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Self-criticism in therapist training: A grounded theory analysis

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Abstract
Objective: The primary objective of this study is to engender an understanding of how therapists-in-training experience and cope with self-criticism in the context of their clinical training and therapy experiences. **Method:** In this study, trainees were interviewed about their experience of self-criticism related to psychotherapy practice and these interviews were subjected to a grounded theory analysis generating a core self-critical process. **Results:** The analysis highlighted the vulnerability of self-criticism in therapists' training experiences, especially when they related to balancing the "expert" role while maintaining authentic interactions with their clients. The results also described ways in which self-criticism is mitigated by a sense of interpersonal safety and the provision of clinical freedom and flexibility in therapists' training. **Conclusions:** The implications for future psychotherapy research and clinical training within clinical training environments are discussed.

Keywords: supervision; psychotherapy training; self-criticism; therapist training; clinical competencies

Research on self-criticism has been gaining emphasis in the psychopathology and psychotherapy literature (Bergner, 1995; Blatt, 1974; Cox, Enns, & Clara, 2002; Kannan & Levitt, 2013; Whelton & Greenberg, 2005; Zuroff, 1994). While self-criticism may be experienced universally, there can be differences in its form, severity, and consequences for each individual (Whelton & Henkelman, 2002). Typically, self-criticism has been conceptualized as functioning for multiple reasons and purposes (Gilbert, Clarke, Hempel, Miles, & Irons, 2004), including constructive and adaptive ones (Chang, 2008; Rogers, 1951). For instance, Gilbert et al. (2004) noted that the process of being self-critical can have different functions and underlying rationales. Using the Functions of Self-Criticism Scale they identified two components of self-criticism: self-correction (e.g., to help me perform better) and self-persecution (e.g., to punish myself). This conceptualization of self-criticism suggests that healthy self-criticism might be key in the development of therapists in training as they work to incorporate new skills and ways of relating into their repertoire.

Excessive self-criticism, however, has been most often been studied in connection with depression and perfectionism (Campos, Besser, & Blatt, 2013; James, Verplanken, & Rimes, 2015; Zuroff, Koestner, & Moskowitz, 2012). Self-criticism also has been associated with numerous psychological conditions such as anxiety, trauma, personality disorders, and suicide (e.g., Cox, MacPherson, Enns, & McWilliams, 2004; Firestone, 1988; Zuroff, 1994). Instead of serving the function of self-enhancement, this form of self-criticism can become self-destructive. Reflective of both of these traditions, self-criticism is defined in this paper as *a conscious or unconscious negative evaluation of oneself that can be a healthy and reflexive behavior, but can have harmful effects and consequences for an individual* (Blatt, 1974; Chang, 2008; Gilbert & Irons, 2005; Whelton & Greenberg, 2005). This definition was drawn from a recent review of the literature on self-criticism across multiple psychopathologies and theoretical orientations (Kannan & Levitt, 2013) and is borrowed in this paper to refer to novice therapist self-criticism as we explore

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its occurrence within the context of their clinical training experiences.

Self-criticism and Psychotherapy Training

Self-criticism has been found to impact various aspects of psychotherapy training and development. This evaluative process appears to influence both trainees' learning experiences and their ability to form alliances with clients. For instance, Orlinsky, Rønnestad, and Willutzki (2004) predicted that the overall level of a trainee's stress can predict client outcomes in therapy. Supervisors and trainees should jointly work to reduce the perceived stress in their trainees as it has been found to impair the formation of strong working alliances with clients (Gnilka, Chang, & Dew, 2012). Also, the literature on therapist and trainee development suggests that self-criticism restricts trainees' ability to attend to clients' emotion in session. Self-criticism has been found to be inversely and significantly correlated with aspects of emotional intelligence such as attention to emotions, clarity of emotions, ability to repair and discern others' emotions (Myers, 2007).

Wampold and Imel (2015) described therapists as a central factor in therapy outcomes that accounts for approximately 3–7% of the variance within client outcome, far exceeding the effects of treatment orientations (approximately 1%). Developing one's own style as a therapist can be a daunting task at first. Difficult experiences for novice therapists can include calming performance-related fears, negotiating therapeutic ruptures with clients, and adjusting an inflated sense of responsibility for clients. Through these initial tasks, being able to negotiate self-doubt and self-criticism appears likely to influence their developing clinical practice (Oliveira & Vandenberghe, 2009; Orlinsky & Rønnestad, 2005).

