Dual Autonomy: A Culturally Encompassing

Reinterpretation of Traditional Autonomy in Clinical Supervision

by

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ABSTRACT

Traditional autonomy within clinical supervision was reinterpreted by incorporating culturally-encompassing autonomy types (individuating and relating autonomy) from the dual autonomy scale. The relations of vertical collectivism and autonomy measures were examined. Lastly, potential moderating effects of vertical collectivism on experience level and autonomy were assessed. The sample consisted of 404 counseling trainees enrolled in graduate programs across the US, aged between 21 and 68. Results from the confirmatory factor analysis supported the proposed two-factor structure of individuating and relating autonomy among counseling trainees for the adapted dual autonomy scale. Results indicated that individuating autonomy was moderately correlated with relating and traditional autonomy, and relating autonomy was not correlated with traditional autonomy. Vertical collectivism was not correlated with relating autonomy, but significantly predicted individuating and traditional autonomy. Moderating effects of vertical collectivism on experience level and autonomy were not supported. Further implications and future directions are discussed.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Clinical supervision has been recognized as one of the top five activities of practicing psychologists (Norcross, Hedges, & Castle, 2002) that passes on the integrity of the mental health profession to future generations and is highly influential in the development of professional counselors (Bernard & Goodyear, 2014). Among scholars in the clinical supervision literature, there is broad agreement that good supervision is necessary in the development of clinical competence (Bernard & Goodyear, 2014; Falender et al., 2004). According to Johnson (2007), supervisory functions include (a) provision of performance feedback, (b) coaching and guidance in psychotherapy conduct, (c) communication of alternative views and perspectives about supervision dynamics and interventions, (d) contribution to the trainee's professional identity development, and (e) the provision of a secure and supportive environment to explore theories, interventions, and styles. In addition to these discrete options, Johnson (2007) adds that clinical supervision also incorporates aspects of teaching, personal therapy, collegial problem solving, apprenticeship, and formal evaluation.

Based on where a trainee is developmentally in their clinical training, supervisors may need to make adjustments in their supervisory style to best accommodate the trainee (Bernard & Goodyear, 2014; Rigazio-Digilio et al., 1997). Our current leading models outlining counselor development include Loganbill, Hardy, and Delworth's model (1982), Stoltenberg's Integrative Developmental Model (IDM) (Stoltenberg, McNeill, & Delworth, 1998; Stoltenberg & McNeill, 2010), systemic cognitive-developmental

supervision (SCDS) model (Rigazio-Digilio et al., 1997), and lifespan developmental model (Ronnestad & Skovholt, 2003). Loganbill and colleagues' model (1982) outlines three developmental stages among eight specific professional issues. The IDM (Stoltenberg, McNeill, & Delworth, 1998) outlines four developmental levels across three professional counseling "structures" or constructs. The SCDS (Rigazio-Digilio et al., 1997) outlines development among four specific orientations, each containing advantages and disadvantages for conducting therapy. The lifespan developmental model (Ronnestad & Skovholt, 2003) outlines the development of counselors not only in graduate school, but throughout the lifespan. Each of these models will be discussed in further detail.

As our field continually strives toward diversity, cultural competence and responsiveness within clinical supervision become increasingly important. One of these cultural variables that play a significant role within clinical supervision is autonomy. Despite having differing societal emphasis on autonomy between individualistic and collectivistic cultures, Western models of counselor development have all acknowledged autonomy as a construct that is expected to increase over time as trainees gain experience within the counseling field (Loganbill et al., 1982; Stoltenberg, McNeill, & Delworth, 1998; Ronnestad & Skovholt, 2003). As outlined by these models, as trainees gain experience in the counseling profession, their own perceived level of clinical competence increases, which results in an increase in autonomy. Indeed the reigning view is that this shift of behavior in supervision from dependency on the supervisor for directional instruction to autonomy with respect to self-guidance. However, not all trainees are individualistic in nature. For trainees who are more collectivistic in nature, the

development of autonomy within clinical supervision may not only be a function of clinical experience, but cultural factors as well.

For the above reasons, it is important to re-examine autonomy within clinical supervision to better accommodate trainees with high collectivistic values. Clinical supervisors can also benefit from a reinterpretation of traditional autonomy to recognize the cultural differences between trainees and better assist them in their development. In order to accommodate these noticeable cultural differences in clinical supervision, the adaptable model of autonomy has to be culturally encompassing of both traditional autonomy and relatedness.

The current study proposes the application of the dual autonomy model within clinical supervision. Contrary to defining autonomy only as a bipolar, unidimensional construct ranging from dependency to independence, the dual autonomy model conceptualizes autonomy in two primary components: individuating autonomy (IA), an autonomy type that represents the volitional capacity to act against social constraints and in favor of one's own self-expression, more associated with how autonomy is traditionally defined in the Western culture, and relating autonomy (RA), an autonomy type that represents the volitional capacity to act emphasizing social harmony and of the self in relation to others, more associated with non-Western cultures' emphasis on relatedness (Yeh & Yang, 2006; Yeh, Bedford, & Yang, 2009). The model specifies that both types of autonomy are needed and exist within any individual, and that both are associated with positive outcomes, but in separate interpersonal and intrapersonal domains.

