2002). The DSM and Individual Psychology: A general comparison. *Journal of Individual Psychology, 54*(4), 356-362.

Mana, A., Orr, E., & Mana, Y. (2009). An integrated acculturation model of immigrants' social identity. *Journal of Social Psychology,149*(4), 450-473.

Marshall, J.P. and Weiling, E. (2003). Marriage and family therapy students' phenomenological experiences of cross-cultural supervision. *Journal of Family Therapy, 30*(3), 167-187.

Maxwell, J.A. (2005). *Qualitative research design: An interactive approach* (2nd Ed.). Thousand Oaks, CA: Sage Publications.

McCurdy, K.G. (2006). Adlerian supervision: A new perspective with a solution focus. *Journal of Individual Psychology, 62*(2), 141-153.

McMahon, H.G., & Fall, K.A. (2006). Adlerian group supervision: Concept, structure and process. . *Journal of Individual Psychology, 62*(2), 126-140.

McMullin, J.A., Comeau, T.D., & Jovic, E. (2007). Generational affinities and discourses of difference: A case study of highly skilled information technology workers. *British Journal of Sociology, 28*(2), 297-316.

McNamee, S. (2004). Promiscuity in the practice of family therapy. *Journal of Family Therapy, 26*(3), 224-244.

Mead, D.E. (1990). *Effective supervision: A task-oriented model for the mental health professions*. New York: Brunner/Mazel.

Medscape (2008). "Internet-based CME leads to good evidence-based clinical choices." Retrieved 12 December 2008 from http://www.medscape.com/viewarticle/585122.

Meeus, W., Iedema, J., Helsen, M., & Vollenberg, W. (1999). Patterns of adolescent identity development: Review of literature and longitudinal analysis. *Developmental Review, 19*(4), 419-461.

Miller-McLemore, B.J. (April 7, 1995). The human web: Reflections on the state of pastoral theology. *Christian Century*, pp. 366-369.

Milne, D. L., & James, I. (2000). A systematic review of effective cognitive-behavioural supervision. *British Journal of Clinical Psychology, 39*, 111-127.

Mittal, M., & Wieling, E. (2006). Training experiences of international doctoral students in Marriage and Family Therapy. *Journal of Marital and Family Therapy, 32*(3), 369-83.

Monolescu, D., Schifter, C.C., & Greenwood, L. (2004). *The distance education evolution: Issues and case studies*. London: Information Science Publishing.

Montagu, A. (1955). *The direction of human development: Biological and social bases*. New York: Harper.

Montagu, A. (1981). *Growing young*. New York: McGraw-Hill.

Morabito, M.G. (1999). *Online distance education: Historical perspective and practical application.* Boca Raton, FL: Universal-Publishers.

Morgan, M. M., & Sprenkle, D. H., (2007). Toward a Common-Factors Approach to Supervision. *Journal of Marital and Family Therapy, 33*(1), 1-17.

Murphy, M.J., & Wright, D.W. (2005). Supervisees' perspectives of power use in supervision. *Journal of Marital and Family Therapy, 31*(3), 283-295.

Nasseh, B. (2006). *A brief history of distance education*. Retrieved 28 July 2010 from http://www.seniornet.org/edu/art/history.html.

Nelson, K.W., and Jackson, S.A. (2003). Professional counselor identity development: A qualitative study of Hispanic student interns. *Counselor Education and Supervision, 43*(1), 2-14.

Nelson, T. (1999). The Basic Skills Evaluation Device. *Journal of Marital and Family Therapy* (January 1999). Retrieved December 29, 2007 from http://findarticles.com/p/articles/mi_qa3658/is_199901/ai_n8842467/print.

Neuhauser, C. (2002). Learning style and effectiveness of online and face-to-face instruction. *The American Journal of Distance Education, 16*(2), 99-113.

Newman, R. D. (2003). *Distance education best practices manual*. University of Phoenix. Retrieved on September 11, 2008, from http://www.rdnewman.com/manual/.

Norlander, T., Blom, A., & Archer, T. (2002). Role of high school teachers in Swedish psychology education: A phenomenological study. *The Qualitative Report, 7*(3). retrieved 11 January 2006 from http://www.nova.edu/ssss/QR/QR7-3/norlander.html.

Ober, A.M., Granello, D.A., and Henfeld, M.S. (2009). A synergistic model to enhance multicultural competence in supervision. *Counselor Education and Supervision, 48*(3), 204-221.

O'Reilly R.O., Bishop J, Maddox K, Huchinson L, Fisman M, and Takhar J (2007). Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results From a Randomized Controlled Equivalence Trial. *Psychiatry Services, 58*, pp. 836-843. Retrieved 7 November 2007 from www.medscape.com/psychiatry.