In one of the few qualitative studies on novice therapists' internal experiences, Hill, Sullivan, Knox, and Schlosser (2007) studied trainees' experiences of their training through a semester long training that included components of experiential skills training, psychological theory, and individual supervision. Trainees were instructed to make weekly journal entries about their experiences (e.g., therapist competence, anxiety, self-efficacy, self-criticism, reactions to supervision). The authors concluded that self-criticism was prominent across multiple aspects of therapist development (e.g., being fully present with the client, feeling incompetent in establishing a good therapeutic relationship, not having adequate termination skills). Although this study utilized a small sample of graduate trainees, the results indicated that self-criticism is not an isolated phenomenon, but that trainees were found to come up against their critical thoughts frequently in their training (Hill, Sullivan et al., 2007).

In another qualitative study, Oliveira and Vandenberghe (2009) explored the ways in which therapists with up to three years of experience in independent practice coped with upsetting experiences in session. The most distressing experience for therapists in the study was when clients closed themselves off in session and resisted therapists' attempts at deeper exploration of presenting issues. Therapists reported subsequently feeling self-critical, insecure about their effectiveness, and angry toward the client. The authors described a number of coping strategies used by the therapists in dealing with their feelings such as disclosing the nature of their distress to clients and reframing client hostility in supervision so as to explore the specific function that the interaction may have had in their relationship.

While therapists-in-training may be likely to encounter self-criticism in their work with clients, researchers also have examined the role of self-criticism in the supervisory alliance and supervisor style (Gard & Lewis, 2008; Gray, Ladany, Walker, & Ancis, 2001), and the developmental process of learning to be a competent therapist (Aronov & Brodsky, 2009; Hill, Stahl, & Roffman, 2007; Mehr, Ladany, & Caskie, 2010). Many discussions of supervision describe how supervision can influence emerging trainees' self-evaluation and confidence (e.g., Falender, Shafranske, & Olek, 2014). Research has explored trainees' experiences in supervision, finding that their attributions of supervisors' dismissal of trainees' thoughts and feelings weakened the supervisory relationship (Gray et al., 2001). In his meta-analysis of 18 outcome studies on the effects of supervision on therapy outcome over the past 30 years, Watkins (2011) found that the supervisory alliance was related to both theoretical orientation coherence between the supervisor and supervisee as well as to client satisfaction. This body of research suggests that supervisory relationships provide a context that can influence supervisee self-criticism and they have implications for the training of therapists to work successfully with clients.

Study Objectives

The primary objective of this study is to engender an understanding of how therapists-in-training experience and cope with self-criticism in the context of their clinical training and therapy experiences. Our focus is on the phenomenological experience of self-criticism. Within this mode of research, it is understood that self-criticism could overlap with other

concepts that are experientially related to it, such as self-evaluation, or self-awareness. However, the objectives include looking to understand the lived experience of self-criticism for therapists-in-training. This holistic focus is typical in qualitative research that is often recruited to study subjective experiences that do not have sharp demarcations from other concepts.

Method

Participants

Therapists-in-training. Participants in this study ($N = 14$) included graduate trainees in clinical and counseling psychology doctoral programs in an urban university in the Mid-South region who were receiving supervised training in psychotherapy ($n = 13$). An additional participant was a recent graduate who was training at the postdoctoral level ($n = 1$). Participants were between the ages of 24 and 48 (Mean = 29.60, $SD = 6.80$). Majority of the trainees were women (78.6%; men = 21.4%) and Caucasian ($n = 13$). They reported a range of years conducting psychotherapy (0.5–6 years). The estimated number of hours of supervision trainees had received ranged from 25 to 800 hr and had taken anywhere from 1 to 5 therapy courses during their training. When asked about theoretical orientations, participants listed the following orientations as being most influential so far in their training: cognitive-behavioral ($n = 8$), humanistic/existential ($n = 4$), and interpersonal ($n = 1$).

Although most of the trainees were from the same program, it appeared to the researchers from their recruitment effort response, feedback from the trainees, and the study of our data that knowing the researchers and the ways they analyzed their data allowed trainees to feel comfortable disclosing data that would have been very vulnerable to confess to someone unknown. Still, there was a great deal of diversity among the participants in many regards. Most trainees ($n = 12$) changed their supervisors every year and had both internal departmental clinic supervisors as well as external supervisors in inpatient hospitals, private practice, veteran's hospital, prisons, and community mental health settings and thus drew their experiences from multiple contexts. Only three trainees had one supervisor and the other trainees ($n = 11$) ranged between having 3–12 supervisors by the time of the interview. Although the trainees being associated with one university could limit the study's transferability, the sensitive nature of this data makes it all the more important to study.