Yeh and Yang (2006) created the dual autonomy scale, measuring both IA and RA across cognitive, functional, and emotional domains. The scale has been tested with Taiwanese adolescents and college students, as well as American college students regarding the properties of IA and RA claimed by Yeh and Yang (2006), as well as Yeh et al. (2009). Findings have generally supported the authors' hypotheses, that the dual autonomy two-factor structure was supported through confirmatory factor analysis for the Taiwanese sample and that both IA and RA are associated with adjustment variables, but in distinctive domains for both Taiwanese and American samples. Specifically, IA was more associated with adjustment variables in the intrapersonal domain, and RA was more associated with adjustment variables in the interpersonal domain. Because Yeh et al. (2009) found both IA and RA to be associated with adjustment variables similar to the positive associations of traditional autonomy found within the Western literature on autonomy (Deci & Ryan, 2008; Gagne, 2003; Williams & Deci, 1996) across both a Western and non-Western sample, the model offers convincing potential of its applicability within clinical supervision.

In the context of clinical supervision, IA is synonymous with traditional autonomy and as outlined by existing models of counselor development, will most likely increase along with clinical experience and knowledge. RA is a proposed new form of autonomy accounting for the cultural differences that exist among trainees of various cultural backgrounds not previously accounted for by existing Western models of counselor development. Because IA stems from the individual whereas RA is autonomy based on interdependence, both forms of autonomy may impact a trainee's decision-

making process within clinical supervision. This incorporation of RA is important because it helps conceptualize autonomy in a culturally inclusive manner and takes relatedness, a value highly prioritized in collectivistic cultures, into consideration.

Furthermore, as previously mentioned, existing models of counselor development (Loganbill et al., 1982; Stoltenberg, McNeill, & Delworth, 1998; Ronnestad & Skovholt, 2003) have outlined that trainees become more autonomous within clinical supervision as they gain more experience and knowledge over time. However, for trainees who are ingrained with collectivistic values emphasizing social harmony, interdependence, and following social norms, the process of developing autonomy within clinical supervision is different. Not only would trainees with high collectivistic values need to accumulate experience to gain a sense of clinical competency, they would also have to adapt to the expectation to develop autonomy, an individualistic cultural expectation, different from their own. Therefore, it is important to examine the relation between collectivism and autonomy in clinical supervision.

I will examine how both types of autonomy manifest in clinical supervision using an adaptation of the dual autonomy scale. Specifically, as an initial indication of construct validity, the dual scale will be compared to the established Western autonomy subscale (Dependency-Autonomy subscale from the SLQ-R) (Stoltenberg et al., 1998) that is frequently used in clinical supervision. I hypothesize that only the IA subscale will be correlated with the SLQ-R Dependency-Autonomy subscale and that the RA subscale will not, demonstrating that RA is indeed capturing a different aspect of the supervision experience. Since Yeh and Yang (2006) have conceptualized IA similarly as traditional

autonomy, emphasizing the volitional capacity to express oneself through individualistic attributes and distinctions, the two will likely be correlated. RA, on the other hand, was conceptualized as the volitional capacity to express oneself through social harmony and the self in relation to others. This conceptualization of autonomy has not been previously incorporated into the autonomy literature within clinical supervision and thus will most likely be unrelated to traditional autonomy.

The main focus of the study will be to examine how collectivism is associated with autonomy and experience. Specifically, I hypothesize collectivistic orientation to covary with RA due to the overlapping emphases of relatedness from both constructs, but not with IA and traditional autonomy, as they focus on the expression through individualistic attributes. Furthermore, I hypothesize that collectivistic orientation will moderate the relation between autonomy and experience. Specifically, with little experience in clinical work, all trainees will have low IA and traditional autonomy. Existing supervision models outlining counselor development have found that beginning trainees preferred more structured and directive supervision compared to advanced trainees (Loganbill et al., 1982; Stoltenberg et al., 1998; Ronnestad & Skovholt, 2003). When trainees start accumulating experience, however, those with low collectivistic orientation will develop IA and traditional autonomy at a quicker pace compared to those with high collectivistic orientation due to perceiving interdependence, social norms, and power differentials as less important in clinical supervision. As a result, trainees with low collectivistic orientation are more likely to act according to their own volition in clinical supervision.

CHAPTER 2

REVIEW OF THE LITERATURE

The dissertation study is structured in the following way. Readers are first introduced to prominent Western developmental models of counselor development. These models include Loganbill, Hardy, and Delworth's model (1982), Stoltenberg's Integrative Developmental Model (IDM) (Stoltenberg et al., 1998; Stoltenberg & McNeill, 2010), systemic cognitive-developmental supervision (SCDS) model (Rigazio-DiGilio et al., 1997), and lifespan developmental model (Ronnestad & Skovholt, 2003). The role of autonomy is critically examined within each of these models. In general, Western developmental models view autonomy as an indicator of a trainee's maturity as a clinician (Loganbill et al., 1982; Stoltenberg et al., 1998; Ronnestad & Skovholt, 2003).