Palmer-Olsen, L. (2008). A phenomenological exploration of the EFT therapist's experience of EFT training and supervision. *Dissertation Abstracts International, 68*(07). (UMI No. 3273263).

Piercy, F.P., and Hertlein, K.M. (2005). Focus groups in family therapy research. In Sprenkle, D.H., and Piercy, F.P. (Eds.). *Research methods in family therapy* (2nd Ed.) (pp.. 85-99). New York: Guilford Press.

Pearson Education (2009). *Computer Usage in the US*. Retrieved on 13 may 2010 from http://www.infoplease.com/ipa/A0921872.html.

Ronnestad, M.H., & Skovholt, T.M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*, 5-44.

Sax, P. (2006). Developing preferred stories of identity as reflective practitioners. *Journal of Systemic Therapies, 25*(4), 59-72.

Scherl, C. R., & Haley, J. (2000). Computer monitor supervision: A clinical note. *The American Journal of Family Therapy, 28,* 275-282.

Schwallie, L. (2005, July-August). Competence and marriage and family therapy regulatory activity. *Family Therapy Magazine, 4*(4), 24-27.

Schwartz, S.J. (2007). The structure of identity consolidation: Multiple correlated constructs or one superordinate construct? *Identity, 7*(1), 27-49

Selicoff, H. (2006). Looking for good supervision: A fit between collaborative and hierarchical methods. *Journal of Systemic Therapies, 25*, 37-51.

Sherman, R., and Dinkmeyer, D. (1987). *Systems of family therapy: An Adlerian integration*. New York: Brunner/Mazel.

Singer, M. (2005). A twice-told tale: A phenomenological inquiry into clients' perceptions of therapy. *Journal of Marital and Family Therapy, 31*(3), 269-281.

Slotten, H. R. (2000). *Radio and television regulation: broadcast technology in the United States, 1920-1960*. Baltimore : Johns Hopkins University Press.

Sprenkle, D. H., & Moon, S. M. (Eds.) (1996). *Research Methods in Family Therapy*. New York: Guilford Publications.

Sprenkle, D.H., & Piercy, F.P. (Eds.) (2005). *Research Methods in Family Therapy* (2nd Ed.). New York: Guilford Publications.

Stoltenberg, C.D. (2008, June). Applying Evidence Based Practices (EBP) to the Process of Clinical Supervision. Paper presented at the International Interdisciplinary Conference on Clinical Supervision, Buffalo, NY.

Stoltenberg, C. D., McNeill, B., & Delworth, U. (1997). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco: Jossey-Bass.

Stoltenberg, C.D., Pierce, R.A., & McNeill, B.W. (1987). Effects of experience on counselors needs. *Clinical Supervisor, 5*, 23-32.

Storm, C.L., McDowell, T., and Long, J.K. (2003). The metamorphosis of training and supervision. In Sexton, T.L., Weeks, G.R., and Robbins, M.S. (Eds.). *Handbook of family therapy: Theory, practice and research* (pp. 431-446). New York: Brunner-Routledge.

Storm, C.L, Todd, T.C., Sprenkle, D.H., & Morgan, M.M. (2001). Gaps between MFT supervision assumptions and common practice: Suggested best practices. *Journal of Marital and Family Therapy, 27(*2), 227-240.

Strauss, W., & Howe, N. (1991). *Generations: The history of America's future, 1584 to 2069*. New York: William Morrow & Company.

Swan, K. (2003). Learning effectiveness: what the research tells us. In J. Bourne & J. C. Moore (Eds.). *Elements of quality online education, practice and direction*. Needham, MA: Sloan Center for Online Education, 13-45.

Sweeny, T.J. (1989). *Adlerian counseling: A practical approach for a new decade* (3rd Ed.). Muncie, IN: Accelerated Development.

Taylor, J.C. (2001) Fifth generation distance education. *e-Journal of Instructional Science and Technology (e-JIST), 4*(1), 1-14. Retrieved 27 July 2010 from http://eprints.usq.edu.au/136/.

Tesch, S.A., & Cameron, K.A. (2006). Openness to experience and development of adult identity. *Journal of Personality, 55*(4), 615-630.

The Book of Discipline of the United Methodist Church – 2008 (2008). Nashville: United Methodist Publishing House.

Thurber, S. (2005). The effects of direct supervision on therapist behavior: An initial functional analysis. *Dissertation Abstracts International, 66*(01), 578B.

Todd, T.C., & Storm, C.L. (1997). *The complete systemic supervisor: Context, philosophy, and pragmatics.* Boston: Allyn and Bacon.

Ungar, M. (2006). Practicing as a postmodern supervisor. *Journal of Marital and Family Therapy, 32*(1), 59-71.

U.S. Department of Education. (25 June 1999). New ed projects promote distance learning for college. *U.S. Department of Education News*. Washington, DC: Author.