Procedure

Recruitment. Participation in this study was optional. The faculty member second author did not know which trainees participated and the trainees were informed that faculty would not know. Although the researcher was known to most participants in the study, trainees were asked about how they felt about being interviewed by someone they knew and if the process was comfortable. All participants reported feeling comfortable and in fact some signaled that it helped them to disclose. Trainees were individually invited to participate in the study via a letter emailed to all clinical and counseling trainees in training at the researchers' university. The initial invitation letter was also sent to online psychotherapy listservs and discussion groups. Additionally, this letter was sent to faculty and off-campus supervisors who supervised other trainees and agreed to forward the letter to their supervisees. Trainees who responded to the invitation letter and indicated their interest in the study were contacted individually by the researchers to schedule an in-person ($n = 13$) or a telephone interview ($n = 1$) for an out-of-town therapist. Prior to beginning the interview, trainees were told the following about the nature of the study.

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

Qualitative Method

Retrospective recall interviews. Participation in interviews was voluntary and confidential and participants were told that they could withdraw at any time during the interview. Interviews were semi-structured and questions were posed as needed to fully explore trainees' experiences. The interview was developed based upon reviewing the literature for important concepts and consulting with clinical supervisors and students about the function of self-criticism in trainees' development. The overarching interview question was, "What is your experience of self-criticism as it relates to learning and performing psychotherapy across your training?" Additional questions were asked to clarify the role of other factors that may impact self-criticism. These focused within the following areas: moments that trigger self-criticism, supervisory experience, effect upon development as a therapist, relationship with

clients, shifts in self-criticism over time. Example questions included: "Are there events, feelings, and thoughts that have triggered self-criticism in your therapy or training?" and "Does your relationship with your supervisor influence your self-criticism? If so, how?"

Using the retrospective recall method for this study enabled trainees to think back across their many cases and developmental experiences and was advantageous in that this method appeared to elicit durable criticisms. Enduring criticisms have the potential to influence trainees' assessment of their comfort with psychotherapy and lead them to be less likely to feel reassured (Gilbert & Irons, 2005; Gilbert & Procter, 2006). However, multiple sources of self-criticism that can arise from training experiences (e.g., supervision, peer interaction, therapy) can also be identified. Each interview lasted 45–60 min and consent was obtained to audio record and transcribe the interviews. Although given the option, none of the trainees in the study asked for any part of their transcript to be excluded from the analysis or the transcripts. The audio recordings of these interviews then were transcribed by the first author and subjected to a grounded theory analysis coded by both authors.

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

Once the interviews were transcribed by the first author, the data were divided by her into meaning units (MUs), which are segments of texts that contain one main idea (Giorgi, 1985). In the initial stages of the analysis, the MUs were labeled in a manner that remains very close to the language used by the interviewees in the study. The MUs then were compared and organized according to their similarities by both researchers in this study, creating lower-level categories of MUs, which were further grouped into higher order clusters based upon the commonalities among the lower-level categories. The second author supervised the project and acted as a co-analyst. She reviewed the interviewing, unitizing and categorization processes, and provided feedback in weekly meetings. Interviews continued until saturation was reached; specifically, the point at which transcripts added to the hierarchy did not result in additional higher order categories or clusters. In this study, saturation was achieved at the 11th interview, and the last three transcripts did not add any new data. In this process, both authors reviewed the hierarchy and agreed that saturation had been met.

The researchers also kept a record of developing theories about interviewees' experiences of self-criticism throughout the process of analysis. This process of note-taking allows researchers to keep a record of salient ideas emerging from the analysis, to record method-related decisions, and help them become more aware of their biases so they can consider how to limit their effects on the study (Rennie, 2000).

Researchers. Information on the authors' perspectives and backgrounds is helpful in qualitative methods as it provides a context for the reading of findings (Fassinger, 2005; Morrow, 2005). The researchers were an East-Indian heterosexual doctoral student in clinical psychology and a White lesbian clinical psychologist. The researchers shared interests in constructivist therapies and had integrative theoretical orientations. The primary researcher had a history of studying self-criticism and therapist development. The secondary researcher had expertise in qualitative methods—having taught qualitative methods courses and been recognized for the quality of her work in this area. The researchers began this work believing that self-criticism is a universal phenomenon that can be an adaptive experience. They also believed that self-critical and self-questioning attitudes are salient for many therapists-in-training, and that supervisory experiences can help shape the ways in which they learn to cope with their self-criticism.