Following, readers are introduced to how autonomy has been historically conceptualized. Self-determination theory (SDT) (Deci & Ryan, 1985) has been very influential in how autonomy is conceptualized within the Western culture. It operationalizes autonomy as self-governance, acting on one's volition, free from social constraints, and is a psychological need that facilitates growth and functioning (Hmel & Pincus, 2002). Researchers have also found autonomy to be positively associated with psychological well-being and effective behavioral outcomes (Deci & Ryan, 2008; Gagne, 2003; Williams & Deci, 1996). Despite the benefits associated with autonomy, researchers have also questioned the applicability of autonomy in non-Western, collectivistic cultures. Iyengar and Lepper (1999) found that American children were less motivated and performed worse at tasks when choices were made for them. However,

Asian-American children were more motivated and performed best at tasks when their mothers made choices for them.

The conflicting findings regarding autonomy across different cultures provide support that different cultures have different societal values. While individualistic cultures prioritize autonomy, collectivistic cultures emphasize the importance of "relatedness", group membership, and social harmony. Researchers have found interpersonal relations to be positively correlated with well-being, and difficulties in maintaining social harmony to be positively correlated with poorer mental health outcomes for individuals residing in collectivistic, non-Western cultures (Kitayama et al., 1994; Zhang & Jin, 1998). Despite the importance of relatedness, it has been a concept that was very much looked down upon within the Western literature (Janis, 1982; Asch, 1951; Wallach, Kogan, & Bem, 1964).

To properly accommodate and legitimize the importance of both traditional autonomy and relatedness across both individualistic and collectivistic cultures, Yeh and Yang (2006) created the dual model of autonomy which defines autonomy in two forms – individuating and relating, each serving distinct purposes for functioning. The dual autonomy scale (Yeh & Yang, 2006) is utilized to measure both forms of autonomy. The structure of the model, scale, as well as the associations of IA and RA with other outcome measures will be discussed in detail.

Following the literature review, readers are informed regarding specific research questions for this study, method of conducting the study, measures used, as well as how the data is analyzed. Results of the study are listed, and implications are discussed.

8

Autonomy within Developmental Models of Clinical Supervision

Throughout the history of clinical supervision, numerous Western developmental models have been generated to outline the trajectory of development for counselors-in-training. One of the first comprehensive developmental models of counselors was generated by Loganbill, Hardy, and Delworth in 1982 (Loganbill et al., 1982).

Loganbill and colleagues (1982) pinpointed developmental tasks of youths and refined them into professional issues relevant to the development of therapists – competence, emotional awareness, autonomy, professional identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics. For each of these issues, one can exist within one of three main stages – stagnation, confusion, or integration. The possibility for one to be in transition between stages also exists.

In the stagnation stage, novice trainees are mostly unaware of their deficiencies or difficulties. For more advanced trainees, being in this stage may be characterized by feeling "stuck" in certain issues. Trainees in this stage may exhibit two types of behaviors in supervision – dependency on the supervisor, or possibly viewing the supervisor as somewhat irrelevant in respect to the issue that the trainee is dealing with (Loganbill et al., 1982). The confusion stage is primarily characterized by "instability, disorganization, erratic fluctuations, disturbance, confusion, and conflict" (Loganbill et al., 1982, p. 18). The trainee starts to move away from their original rigid belief system and starts to see issues differently from how they did before. Because of this shift in thinking, trainees in this stage may become frustrated with their supervisor, who they believe is either not giving straight-forward answers they are looking for or is simply incompetent (Bernard &

9

Goodyear, 2014). In the integration stage, trainees typically develop "a new cognitive understanding, flexibility, personal security based on awareness of insecurity and an ongoing continual monitoring of the important issues of supervision" (Loganbill et al., 1982, p. 19). Trainees view their supervisors realistically with both strengths and weaknesses. The trainee also takes responsibility for what happens in supervision and utilizes supervision time effectively (Bernard & Goodyear, 2014).

Loganbill and colleagues (1982) specified that for their developmental model, trainees may cycle and recycle through each of the three stages, increasing their levels of integration at each cycle. Additionally, since there are a total of eight issues that are focused within the model, and trainees can be at any of the three stages for any of these eight issues, supervisors have to be especially attentive on each of these eight domains and meticulously track the trainee's progress, which could serve as a challenging task.

Autonomy is one of the eight identified developmental issues in this model. Similar to other developmental models, trainees are expected to become more autonomous in the clinical setting as they become more advanced. In the stagnation stage, trainees are described by Loganbill et al. (1982) as either being completely reliant upon the supervisor or completely detached from the supervisor. In the confusion stage, trainees realize that their needs are not going to be directly met by their clinical supervisors. Forced to become autonomous within the clinical setting, trainees in this stage may become angry or frustrated at their supervisors as a result. In the integration stage, the trainee appears to be more autonomous due to higher level of perceived

competence. The trainee is able to take responsibility for what occurs during supervision sessions and make the best use of the supervisor's time and expertise.