Walling, S. (2009). *Forget Gen Y: Gen X is making real change*. Retrieved 19 March 2009 from http://www.readwriteweb.com/enterprise/2009/09/forget-gen-y-gen-x-is-making-r.php.

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

White, M. (1992). Family therapy training and supervision in a world of experience and narrative. In Epston, D. & White, M. *Experience, contradiction, narrative and imagination*. Adelaide: Dulwich Centre Publications.

Wilcoxon, A.S., Remley, T.P., Gladding, S.T., and Huber, CH. (2007). *Ethical, legal and professional issues in the practice of marriage and family therapy* (4th Ed.). Upper Saddle River, N.J.: Prentiss-Hall.

Wilson, E., & Deaney, R. (2010). Changing career and changing identity: how do teacher career changers exercise agency in identity construction? *Social Psychology of Education: An International Journal, 13*(2), 169.

Wilson, W.M. (2002). Faculty and administrator attitudes and perceptions toward distance learning in Southern Baptist-related educational institutions. (Doctoral dissertation, The Southern Baptist Theological Seminary, 2002). *Dissertation Abstracts International, 63*(04A): p. 1277, ISBN: 0-493-64879-8.

Winslade, J. (2003). Storying Professional Identify. Paper retrieved from the Dulwich Center website, http://www.dulwichcentre.com.au/johnwinsladearticle.htm, on 3 July 2008.

Winslade. J., Crocket, K., Monk, G. & Drewery, W. (2000). The storying of professional development. In McAuliffe, G. & Eriksen, K. (Eds.). *Preparing counselors and therapists: Creating constructionist and developmental programs* (pp. 99-113). Virginia Beach, VA: Association for Counselor Education and Supervision.

Wood, A. (2003). Alfred Adler's treatment as a form of brief therapy. *Journal of Contemporary Psychotherapy, 33*(4), 289-301.

Worthen, V., & McNeil, B.W. (1996). A phenomenological investigation of "good" supervisory events. *Journal of Counseling Psychology, 43(*1), 25-34.

Appendix A
Transcript of Conversation with ALAMFT Supervisors

Key – M = male (#) F = Female (#) W = Wayne

W: I have a real fascination for what makes for good supervision. I figure what better thing to do than to consult with the experts because, by definition, everybody here is a supervisor. We all went through those hoops to become a supervisor because, I assume we all had an interest in the continuing development of folks. Some of us work within academic programs, some of us are supervising towards licensure, and that's really the piece I'm more concerned with right now in my research. Not so much supervision of supervision as it used to be called, or supervision mentoring as it is called now, but I'm more interested in supervision towards licensure…both within the academic program and afterwards. I basically have one question I am most interested in and that is what I would like for us to kick around and discuss. And that is, "What's the point of clinical training?" If you consider clinical training while the person is in the academic program, or even post-degree towards licensure. I mean, we require it, and we have for as long as I've been in the profession. Why? What's the point? What are you hoping to gain? So, whether you are seeing folks after graduation working towards licensure, what is it you're hoping to see different at the end of that versus the beginning. Or, if you're in an academic program what are you hoping to see different in that from the beginning. What's the point of clinical training? There's no right answer here, by the way. I really, seriously, want to know what you have to say.

F1: People who can help other people through counseling competency. Anybody can sit and listen to anybody and {garbled} it happens all the time. People can get better, but if we're going to be professional and intentional about it then we have to be intentional in some manner that has some goals.

W: So, the purpose is to help our supervisees be intentional. (F2: Be competent!) Be competent.

F2: Both their own skills and, I agree with [F1], tremendously in terms of their own personal growth and development and awareness of the impact they have on other people.

W: So it's not just skills when you say competence. Personal awareness is a part of that competence.

F2: [unintelligible]

W: Somebody else?

F3: As somebody who has gone through training I agree a lot with what she said about personal growth leading to competency and [unintelligible].

W: Okay.

F4: I think that anyone I supervise should be able to bring about change in a very ethical way.

W: Okay, so bringing about change in an ethical way. For those of you just coming in, I'm asking one basic question. I'm consulting the experts here. What's the purpose of clinical training? So if you were king or queen of the world and could make clinical training do what you want it to do what would that one thing be?

M1: [unintelligible] To help build clinical skills. To help the supervisee learn to practice ethics. To learn how to acquire skills and resources, etcetera.

W: Okay, so what I hear you saying is a little different from what I've heard already. Yes, it's the gaining of certain skills, the gaining of certain competence…what I heard you adding though is it's also learning how to gain certain skills.