Credibility checks and epistemology. In order to enhance the credibility of the study, three kinds of credibility checks were used. First, trainees were asked questions at the end of each interview to check that the responses were thorough and seek out any omitted information (e.g., "Was there anything we did not ask that seemed important in this interview?"). Second, a process of consensus was used in the creation of categories and the development of the model of self-criticism between the researchers who met weekly to discuss the analysis for a period of approximately one year. This procedure of seeking consensus was used to support the researchers to raise issues based upon their perspective for the other to consider. In keeping with our epistemological stance, we sought to recognize each other's sources of expertise (as described in the researchers section) in order to increase our

attunement to our data. Through these discussions, differences in interpretation were resolved. Third, interviewees were emailed a summary of the findings of the study and asked to provide feedback by indicating their level of agreement to the summary descriptions of each cluster.

The authors approached inquiry from a constructivist-social justice framework (Levitt, 2015). They were interested in the content of meanings that answer research questions as well as how they are constructed within the interviewees' contexts. Within this perspective, using a research team model is viewed as particularly helpful when it brings different areas of expertise to the analysis that might enhance interpretation of the data—such as expertise in the interviewing process or diversity of experiences—as is the case in the current study. In the process of discussing interpretations and seeking consensus, the source of epistemic privilege of the researchers (i.e., their expertise) is recognized within discussions so that they can develop interpretations. The authors' goal is to value distinct sources of expertise in fine-tuning interpretations.

Results

The data derived from the interview transcripts (N = 14) yielded 517 MUs across all transcripts in this study. This hierarchy produced one *core category*, 5 *clusters*, 14 *categories*, and 34 *sub-categories* (see Table I for cluster and category titles). Levels within the hierarchy are distinguished by these terms. The MUs then were compared and organized according to their similarities into sub-categories, which were then grouped into categories, and then clusters. As is typical in grounded theory, MUs could be assigned to more than one category; therefore the final hierarchy included 543 MUs.

This results section contains a description of each of the main clusters (i.e., second layer) and categories (i.e., third layer) of the hierarchy, in turn, followed by a description of the single core category (i.e., top layer). Descriptive labels and numbers are used to indicate how many trainees contributed to each cluster and category in the hierarchy (i.e., 3 = Few, 4–6 = Some, 7–9 = Many, 10–13 = Most, 14 = All). Because the data collection was based upon the analysis of semi-structured interviews and not a survey, however, trainees were not asked their agreement to each category directly (as these categories were only developed from the analysis of the data). This number should be interpreted instead to suggest how salient a category was for the trainees within the interview. In contrast, a sense of how many trainees agreed with the clusters is presented later in this section via the trainee feedback. Participants were contacted twice via email to provide feedback on the results of the study. For those trainees that did provide feedback (N = 10), when asked whether the research findings overall reflected their experiences of self-criticism, the mean response on a 7-point Likert scale was 6.6 (1 = Not At All, 7 = Very Much). When asked if the findings contradicted their experiences of self-criticism, the mean response was 1.2, suggesting that the findings represented their experiences.

Cluster 1: Self-criticism Is Tied to Misconceived Responsibility

The complete title for this cluster was: "I am more Vulnerable to Self-Criticism When I Feel Entirely Responsible for Solving my Clients' Problems." Participants who contributed to this cluster (n = 13) described feeling as though they were solely responsible for the outcome of therapy. Trainees' perceptions of their connection with clients and their ability to successfully guide them toward better outcomes appeared to make them more vulnerable to the effects of self-criticism. When they were asked to give feedback on whether this cluster fit with their experience of therapist self-criticism, the mean response was 6.1 suggesting that the findings fit with their experience. There were three categories in this cluster.

Category 1 of Cluster 1: my self-criticism increases when I am doubtful about how to direct the session, especially if I am viewed as an expert. In this category, many trainees' self-criticism was activated when they were unsure about how to direct their clients in session. One trainee said:

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

Trainees' self-doubt about how to lead clients in session was particularly heightened when clients expected ready solutions for their problems. For instance, one participant said, "Anytime they're [clients] turning to me like, 'You're the expert tell me what to do,' then that's when I start to … like I don't want to over-represent my self-criticism but these are times when I am self-critical" (T-1).

Table I. Clusters and category titles.