One of the current leading developmental models of supervision is the Integrative Developmental Model (IDM) (Stoltenberg et al., 1998; Stoltenberg & McNeill, 2010). IDM includes a total of four developmental levels across three overriding professional counseling "structures" or constructs for counseling students. These structures are: Self-Other awareness, Motivation, and Autonomy. Self-Other Awareness consists of both cognitive and affective aspects which characterize the trainee's level of self-awareness, awareness of the client's world, and self-preoccupation. "The cognitive component describes the content of the thought processes characteristic across levels, and the affective component accounts for changes in emotions such as anxiety" (Stoltenberg et al., 1998, p. 16). Motivation refers to "the supervisee's interest, investment, and effort expended in clinical training and practice" (Stoltenberg et al., 1998, p. 16). Autonomy refers to "changes in the degree of independence demonstrated by trainees over time [that] accompany the other structural changes" (Stoltenberg et al., 1998, p. 16).

The levels refer to changes across these three constructs associated with increasing experience. Level 1 characterizes beginning trainees – having limited expertise and training, are in need of structure and feedback in clinical supervision, have limited self-awareness, high self-focus, and are apprehensive about evaluations (Stoltenberg et al., 1998). Trainees in this level typically have limited self-awareness and are unaware of strengths and weaknesses. They may be apprehensive of receiving evaluative remarks from their supervisors, and tend to be more self-focused. Level 1 trainees tend to be

highly motivated towards learning and doing, but can also possess high levels of anxiety. They are heavily dependent on their supervisors and seek supervision structure (Stoltenberg et al., 1998). Regarding autonomy, Level 1 trainees typically rely on the supervisor to provide structure in supervision and their behavior. They look to the supervisor, as well as other authority figures, to provide information they can elaborate on and integrate into an overall schema to understand the clinical work process and to direct therapeutic behavior.

Usually after two to three semesters of practicum, trainees may progress to "Level 2" in which trainees transition from being highly dependent to a supportive and instructional, but less structured environment. Trainees move toward working independently, but may experience conflict between autonomy and dependency (Stoltenberg et al., 1998). Level 2 trainees begin to focus more of their efforts and awareness on their clients, but may become enmeshed or confused with them when struggling to maintain balance. Motivation may fluctuate for trainees in this level, ranging from high confidence to potential confusion. Although trainees in this stage are strongly encouraged to operate independently, they may struggle between autonomy and dependency as clinical cases become increasingly complex (Stoltenberg et al., 1998).

At Level 3, collegial differences between supervisor and trainee may diminish, and trainees move toward independent practice (Stoltenberg et al., 1998). Trainees in this level are continuously refining their professional identities, and the belief in one's autonomy and professional judgment is not easily shaken. They are accepting of their own strengths and weaknesses, demonstrate high empathy and understanding, focus on

the client, process and self. They may experience occasional doubt, but they are not debilitating. While trainees are comfortable working autonomously, they are also aware of when consultation is needed. (Stoltenberg et al., 1998).

Lastly, Level 3i is characterized by trainees who reach Level 3 across multiple domains of awareness, motivation and autonomy. Trainees in this level demonstrate strong awareness of their professional strengths and weaknesses. They utilize a personalized approach to professional practice across domains and can flexibly navigate among them (Stoltenberg et al., 1998).

Another developmental model worth mentioning is Rigazio-DiGilio and her colleagues' systemic cognitive-developmental supervision (SCDS) model (1997) which adapts four cognitive orientations similar to those Piaget used in his stages of cognitive development. According to the SCDS model, there are four specific orientations synonymous with stages from other developmental models, each containing advantages and disadvantages for conducting therapy. The goal of the supervisor is to help the trainee flourish within one's natural orientation, while also encouraging the trainee to expand conceptual and experiential capabilities from other orientations. Although the model does not directly outline autonomy in clinical supervision, it does encourage clinical supervisors to be accommodating towards the trainee's natural style in clinical work and in supervision.

Ronnestad and Skovholt (1993, 2003) believed that the development of counselors does not only transpire during graduate training but also lasts a lifetime. Their refined lifespan developmental model (2003) outlined a total of six phases, synonymous

with stages from other models, as well as fourteen themes important for professional development. Phase 1 begins as *The Lay Helper Phase*, where novices have had experiences of helping others and are eager to offer assistance. Trainees in this phase may struggle with boundary issues and may become overly involved. In Phase 6, *The Senior Professional Phase*, professionals who have typically worked for over 20 years in the field already are looking toward their own retirement. They generally have become modest of their own impact on clients and doubt that anything groundbreaking will be introduced to the field. The three primary phases directly address trainees in graduate training, while the latter three outlines post-graduation. Autonomy was primarily addressed in *Phase 2: The Beginning Student Phase*, where trainees are outlined to be dependent, vulnerable and anxious due to their lack of self-confidence. As a result, they rely on their clinical supervisors for support, structure, and encouragement. As trainees progress to *Phase 3: The Advanced Student Phase*, they become less dependent and more autonomous, being able to function at an early professional level.