M1: Yeah. One of the things I find in the people that I supervise is, and I've been at 3 or 4 different schools now, is I always ask this question when they first come out and when they finish their supervision, "If you were going to tell the next supervisee who comes in here"…and when I have one overlapping I make the next one come in and sit in on this conversation…"what is it you felt you weren't prepared for or surprised you when you got out of the academic setting and in to real world counseling? What is it you wish your training had prepared you for?" I guess what I'm going for is when you come out of the academic situation…because with all of the internships and all those things that you do it ought to be a fairly easy transition…so this question comes almost regardless of where they train "I wish somebody had prepared me better for whatever." You know when I've got 4 clients or 5 clients or I'm in school and I see them every week and I get my hours in and I can keep up with all my notes and I'm never staying up late at night making notes and that kind of stuff…I find a lot of people [unintelligible] but the real right perspective is this is real work and when you get out here and you're investing in somebody's life it's not always something that you can just do and your forms may not always get checked off. Different people have different perspectives.

W: Have you noticed any similarities to the answer "I wish I had learned?"

M1: I think that one of the things I have seen is that people from out of a program kind of pick their favorite theoretical approach and they may or may not be well rounded in it. Some people are going to come out and be solution focused so that they can be finished in 8 sessions. #1 they didn't understand what that was and whatever and one of the things that was preached towards me, especially as I was going for my license is to have a treatment plan. I'm just real big on treatment plans and it surprises me the number of people who are just kind of there. Where are you going? What do you want to achieve? [several people talking – laughing – unintelligible] Because when they come in they go "Okay now I've got insight"…and I remember being here myself…and they say, "Okay, what I'm supposed to do next" and I say, "Work on your treatment plan." [unintelligible] The truth is when you get

out in the real world and you're going to be in private practice most of your third party payers are going to say by the second or third session you've got to have a treatment plan. I may not like the treatment plan they send me to do. Blue Cross/Blue Shield just came up with a book that they had never told me I had to do before and now I've got all of this Blue Cross/Blue Shield stuff up in my filing cabinet…re-writing everything according to their specs. I don't care whether you do that, I care about "Do you know where you're going with this person." If you want to be structured…heck, if you want to eclectic it's okay with me if you know where you're going. I think that…

W: If I'm hearing you correctly, that would be part of some of the competence that's been talked about…that another piece of that competence would be being able to…not just being competent in this session but being competent in being able to plan and to know where this is going.

M1: And you're not going to know that at the end of the first session necessarily, but you ought to have some idea.

F5: I think something he's saying is very important and that's to help the supervisee develop their own style and generally, at least what my own experience was, I found that I generally did things the same way every time and had my own style. It's important to do something you feel comfortable with that's within your theoretical approach.

W: What about some others? I appreciate those who are contributing. From your perspective what's the purpose of clinical training?

M2: I see the goal of therapy is for a person to improve their psychological, emotional, [unintelligible] health. So the goal of clinical training is to improve the skills to bring that about. The outcome is the client. The client's needs, or clients' needs. And clinical training is there to bring that about as expeditiously and as thoroughly as possible. When I'm training a therapist it's about training them to meet the needs of the client. As many as they possibly can with the skills necessary to treat this broad context in [not sure…I think he said "two years."] So, I'm training you to help other people.

M3: Kind of building on what [M2] said, I had a really energetic conversation this morning about self-focused therapy and I really enjoyed that conversation, but one thing I thought over lunch as we kind of commiserated over things, are we doing a good job in not only saying where are you in this, but also where is the client? And if we are thinking systemically what are the systems…are we really thinking, "Okay I got in this new kid today who looks like he might be ADHD the doc's got him on Ritalin [unintelligible]. So what should I do? I don't think that's the question to bring to your supervisor… "What should I do?" I think you should have some ideas. [unintelligible] Maybe that's just the beginning level…stepping out of the classroom…grabbing the steering wheel yourself. I don't know if anybody else has that experience or not.

M4: So, sort of helping the supervisee with integrating the theoretical minds into clinical practice. You got a lot of things in your head that you've learned and now out of that what does that look like when you're sitting in front of a client and in front of different clients?

W: Okay, so I'm hearing lots of variations on a similar kind of theme, or so it sounds to me. I want to pick up on something you said [M2] with your emphasis on that ultimately it's the change that's happening within the client. So, how do you know with your supervision, and maybe you answer is the same as [M2]'s, I don't know, but how do you know that your supervision is successful? In other words at whatever level you're supervising how do you know that this person is ready to fly solo…or not?
M1: Well, currently within the field or [unintelligible]

W: Current in the field. Let's be real. Not this pie in the sky stuff. How do you know that they're good enough?