Clusters	(*N*)	Categories	(*n*)
Cluster 1: Self-Criticism is Tied to Misconceived Responsibility	13	My self-criticism increases when I am doubtful about how to direct the session, especially if I am viewed as an expert	8
		Early termination and poor alliance with clients creates feelings of inadequacy and self-criticism	9
		Accepting that the client plays a part in making therapy successful can relieve my self-criticism	6
Cluster 2: Self-Criticism Functions as an Interpersonal Barometer	14	Contrasting clinical perspectives and opinions make me question my efficacy as a therapist	6
		My self-criticism is normalized when supervisors share their past clinical struggles and give me feedback on the appropriateness of my self-criticism	9
		Sharing my self-criticism with peers is a supportive experience and relieves my sense of isolation in my struggles	6
		When I compare my performance to an ideal standard or with a supervisor whom I respect, I am less forgiving of my clinical mistakes	7
Cluster 3: Supervisors' Judgments Increase Shame and Self-Protection	13	Painful self-criticism about my incompetence can result from being critiqued in self-revealing exercises and videos in supervision	12
		Fears of being viewed negatively by my supervisor leads me to masquerade as a competent therapist and hide my true feelings	8
Cluster 4: Self-Criticism Reduces with Experience and Clinical Exploration	14	Self-criticism hinders my development, especially taking the form of a meta-critical process in my therapy	14
		Anxiety about supervision intensifies self-criticism when supervision is rigid and prescriptive	5
		My anxious self-criticism decreases as I become more comfortable with interventions	14
Cluster 5: Supervision can Foster Learning From Self-Criticism	14	Feeling supported by my supervisor makes it easier to show my clinical weaknesses and learn from them	7
		Supervision is a safe space for open dialogue about how my feelings can impact my growth as a therapist	14

Ironically, having their self-confidence and expertise undermined in these ways could potentially lead to a cyclical process wherein some trainees experienced self-doubt over similar clinical interactions with clients across time.

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

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

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

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

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

Category 3 of Cluster 1: accepting that the client plays a part in making therapy successful can relieve my self-criticism. Some trainees expressed that when they considered clients' responsibility in participating in therapy, this tended to buffer the harsh impact of self-criticism on their perceptions of their therapy. One trainee said, "I think I've become less critical as I come to see therapy as more of a collaborative process rather than me being in charge of the direction of how things are going" (T-6). Additionally, when clients

shared with their therapist what they learned in therapy, trainees were less critical about their work.

Cluster 2: Self-criticism Functions as an Interpersonal Barometer

For this cluster, the complete title was: "My Self-Criticism Functions as an Interpersonal Barometer that Sometimes Makes me Question my Efficacy, but Also Normalizes my Clinical Experiences." All participants in the study revealed that their self-criticism often was characterized by a drop or an increase in their self-criticism, as determined by their interpersonal interactions with clients, peers, and supervisors. While self-criticism was also endorsed as an intrapersonal phenomenon in the previous cluster, the interpersonal dimension here is additive. The metaphor of a barometer has been selected because it reflects the atmosphere that is the context for the process of learning therapy. When trainees were asked to give feedback on whether this cluster fit with their experience of self-criticism as a developing therapist, the mean response was 6.4.

There were four categories in this cluster.

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

> It [self-criticism] can come in little things, like do you use the overhead lights [in session] or do you use the lamps. And I thought, "Well of course, you shouldn't use those overhead lights; it's like an interrogation room." But one of the girls [peer] was like, "I've read the literature on this and apparently clients are more honest and divulge more with the lights bright." So then it threw my whole vision of therapy. (T-3)

Category 2 of Cluster 2: my self-criticism is normalized when supervisors share their past clinical struggles and give me feedback on the appropriateness of my self-criticism. Many trainees appreciated their supervisors' candidness and self-disclosures about their own mistakes in their training as it helped normalize their clinical experiences. One trainee emphatically stated:

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

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

> I want it to be a more complex self-criticism that knows how to differentiate the things I should be critical about vs. the things I shouldn't be and I don't think that's going to happen until I have just lots of experience on top of lots of education. Now it touches everything instead of discriminating against what I should be critical about and what I shouldn't be. (T-3)

Therapists-in-training noted that when they perceived their supervisors as being candid about their own developmental process and errors in clinical judgment, they were less likely to perceive their mistakes as failures, but more as a building block in their training toward honing their skills.

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

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

how her self-criticism was triggered in the presence of her supervisor.

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

Cluster 3: Supervisors' Judgments Increase Shame and Self-protection

The third cluster was titled, "Negative Judgments by my Supervisor can Lead me to Don a Facade of Competence in my Training and Hide my Shame." Trainees discussed their concerns about how they would be perceived by their supervisors and their desire to hide feelings of uncertainty or anxiety about their performance. To mask these feelings, they described portraying a false sense of competence and confidence at times. When they were asked to give feedback on whether this cluster fit with their experience, the mean response was 6.0 suggesting high agreement with the findings within this cluster. There were two categories in this cluster.