All of the developmental models described are different due to the theories that were used to generate each model. Loganbill and colleagues (1982) heavily utilized psychosocial developmental theory for their model. The SCDS model was heavily inspired by Piaget's stages of cognitive development (Rigazio-DiGilio et al., 1997). Ronnestad and Skovholt (2003) were inspired by Loganbill and colleagues' (1982) conceptual contributions to the literature prior to using inductive logic of grounded theory (Glaser & Strauss, 1967) in generating their own developmental model. The IDM, however, was established using theories from a variety of different disciplines.

Stoltenberg and colleagues (1998) utilized cognitive learning theory, interpersonal influence and social learning, motivation theory, and models of human development as the theoretical framework for the IDM. One reason why the Dependency-Autonomy subscale from the IDM was utilized as the primary scale for traditional autonomy in clinical supervision for the current dissertation study is due to the model's diverse incorporation of theoretical influences from various disciplines. Additionally, the IDM identifies autonomy as one of the three main counseling structures that will gradually increase as the level of the trainee increases. Namely, Level 1 trainees start off very dependent upon their supervisors, but as the trainee gathers more training and experience, their level of autonomy steadily increases along with their structural level (Stoltenberg et al., 1998; Stoltenberg & McNeill, 2010).

It is important to note that all models of counselor development that separate trainees between developmental stages previously described implicitly state that trainees are expected to become more autonomous within clinical supervision over time and experience. Loganbill et al. (1982) described the potential frustration trainees may experience as they progress through developmental stages with the expectation of becoming more autonomous, with autonomy identified as one of eight developmental issues. The lifespan developmental model (Ronnestad & Skovholt, 2003) outlined a similar trend as trainees progress from the very dependent Phase 2 to becoming more autonomous in Phase 3. The IDM (Stoltenberg et al., 1998), similar to Loganbill and colleagues' model, also heavily incorporated autonomy, as it is one of the three professional counseling structures that contributes heavily to a counselor's development.

As outlined by the model, Level 1 trainees heavily rely upon their clinical supervisors during supervision. As they gain clinical experience and progress to Level 2, they may struggle between autonomy and dependency, as they are strongly encouraged to operate autonomously while possibly encountering complex cases beyond their current clinical knowledge. All of these developmental models of counselor development heavily incorporate autonomy as an indicator of advancement for counseling trainees. It is expected that as trainees become more advanced in the clinical setting, they take on a more proactive role in clinical supervision. However, as counseling trainees become more culturally diverse than ever before, it is important for existing developmental models to consider the limitations of autonomy, a primarily Western, individualistic construct, and how similar patterns of development outlined by these Western models may not apply the same way for trainees with high collectivistic ideals. A key to critically examine autonomy within clinical supervision is to understand how it is defined.

Operationalizing Autonomy

Autonomy has evolved from a simple term referring to independence to a complex psychological construct that can be conceptualized in a variety of different ways (Hmel & Pincus, 2002). This construct is represented in literature across personality, clinical, developmental, and industrial psychology, as well as in medicine and philosophy. Previous researchers have associated autonomy with interpersonal relationships (Rankin-Esquer et al., 1997), sense of self (McCurdy & Scherman, 1996), psychological adjustment (Deci & Ryan, 1991), and occupational group performance (Wageman, 1995). In regards to counseling, autonomy has been identified by various

16

developmental supervision models as a mark of trainee's maturity as a clinician (Loganbill et al., 1982; Stoltenberg et al., 1998; Ronnestad & Skovholt, 2003).

Despite the relevancy of autonomy across multiple disciplines, it is a construct that lacks theoretical homogeneity (Hmel & Pincus, 2002). Autonomy can generally be characterized as a sense of competence, control, achievement, or agency. The autonomous portion of one's self focuses on bodily functioning and control over one's environment. For the autonomous part of one's self, a sense of competence, achievement, or agency enhances a person's sense of well-being and self-worth (Sato, 2001). Autonomy has often been found to be associated with well-being, specifically reduced levels of depression (Holahan & Spence, 1980; Roos & Cohen, 1987) and anxiety (Holahan & Spence, 1980; Nezu & Nezu, 1987), as well as high levels of self-esteem (Carlson & Baxter, 1984). Based on existing literature, models of autonomy were proposed based on the concept of active agency (Bakan, 1966; Deci & Ryan, 1985).

Bakan's (1966) conceptualization of autonomy involved the principle of agency. According to Bakan (1966), agency was defined as an innate pressure to individuate, exhibited by the urge to master one's environment. Active agency placed an emphasis on areas involving "self-protection, self-assertion, and self-expansion", as well as the desire to master one's environment (Bakan, 1966, p. 15).