M5: [this one was really garbled with a lot of background noise. I never could make out a coherent sentence, but the gist of the scattered words I could pick up here and there basically seemed to be saying that you just know in your gut, that your instinct will tell you if someone is making improvement. This picks up when the background calmed down and I could understand again]. One of the things I look for is whether my therapist is beginning to move beyond the content of the room and seeing the process and interactions. They don't see multiple members as stifling anymore. They see the process going on as being much more informative than, say, the story that is being told. They can pull up a question that would build off the first question instead of just going on to the next question. They can keep going and dig deeper. If I find a vein of information I can keep mining that vein instead of just having this shallow depth of information. They begin to bring in aspects of what was previously said in previous sessions or they weave in previous themes with what is being said. [Unintelligible] They begin to see where they are getting caught in those dichotomies and seeing where they are a part of that system rather than interacting with it. They begin to see how they process this information, where they might be getting sucked in. They know how to calm themselves down. They know when they are getting riled. They know when their buttons are being pushed. So there's a multitude of things where clinically I can see this and say that's really nice but if I were to, like, 1-2-3 list it all out I can't [several people talking – unintelligible]

F6: One of the reasons I like my supervision is I like to be able to ask the clients what the therapist did that they found…what was it like to be with that therapist. What did they find useful? What would they like to see more of or less of? I want to know from the client what they think is making a difference.

M5: Debrief the client?

F6: If possible, that's it.

M5: Which informs the therapist of what to do and what to change.

W: Listening to you two reminds me…we all go back to what's familiar and [M] will recognize Anton Boisen…Boisen was always talking about that the client is the living human document. So, you're wanting to consult the living human document.

F6: There's the one's who know whether it's making a difference.

M5: Even if it's with our own client. Ask them what it's been like to be with us the last 3 sessions.

F6: It's remarkable that they tie in some things that you wouldn't expect them to. [unintelligible chatter]
M6: It's interesting that you say that…I'm thinking back on a period of time in my life in which I was in some family therapy of my own. And I was looking at what I thought was a very good therapist, but I remember thinking to myself…What…I mean, I'm a therapist I deal with this every day and I'm very clear that things are better…I'm clear about that…but I could not tell you what made it better. I even had this discussion with the therapist. I said, you know, I'm a therapist and I've been trying to figure out why it's better and what's happening here. I remember that part of the discussion was something to this effect—maybe when you're in therapy, when you are the client, there's such a lack of [unintelligible]…maybe you just don't know. Maybe if you knew [F6: You would have done something about it. Laughter] would not be the same experience. Does that…I'm just thinking I couldn't tell you…I'm not even sure…now I could write a paper about it today 20 something years later, and I still don't know that it would be very accurate.

F6: I think that's true that people don't often know what makes it better, but they can sometimes tell you what is it like to be here and what do you find that has made some difference for you…it can be something that you would never expect them to say. You just didn't know that was what was speaking to them. But they may not know, in general, what's making the difference.

F7: Also, therapy is a process. There may be something working inside of you that you may not be aware of but it works.

F6: They might tell you that it works.

M7: One of the things that I do on intake is [unintelligible due to several speaking, though it sounds something like asking about previous therapy]. Taking it back to a supervision level maybe the first two or three times that may be all the client knows is that it works. I know we'd live numbers and statistics and all that kind of stuff but…it seems not too long ago there was a conference on the art of therapy and it's not all science, and we're not hard science people, even though our culture might [laughing and several speaking make it unintelligible] but there is a push with government funding and all these kinds of things to have something hard to show. They expect you to do a checklist, but that's not always working. [unintelligible] I had a supervisee who talked about one thing the first session and then the next session she had another personal problem she wanted to talk about and the third session it was something different. It was always something and she was always

saying I'm going to start this or I'm going to join this group or I'm going to do anger management. It really got just tiring and to me..well, eventually I just had to say I wasn't going to be this person's supervisor, but from the very first session I seemed to sense that here was a person more interested in name making than therapy. She was always chasing something.

W: Well, you consented to 30 minutes and I've taken my 30 minutes. I thank you all very much.

Appendix B
Supervisor Conversation Coding Worksheet

✂ Counseling competency

✂Intentional in some manner that has goals

✆Personal growth and awareness

✂Awareness of their impact on other people

✈Bring about change in an ethical way

✎To build clinical skills [group made explicit – this is not the same as competency above]

✎Learning how to gain clinical skills

✎✂To have a treatment plan [discussion clear – not just paperwork but to actually use it]

✂Know where you are going

✆[Supervisee to] Develop their own style. Do something you feel comfortable with that's within your theoretical approach.

✒The goal of supervision is to bring that [psychological, emotional, spiritual health in client] about. The outcome [of clinical training] is the client.

✆Integrating the theoretical minds in clinical practice.

✚Know in your gut [the supervisee is making improvement]

✚ [Referring to his own personal therapy] I'm very clear that things are better…I'm clear about that…but I could not tell you what made it better.

✂✖Move beyond the content of the room and seeing the process and interaction.

✂If I [supervisee] find a vein of information I can keep mining that vein instead of just going on to the next question. They can go deeper and deeper.