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

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

Another participant described a supervisor's feedback as leading to depression.

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

However, trainees were more receptive to feedback when they felt that their supervisors acknowledged their strengths and weaknesses, as they were perceived as more constructive and balanced.

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

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

Additionally, many trainees tended to hide their anxiety and weaknesses in supervision if they felt that they might be criticized or dismissed by their supervisor for admitting their mistakes. One trainee said, "I guess also feeling a little put down … with the two supervisors what I needed to say wasn't important enough to hear? Certainly a feeling of being dismissed or less important than I wanted to feel" (T-8).

Cluster 4: Self-criticism Reduces with Experience and Clinical Exploration

The analysis of the data in this cluster produced the following cluster title: "My Self-Criticism can be Harsh, but is Being Tempered over Time through Experience and Increased Clinical Freedom Versus Overly Prescriptive Supervision." The results in this cluster underscores the salience of self-criticism at the beginning stages of therapist training as well as factors that help moderate their self-criticism over time and experience in their training. When they were asked to give feedback on whether this cluster fit with their experience of self-criticism as a developing therapist, the mean response was 6.3, suggesting a high level of agreement. There were three categories in this cluster.

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

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

Trainees often used words such as "beating myself up" and "ruminating" to describe how their criticism evolved. One trainee said:

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

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

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

Another trainee described what helps her self-criticism and builds her confidence by stating:

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

Trainees who tended to view their supervisors as overly controlling were more self-critical of their clinical skills. In contrast, when they viewed their supervisors as guiding them to consider the reasons for and effects of their choices therapists were prompted to reflect upon their approaches to treatment and develop confidence.

Category 3 of Cluster 4: my anxious self-criticism decreases as I become more comfortable with interventions. All trainees endorsed anxiety about conducting unfamiliar interventions in therapy that could trigger self-criticism and interfere with their ability to conduct therapy effectively. One trainee describes anxiety around implementing a new intervention.

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

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

Cluster 5: Supervision Can Foster Learning from Self-criticism

The complete title of the fifth cluster was: "Supervision can Sometimes be a Holding Environment Where it's Safe to be Imperfect and Self-Divulging, and to Learn From Self-Criticism." All trainees acknowledged that their personal and professional growth was greatly enhanced and nurtured by the supervision process. Supervision represented a holding environment for them, where they could use this time for self-reflection and to better understand how to improve as a therapist, with the guidance of their supervisors. When trainees were asked to give feedback on whether this cluster fit with their experience of self-criticism as a developing

therapist, the mean response on a 7-point Likert scale was 6.7, indicating a high level of agreement on this cluster. There were two categories in this cluster.

Category 1 of Cluster 5: feeling supported by my supervisor makes it easier to show my clinical weaknesses and learn from self-criticism. Many trainees noted that feeling supported by their supervisors in their clinical efforts made it easier to be vulnerable in supervision about their clinical weaknesses, and allowed them to be more open to learn from their mistakes. One trainee described how her supervisor was accepting of mistakes that were made yet did not lose sight of the strengths of her supervisee.

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

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

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

Category 2 of Cluster 5: supervision is a safe space for open dialogue about how my feelings can impact my growth as a therapist. All trainees noted that supervision could be a safe space in which they could examine their self-critical feelings and ways in which self-critical processes could impact their clinical work. One trainee talked about how her supervisor encouraged her process of self-examination.

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

Core category: the intensity of my self-criticism is mitigated as I balance the expert role with greater authenticity—a learning process that is strengthened by my sense of interpersonal safety and clinical flexibility in my development. The core category in a grounded theory analysis represents the central finding of the analysis. The core theme in this analysis underscored the ways in which trainees' self-criticism was mitigated so they developed their identity as therapists in a productive manner. When trainees were asked to give feedback on whether this core theme fit with their experience of self-criticism as a developing therapist, the mean response on a 7-point Likert scale was 6.4.Trainees emphasized that they were engaged in the intensive experience of learning how to be authentic in relationships with their clients and supervisors. For example, new trainees might begin the process of supervision feeling a pressure to provide their client with expertise while having a less developed sense of their own competence. Supervisors who provide a sense of interpersonal safety, in which trainees can take risks to present challenging therapeutic moments and be met with both guidance and reassurance about their competence, may be better positioned to develop a genuine confidence in their therapy skills. Similarly, when supervisors encourage trainees to flexibly adapt recommendations to their own styles and to their clients' needs, trainees may internalize a stronger sense of authenticity in the therapist role, which could quell potentially destructive self-criticism. Self-criticism could make that learning process all the more difficult; particularly when they felt pressured or socialized to adopt an expert role as clinicians. When supervision was viewed as a "safe" space in which supervisors saw the process of learning as positive, therapists were better able to be authentic and explore and learn from their self-criticism as it impacted their clinical work. The process of being authentic about their evolving identities as therapists also was strengthened by working within a supervision model that allowed for flexibility in making clinical decisions and selecting interventions. Supervisors allowing for trainees input and creativity in executing and personalizing interventions so they are a better fit for themselves and their individual clients increased trainees' self-confidence. This core category has implications for how self-criticism can be shaped