Self-determination theory (SDT) (Deci & Ryan, 1985) operationalizes autonomy as self-governance. It suggests that autonomy is a psychological need that facilitates further growth and functioning (Hmel & Pincus, 2002). In other words, based on SDT, individuals have the freedom to rule themselves and make choices based on their self-

17

awareness rather than external controls. It assumes that people are fundamentally oriented toward their own well-being and psychological growth. Deci and Ryan (1985) identified three causality orientations (autonomous, controlled, and impersonal) that serve as bases for regulating one's behaviors.

Autonomous motivation is composed of both intrinsic motivation and specific types of extrinsic motivation in which people have integrated values associated with activities into their sense of self. When people are autonomously motivated, they experience volition, a natural self-endorsement of their own actions (Deci & Ryan, 2008). Individuals who are highly autonomous-oriented regulate behaviors on the basis of choice through interests and self-endorsed values. These individuals often maintain a higher level of self-determination as well as intrinsic motivation. They attend to environmental cues that signal personal interest and options for free choice of behavior. There is often a high level of awareness of their own motivations, as well as a great sense of freedom in regulating their own behaviors (Deci & Ryan, 1985). The autonomy orientation has been positively associated with psychological well-being and effective behavioral outcomes (Deci & Ryan, 2008; Gagne, 2003; Williams & Deci, 1996). The controlled orientation is mainly descriptive of individuals who are oriented towards being controlled by either the environment (i.e., external demands and desires of others, reinforcements, or punishments) or within themselves (i.e., self-esteem, avoidance of shame, ego-involvements) (Deci & Ryan, 2008). When people are controlled, they experience pressure that motivates them to think, feel and behave in different ways. They are also more sensitive towards external, environmental demands than their own desires

18

and interests and tend to regulate their behaviors accordingly (Deci & Ryan, 2000).

Individuals who are highly controlled may have limited self-determination and may only develop competence after learning the operative contingencies or rules in particular environments (Deci & Ryan, 1985). The controlled orientation has been associated with regulation of behaviors through external contingencies, rigid functioning, and diminished well-being (Deci & Ryan, 2008). The impersonal orientation involves sensitivity to cues one interprets as incompetence. People that are highly impersonal tend to believe they are unable to competently act in situations and regulate their behaviors to achieve desirable outcomes (Deci & Ryan, 1985). The impersonal orientation had been highly associated with poor functioning and symptoms of ill-being, such as personal helplessness, depression, social anxiety, and self-blame (Deci & Ryan, 1985, Deci & Ryan, 2008; Koestner & Zuckerman, 1994). Deci and Ryan (2008) stated that the development of the impersonal orientation most likely results in a general thwarting of obtaining three basic, universal psychological needs.

Due to the heavy emphasis on the need for autonomy in individualistic cultures and how it is conceptualized in SDT (Ryan & Deci, 2000), various researchers have questioned the applicability of this original Western concept in collectivistic cultures (Iyenger & Lepper, 1999; Sato, 2001). Specifically, Iyengar and Lepper (1999) examined whether choice is associated with intrinsic motivation, persistence, performance, and satisfaction in both Western and non-Western children aged 7-9 years. They found that for Anglo-American children, intrinsic motivation and performance decreased when choices were made for them. However, Asian-American children appeared more

motivated and performed best at the required tasks when their mothers made choices for them. Their study had provided support that individual choice was more crucial for Western children to become more intrinsically motivated in comparison to non-Western children.

Due to the lack of cross-cultural considerations of how the concept of autonomy can be conceptualized, Yeh et al. (2009) proposed a dual model of autonomy, which accepts SDT's premise that the self is the boundary determining the locus of causality for behavior, but then goes a step further to consider the different types of self, which can then expand to different forms of autonomy. The dual model of autonomy considers relatedness, a value highly emphasized in collectivistic cultures, into one's interpersonal distance (the balance between intrinsic motivation and one's own volition with one's environmental cues) on the expression of autonomy.

Vertical Collectivism

Western and non-Western cultures have often been distinguished through their respective cultural values through existing literature. Specifically, Western cultures are closely associated with individualism, and non-Western cultures are closely associated with collectivism (Triandis, 1995; Markus & Kitayama, 1991). According to Triandis (1995), there are four defining attributes of individualism and collectivism. First, collectivists define themselves as aspects of a group, whereas individualists focus on the self, autonomous from groups (Markus & Kitayama, 1991). Second, personal goals of collectivists overlap with the goals of their in-groups, and if there is a discrepancy between personal and group goals, collectivists consider group goals a priority whereas

individualists prioritize personal goals over group goals (Schwartz, 1990). Third, behavior among collectivists is best predicted from social norms, perceived duties and obligations, whereas social behavior among individualists is best predicted from personality and other internal processes (Bontempo & Rivero, 1992). Fourth, relationships are of the greatest importance among collectivists, and if the costs of relationship outweigh the benefits, collectivists tend to stay in the relationship. For individualists, if the costs of the relationship exceed the benefits, the relationship is often forsaken (Kim et al., 1994).