✆They begin to see how they process this information, where they might be getting sucked in.

✖✒Ask the clients what the therapist did that they found…what was it like to be with that therapist.

✖✆Therapy is a process

Themes – Axial coding

✂ Good Executive Skills (6 instances)

✆ Application of theory to practice (3 instances)

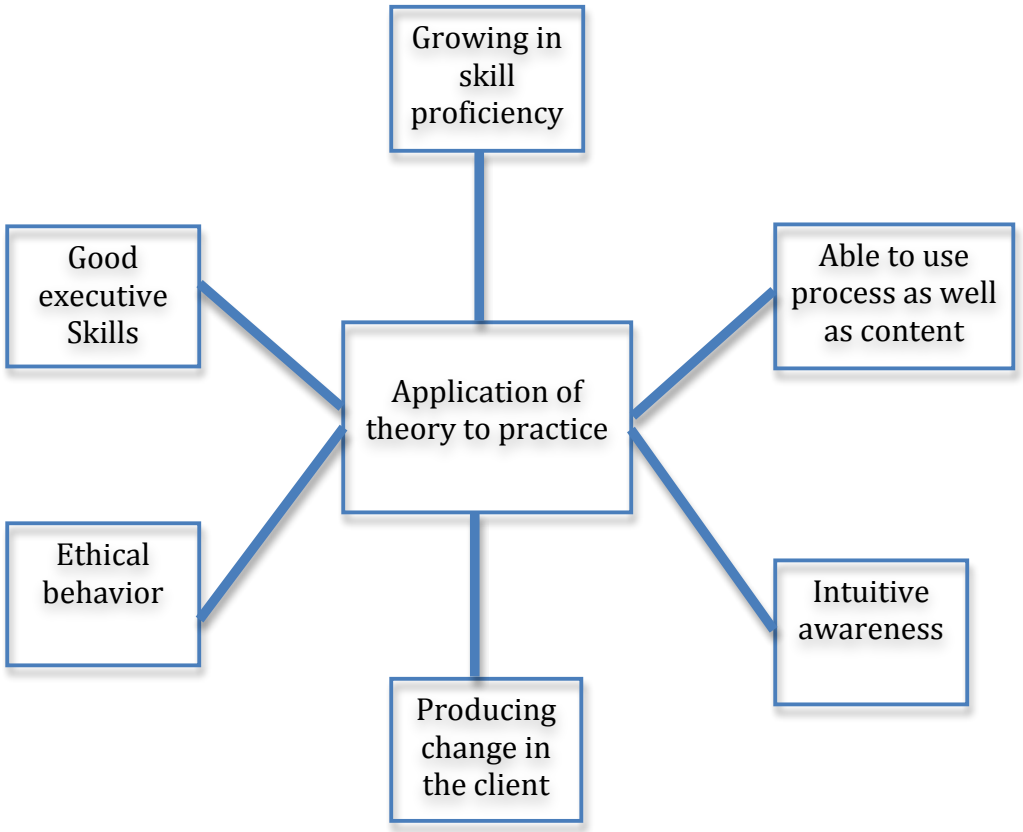
✈ Ethical behavior (1 instance)

✎ Growing in skill proficiency (2 instances)

✒ Producing change in the client (2 instances)

✖ Able to use process as well as content (2 instances)

✚ Intuitive awareness (2 instances)



Appendix C
IRB Approval Documents

Approval for the Focus Group study:

From: John M. Trent
Sent: Wed 1/21/2009 8:15 AM
To: Wayne Perry
Subject: RE: Abbreviated IRB approval

Wayne,

Looks fine with me...for the records include this in your original IRB application...and it will become part of your dissertation...

John Mark

John Mark Trent, PhD
Educational Psychologist
Family Therapist

Asking the right question remains the best strategy to get the right answer...

Change occurs only as we begin thinking about and working on the self ---
rather than staying focused on and reactive to the other
http://relationalgrace.blogspot.com/
My Link to Services Offered

———

-----Original Message-----
From: Wayne Perry
Sent: Wednesday, January 21, 2009 6:48 AM
To: John M. Trent
Cc: Dale Bertram
Subject: Abbreviated IRB approval

John Mark

As on step toward my dissertation, I proposed to do a modified Delphi study. Here are the details.

At the ALAMFT Supervisor's Workshop in February, I proposed to interview the assembled supervisors with just one question: "What is the purpose of clinical training?" There will be follow-up questions to clarify the supervisors' responses but everything will focus on getting a clear response to that one question. I will record those responses via digital voice recorder and make a transcription of that data. That transcript will become one potential resource for my PhD dissertation.