within training to be a constructive force, and supervisory teams might actively consider how therapeutic expertise might differ from having ready solutions for problems, following rigidly laid out interventions, or being perfect as a therapist.

Discussion

Trainees' descriptions of self-criticism yielded several themes that were salient aspects of their training. The core category, *The intensity of my self-criticism is mitigated as I balance the expert role with greater authenticity—a learning process that is strengthened by my sense of interpersonal safety and clinical flexibility in my development*, underscored that most therapists-in-training thought that their self-criticism could be more productive and motivate them to better their skills in the context of connected relationships with clients, interpersonal connection and safety with supervisors, and with greater clinical freedom to make treatment decisions. These findings make a number of contributions. They help to: (1) normalize novice therapists' self-critical processes; (2) draw attention to what is rarely spoken in supervision (and what trainees will go to lengths to hide)—that many trainees are interested in saving face and not sharing their vulnerable self-doubt; (3) smooth over the interpersonal challenges that are experienced by beginning therapists across different training contexts; and (4) create a safer context for supervision.

Implications for Therapist Learning

The analysis of the data as noted by participants in this study revealed that the harshness of trainee self-criticism could be buffered by factors such as the quality of the supervisory relationship, clinical flexibility, and experience conducting psychotherapy. Preliminary implications presented in this section are based in therapists' perspective. In qualitative methods, "transferability" refers to the extent to which the reader is able to generalize the findings of a study and in qualitative samples that are generally small, generalizability is not used in the conventional sense. Readers assess the implications to their own context by considering the context of the trainee and the description provided via the quotes and of their subjective experiences.

Trainees' self-criticism was driven by their striving toward a sense of competence in their clinical work. Specifically, their experience of self-criticism resembled an "interpersonal barometer" that could increase or decrease as they compared their skills and knowledge to their peers and supervisors and many trainees perceived the gaps in their skills as a lack of potential as opposed to a competency that continues to evolve. Therapists-in-training would benefit from a more focused shift to striving for relative competence based on their developmental level of skill (Kaslow et al., 2009). Their descriptions of self-criticism in this study suggest that teaching trainees to gauge self-assessment within their developmental levels, especially at early stages of training and supervisors to talk explicitly about developmental framework of learning could promote a shift toward a more balanced view of their performance in therapy.

Many trainees noted that while they were novice therapists, they often struggled with maintaining a balance between being perceived by their clients as the expert while still holding a sense of real connection with clients in session. While alliance difficulties are not necessarily due to self-criticism, they described challenges in that they did not yet feel they had the ability to discern why an alliance is difficult and so tended to internalize alliance difficulties and become self-critical. Angus and Kagan (2007) in their work on empathic relational bonds stated that in order for therapist agency and authenticity to be optimized, a safe and trusted relationship is needed, a sentiment that was voiced by all participants in this study. Since the charge of supervision is primarily a mentoring one that includes teaching and nurturance to help the trainee grow into a stronger therapist, it can help to remember that based on the results of this study, trainees described the process of learning as best occurring in the context of feedback that is more supportive and empathic in nature. The emphasis on the supervisory context reflected the powerful impact of supervision on the interviewees. Although the interviews asked about self-criticisms in the context of their training and development broadly, in relation to the therapies that they were learning, and in relation to their in-session experiences, the interviewees disproportionately focused upon the supervisory context as the primary influence upon their self-criticism related to their therapy skills.