Singelis et al. (1995) further specifies collectivism into vertical and horizontal dimensions. Those with high vertical collectivism (VC) see themselves as a part of an in-group, but also accept the existing inequalities and discrepancies within the group. They see the self as interdependent and also different from other members of the group. Similarly to VC, those with high horizontal collectivism see themselves as a part of a collective but also equal in power and status compared to others of the collective. Given the evaluative and mentoring roles of the clinical supervisor, there exists a clear power discrepancy within the supervision dynamic and thus, VC will be used as the more applicable collectivism construct for the current study.

Additionally, it is important to note that not all members of individualistic cultures are individualists and not all members of collectivistic cultures are collectivists (Triandis et al., 1985; Gudykunst, 1998). Collectivism and individualism are applicable concepts in any given culture, and all individuals can possess a varying degree of individualistic and collectivistic values. Additionally, how individuals behave within a

given society is also dependent upon the degree to which they internalize the values of the culture in which they are socialized in, as well as how the culture socialize how individuals view themselves (Gudykunst, 1998). Because many past studies associate collectivism with non-Western cultures (Iyengar & Lepper, 1999; Wang & Ollendick, 2001), individual differences of collectivistic values are often not assessed in cultures traditionally considered individualistic. Therefore, it is important to examine collectivistic orientation at the individual level to assess the associations of collectivistic values on variables associated with clinical supervision.

Relatedness and Interdependence

Relatedness can be characterized as being "at one with others", or having a sense of communion or affiliation. It is the central concept in how Markus and Kitayama (1991) describes "interdependent self-construal", and closely associated with defining attributes of collectivism. Rather than looking at the unit as an individual as autonomous people often do, the unit is defined as the group to which the person belongs to. According to Sato (2001), the group may consist of as little as two individuals who are close friends or family, or a large group as the members in a church or a gang. There must be a sense of emotional attachment among members of the group (at least from the individual's perspective). The fostering of relatedness at an early age in non-Western, interdependent cultures may be due to cultural practices in addition to cultural values within these cultures. Individuals in collectivistic cultures are taught at an early age to strive for belongingness within social groups, fulfill social goals and needs, preserving family reputation, and obtaining balance and harmony (Chu, 2007; Wang & Ollendick,

2001). Additionally, common Asian philosophical and religious practices such as Confucianism, Taoism, and Buddhism often devalue individual autonomy and self-expression (Wang & Ollendick, 2001). Taoism teaches the value of interconnectedness and relationship harmony in contrast to autonomy. The Taoist philosophy considers each individual to be interrelated and a part of the whole universe. Individuals influenced by Taoism are taught to merge oneself into the environment in order for the self to exist (Chu, 2007; Leung, 1998). Buddhism also emphasizes the importance of maintaining positive relationships. One may only strive for enlightenment through selflessness, empathy, and care for others (Cho, 2000).

To maintain mental health, people in collectivistic cultures such as in Japan, China and Korea require high levels of relatedness and not necessarily high levels of autonomy whereas the inverse is true for individualistic cultures (Markus & Kitayama, 1991; Sato, 2001). Kitayama and colleagues (1994) found that although a sense of achievement and well-being were positively correlated among Americans, they were not correlated among the Japanese. It was the sense of acceptance from others that was positively correlated with a sense of well-being for Japanese participants. Successful interpersonal relations were also found to be positively correlated with well-being within the Chinese culture, and difficulties to maintain relational harmony was positively correlated with poorer mental health outcomes (Zhang & Jin, 1998). Specifically, Zhang and Jin (1998) investigated the effects of interpersonal relations with suicidal ideation among individuals from China. The results indicated that difficulties in interactions and interpersonal conflict were positively correlated with suicidal ideation ($r = .57$). Based on

their findings, the researchers suggested that interpersonal relations are especially

important among the Chinese culture and that negative relations with others could lead to

feelings of unhappiness, uneasiness, depression, or feeling bad about oneself. For the

Chinese, maintaining friendships, connections, and having warm and positive friendships

are pivotal factors influencing happiness. For individuals with interdependent self-

construals, maintaining psychological well-being seems to require fulfilling social

obligations, fitting in, and maintaining harmony with significant others in order to gain

social acceptance (Markus & Kitayama, 1991).

Despite the relevance of relatedness among collectivistic cultures, it is a concept

often de-emphasized and looked down upon within the Western literature. Concepts such

as group think (Janis, 1982), conformity (Asch, 1951), and diffusion of responsibility

(Wallach et al., 1964) all emphasize the negative aspects of relatedness and promote

relatedness as an undesirable concept related to weakness. On the contrary, some

previous research have found relatedness factors to enhance psychological well-being.

Brown, Harris, and Copeland (1977) found that for women, having an intimate and

confiding relationship (relatedness) with a man, usually a spouse, acted as a strong

protective factor against developing depression when facing aversive life stress.

Henderson and colleagues (1980) found that when individuals face aversive life stress,

strong social bonds (relatedness) acted as a protective factor against developing

pathological symptoms.