I will be using a sample of supervisors in Alabama - the supervisors who register for and attend the ALAMFT Supervisor's Workshop. My conversation will come right after lunch, before the group resumes its regular work. This part of the process has already been approved by Dr. Bertram, the course facilitator. I will have approximately 30 minutes for this conversation. I do intend to count the number of responders, but I do not intend to make any record of who said what. In other words, there will be no direct, personal attribution. I would either summarize what the group said in aggregate, or I would quote one person by saying something like "One supervisor said....."

If this email will suffice for an abbreviated approval, I will appreciate it. If you need me to submit the entire form, I can do that, but I will need approval fairly quickly since the conference is less than a month away.

I appreciate your looking at things.

Wayne

C. Wayne Perry, D.Min., LMFT Approved Supervisor
Professor, School of Human Services
Clinical Programs Director
Amridge University (formerly Southern Christian University)

wayneperry@amridgeuniversity.edu

Approval for Final Study Exception from IRB Review

From: John M. Trent Sent: Sat 9/26/2009 9:58 AM To: Wayne Perry Cc: Dale Bertram Subject: RE: My IRB request

Attachments:
View As Web Page
Looks like you are good to go WAYNE!

Consider this EMAIL OFFICIAL NOTIFICATION that your research activity as defined in the attached LETTER/PROTOCOL is APPROVED by AU HUMANS SUBJECT'S REVIEW BOARD. This approval applies only to this project and any changes in DATA gathering (including types of data) and any changes in how/who your subjects are will need to be approved prior to implementation of 'new' design...

Onward and upward!

JMT

John Mark Trent, PhD Educational Psychologist Family Therapist

Change occurs only as we begin thinking about and working on the self --rather than staying focused on and reactive to the other

http://relationalgrace.blogspot.com/

From: Wayne Perry **Sent:** Sat 9/26/2009 6:55 AM **To:** John M. Trent **Subject:** RE: My IRB request

John Mark

Thanks so much. Here it is. I'll be looking forward to your response. As soon as I get your (hopefully) approval, I'll get back on Chapter 3 and make sure that what I do does indeed match what I say I will do.

Wayne

C. Wayne Perry, D.Min., LMFT Approved Supervisor

wayneperry@amridgeuniversity.edu

Amridge University

25 September 2009

John Mark Trent, Ph.D.
Amridge University
Research and Analysis
1200 Taylor Road
Montgomery, AL 36117

Dr. Trent;

I am completing my dissertation for my Ph.D. in Family Therapy. Prior to beginning the actual research, I am writing for an Exemption from IRB Review for my project. Specifically, I am asking for an exemption under Exemption 1, Research conducted in established or commonly accepted educational settings. The rest of this letter gives the justification for this request.

I propose to conduct a qualitative study of the process by which the Amridge University Clinical Training Program assists our students in developing a professional identity. Specifically, this will be a phenomenological study of what the students, and their site supervisors, have found useful in developing that professional identity. There are three research questions for this study:

> Research Question One: What is the phenomenological experience of the students involved in the clinical training process at Amridge University? Do the students engaged in the process find it helpful? Do they find that the purported benefits translate into actual benefits in their, the students', own experience? How well prepared and trained do they feel compared to other student interns they encounter? The assumption behind this research question is that if the process under investigation is in any sense valid, there will be some degree of perceived benefit on the part of those undergoing the process.
>
> Research Question Two: What is the phenomenological experience of the site supervisors involved with student interns at Amridge University? How well prepared do these supervisors perceive the Amridge students compared to other student interns these supervisors have known and/or supervised? How helpful do the supervisors perceive the connections with Amridge University to be, especially given the issues of distance and even time zones? The first assumption behind this research question is that the supervisors will, by virtue of their experience as licensed mental health professionals, have a broader gaze than the students. This broader gaze will, in turn, give them a larger basis from which to make judgments. The second assumption behind this question is that if the process under investigation is in any sense valid, the supervisors will perceive some degree of similarity between the quality of student interns at Amridge University and other student interns they have known.

> While this current study will not seek to quantify any similarity uncovered, I will attempt to capture the subjective experience of supervisors who experience that similarity.
>
> Research Question Three: What phenomenological evidences of growth in professional identity are evident as a result of this process? To what degree do student interns perceive themselves as more competent, more "at home", in their chosen profession? To what degree do they attribute the Amridge University clinical training process a help to that growth? To what degree do supervisors perceive their student interns have grown in their identity as mental health professionals? The underlying assumption behind this research question is that a primary purpose of graduate clinical training is growth in professional identity. The basis of this assumption is spelled out in the Review of the Literature chapter of this study. If growth in professional identity is a primary purpose of graduate clinical training, then it is reasonable to conclude that the Amridge University clinical training process, if it is valid, will contribute in some measure to the perceived growth in professional identity on the part of the student interns.