Implications for Training

Based on the findings in this study, psychotherapy training may be best approached through supervisor transparency about their own process of development, the mirroring of supervisees' experiences, and peer supervision as a medium to bolster supervision. Participants in this study felt that their supervisors' self-disclosure of their training experiences normalized therapists' fears of incompetence and encouraged supervisees to reveal self-critical concerns instead of concealing them in this study. Ladany

and Walker (2003) discussed the use of supervisor self-disclosure as a tool to promote didactic mentoring, to express trust in the supervisory relationship, and to strengthen the supervisee's willingness to be vulnerable in supervision. Additionally, self-disclosure can be used to reduce the experience of shame that might prevent therapists from admitting what they are really struggling with in their work. Supervisors that model the inevitability of mistakes in therapy can help therapists-in-training become less restricted by a sense of having to hide their mistakes or growth edges (Klein, Bernard, & Schermer, 2011).

This study also has implications for training programs in that it suggests integrating reflective practices across training that asks students to reflect upon their thoughts, feelings, beliefs, and personal assumptions about their work. By engaging in these processes, students can be taught to think more analytically about what they are doing and how they are creating change in themselves and others in their program (Scaife, 2010). Reflective practices could be integrated through different means such as by encouraging personal therapy, modeling this practice in group supervision, as well as in case reviews where feedback might be provided to trainees related to issues such as ethical practice and self-care. Also within academic mentoring, students can be asked to reflect upon their research progress and their goals in such a way that helps self-reflection become routine and less threatening. Training directors might find it helpful to share the current paper with supervisors in their program to increase their understanding of their trainees' internal experiences. As well, they may wish to structure the opportunity for peer consultation as an adjunct to supervision groups. This paper also can act as a resource for beginning trainees and normalize the sense that some self-criticism is a normal part of the learning experience and also to provide insight that can enable them to seek support for problematic self-criticism as needed.

For many trainees, their perceived relationship with their supervisor determined whether they shared self-criticisms. Recent research on the importance of supervision on therapy outcome has suggested the importance of the supervisory alliance (Angus & Kagan, 2007; Boswell, Nelson, Nordberg, McAleavey, & Castonguay, 2010; Sarnat, 2010). All trainees in this study expressed the wish for more discussion with supervisors, with whom they felt safe and connected, around negative reactions to clients, difficult alliances, and anxiety about their skills. This finding might prompt consideration from supervisors about the potential vulnerability that trainees undergo as they learn psychotherapy. Factors that aided the feedback process and reduced the intensity of self-criticism in this study are a sense of safety, open communication about supervisors' and trainees' expectations about supervision, permissibility and normalization of clinical errors, willingness to explore the "person of the therapist," and supervisor disclosures of past clinical mistakes.

Study Limitations and Strengths

Although the novice therapists had diversity in their sex, amount of training, and theoretical orientations, all therapists recruited were trainees of one university in a metropolitan area in the Mid-South region of the USA and most were white and in their 20s; therefore, caution should be exercised before extending the findings to different types of graduate training programs and therapists. Additionally, 12 of the 14 participants in this study came from within the same graduate program and although the therapists had experiences from a wide range of settings and most ($n = 12$) had multiple internal and external supervisors, some had training experiences with the same supervisors. Because self-criticism was a vulnerable topic for trainees who are in the process of developing their professional identities, it was challenging to find trainees who would talk to others who they did not know about their self-criticism. It may be that this was the reason why trainees from other graduate programs were reluctant to participate. In fact, one participant stated, "I think I'd probably be more open with you [knowing you] than anybody else" (T-9). These findings also may be less applicable to in-session supervision or large group/class format as the therapists reported either individual and/or small group supervision. Diversity was present in their supervisors' theoretical approaches (i.e., cognitive-behavioral, constructivist, interpersonal, humanistic, and family systems), although readers might use caution when extending findings to other orientations. The credibility of this study was further enhanced by three credibility checks that were performed by the investigator—asking questions to check on the interview process, using consensus coding, and seeking therapist feedback. Also, memoing was used to reduce the biasing effect researchers' beliefs may have had on the study by explicitly recognizing these assumptions. Finally, saturation of the conceptual categories was achieved and new categories did not appear to be forthcoming with the addition of the last three interviews, which suggests that the analysis was comprehensive.

Future research could have a more intentional focus on the duality of self-criticism and positive self-awareness as participants' described experiences of self-criticism did not elicit much description of

the healthy aspects of self-criticism. It might draw more upon our findings in Cluster 5 that self-criticism promoted learning and development. Also, future research on this topic should include examining the process of supervision from both trainee and supervisor perspectives as therapists in this study noted the importance of the supervision process. Since the American Psychological Association has recommended reflective practices in its guidelines for supervision (see guidelines for clinical supervision, American Psychological Association, 2014), future research upon the effects of the incorporation of these practices might be of interest.

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