Participants in this study will students in Clinical II or Clinical III during the Spring 2010 Semester. From this population of an estimated nineteen students, I will select participants based on two criteria: the student must volunteer to participate, and the student's site supervisor must volunteer to participate. Both criteria must be met before the student participant will be selected. I hope to have a final cohort of approximately 10 students and their site supervisors, making a total of 20 interviews to be coded and analyzed according to the standard hermeneutical phenomenological protocol. Once students and site supervisors have volunteered to participate, I will send them an email acknowledging their offer and thanking them for agreeing to participate.

Principle 5.3 of the AAMFT Code of Ethics requires that "Investigators respect each participant's freedom to decline participation in or to withdraw from a research study at any time." I will explicitly state this principle in the email I send to all those who agree to participate so that they clearly know they have the right to decline or withdraw at any time. I will further explicitly state what students already know – that their clinical training grade is a pass/fail grade based on objective criteria totally under their control. My subjectivity can have nothing to do with their grade, which is and has been the case in clinical training for more than the last 5 years. Therefore, their participation, or decision to decline or withdraw participation, will have no impact on their grade whatever. This should address any concerns student or supervisor participants might have about student participation. The potential for making this an exploitative relationship is minimal if not totally nonexistent.

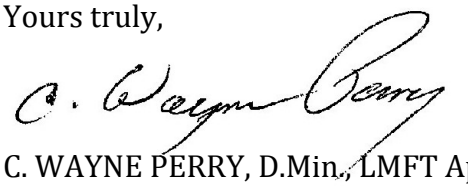
The methodology will involve two telephone interviews. The first will take place early in the Spring Semester. This will be the primary interview and will include the attached questions. The second interview will be a "member check" interview later in the Spring semester, when I feed back to the participant what I heard from them, giving them an opportunity to confirm or modify my observations, as appropriate. Only after the participant has agreed with my accuracy will the data be included in the final analysis.

I believe this fits exactly Exemption 1. The focus of the research is on the effectiveness of an ongoing, standard educational program at Amridge University. The measure of the effectiveness is, as stated above in the Research Questions, the participants' phenomenological experience of the program. The sole focus of the questions is the student's experience of the program, as viewed by the student and as viewed by the supervisor. Beyond that and the information I routinely collect as a normal part of the clinical training program (e.g., information about the supervisor's credentials), I will solicit only minimal demographic data (i.e., student age, student's occupation prior to entering the Amridge University master's program) in case the data suggests that these variables may be useful in interpreting the statements given by participants.

My Chair for this study is Dr. Dale Bertram. I am providing him a copy of this request for his records.

I appreciate your prompt response so I can finalize my Methods chapter and proceed with my plans to actually carry out the research.

Yours truly,



C. WAYNE PERRY, D.Min., LMFT Approved Supervisor
Professor, School of Human Services
Clinical Programs Director

Cc: Dr. Dale Bertram

Questions for Proposed Research

Demographic Data to be obtained from Clinical Training Program files

Participant City and State
Participant Gender
Supervisor License Type and Years of Experience as a supervisor

Questions to be asked of student participants [The researcher will likely amplify each question according to the student's response, in order to capture the student's phenomenological experience accurately. No areas other than these will be covered.]

1. Just for the record, how old are you? What occupation were you in when you entered the master's program at Amridge?
2. I want you to think back as best you can to when you first started Practicum. How clear would you say you were in your identity as a marriage and family therapist/ professional counselor? What experiences up to that point helped you get to where you were in your new identity as a marriage and family therapist/professional counselor?
3. How comfortable with your identity would you say you are now? What experiences in your clinical training have helped you come to where you are now? What experiences did you find most helpful? What experiences did you find least helpful?
4. If you had the opportunity to talk with students from other university programs, how do you think your preparation as an intern compares with these other students?
5. One of the benefits we claim is that our program allows our students to experience a much wider variety of clinical issues and settings than they could if they only experienced their own clinical site. Did you find this helpful to you in your comfort with your own clinical work?
6. According to our definition [on the BSED], you are now either a senior Intermediate or an Advanced intern. How confident are you that you are adequately prepared for your future profession once you graduate?

Questions to be asked of site supervisors [The researcher may amplify each question according to the supervisor's response, in order to capture the supervisor's phenomenological experience accurately. No areas other than these will be covered.]

1. If you think back to when you first met your student intern, how well prepared did he/she appear to be compared to other similar students you know known in your career? What impressed you the most? What concerned you the most? How have those impressions changed over the course of your work with your intern?
2. How helpful has your connection with Amridge University been? Given the limitations of distance, what would you like to see improved?
3. Now that your intern is nearing the end of his/her master's work, how well prepared do you perceive your intern to be to assume the professional role? How comfortable are you with being associated with him/her in his/her future work?
4. What was your impression of clinical training by distance education prior to beginning your work with your Amridge intern? What is your impression now? To what do you attribute this change?