Dual Model of Autonomy

Considering the importance of both autonomy and relatedness across different cultures, the dual model of autonomy (Yeh et al., 2009) defines autonomy in two forms – individuating and relating – each serving distinct purposes for individual functioning. According to Yeh et al. (2009), individuating autonomy (IA) represents the volitional capacity to act against social constraints and to achieve an independent self-identity by expressing individualistic attributes and distinctions, within the intrapersonal domain, much similar to the independent self-construal described by Markus and Kitayama (1991). In Western, individualistic cultures such as Canada, United States, and Great Britain, the self is viewed as a unique, independent entity emphasizing personal achievement and expression through the unique attributes of the individual (Markus & Kitayama, 1991). Relating autonomy (RA) represents the volitional capacity to act emphasizing the harmony of self in relation to others and the quality of interpersonal relationships, within the interpersonal domain, much similar to the interdependent self-construal described by Markus and Kitayama (1991). In non-Western, collectivistic cultures such as Japan, China, and Korea, the self is viewed in relation to others, emphasizing the necessity to attend to significant others in order to achieve and maintain harmonious relationships (Markus & Kitayama, 1991). Both forms of autonomy have been shown to coexist within Taiwanese and American samples and have been identified through structural equation modelling by multi-group analyses (Yeh et al., 2009).

Yeh and Yang (2006) have previously made the clarification that IA differs from detachment and disengagement from relationships, which were concepts associated with

independence in the SDT framework. Instead, IA corresponds to "concentration on achieving personal goals and individuality through one's own volition" (Yeh et al., 2009, p. 215). RA differs from public conformity and compliance; it corresponds to "incorporating significant others' opinions into self-identity through reflection" (Yeh et al., 2009, p. 215). Additionally, Yeh and Yang (2006) clarified that IA and RA are distinct constructs with respective dominant functions in specific domains. Specifically, IA was more associated with adjustment variables in the intrapersonal domain: variables such as self-esteem, personal aspects of happiness, anxiety and depression. It was also conceptualized as a differentiating process for intrapsychic development to allow more complicated cognition, confidence in emotion, and flexibility in regulation. RA on the other hand was more associated with adjustment variables in the interpersonal domain – variables such as social skills, externalizing problems (e.g. aggression, delinquent behavior). It was also conceptualized as a differentiating process for interpersonal relationships, and allowed for more compatibility in handling attitudes different from others, more harmony in managing emotions that conflicted with others, and more integration in regulating difficult situations when interacting with others.

Additionally, it is important to make the distinction that in Yeh and Yang's (2006) autonomy model that IA and RA are not mutually exclusive, meaning that both forms of autonomy may operate in conjunction with one another and that the development of one does not hinder the development of the other. They both coexist within the individual, within both American and Taiwanese samples. Yeh et al. (2009), as well as Yeh and Yang's (2006) earlier work found that within Taiwanese adolescents, college students,

and American college students, individuals developed the capacity to employ both IA and

RA, which allowed unique and authentic expressions of the self and incorporating

significant others when making volitional decisions.

The dual autonomy scale was originally developed in 2006 (Yeh & Yang, 2006),

which measures IA and RA across the cognitive, functional, and emotional domains. The

original measure contained a total of 30 items, with five items targeted to measure each

domain, for both IA and RA. Participants would rate each item on a 5-point Likert scale

from strongly agree to strongly disagree. A two-factor model was supported through

confirmatory factor analysis. Each of the two latent variables: individuating and relating,

had three indicators derived by summing the five items from each of the three-dimension

subscales. Maximum likelihood was used for estimation. Although the chi-square of the

model was significant, other indices showed a good overall fit. There was a moderate .36

correlation between the two latent factors. A shortened form of the scale was later

created, which contains 12 total items, with 2 items targeted to measure each domain, for

both IA and RA. Participants would rate their degree of agreement with each item on a 6-

point Likert scale from 1 (strongly disagree) to 6 (strongly agree). The original 30-item

scale was tested on both Taiwanese college students (N = 517) and senior high school

students (N = 782), while the 12-item scale was first tested with 1246 Taiwanese

adolescents aged between 12 and 18.

However, because the scale was only tested with a Taiwanese sample, it lacked

comparison with a Western sample. Yeh et al. (2009) later tested the scale again, with

both college students in Taiwan (N = 306) and in the US (N = 183) aged between 18 and

23. Yeh et al. (2009) reported the alpha reliabilities of the measure for American and Taiwanese college students aged 18-23 to be .71 and .80 for IA, and .80 and .77 for RA respectively.

To test the premises of the dual model structure, Yeh et al. (2009) had two main hypotheses. First, the authors tested the mutually inclusive nature of the model, where both IA and RA were expected to have a medium positive correlation across individuals and cultures. Additionally, they hypothesized that for both cultures examined, IA is expected to be more associated with adjustment variables in the intrapersonal domain, and RA is expected to be more associated with adjustment variables in the interpersonal domain.

To test the second hypothesis, the authors used two well-validated measures of personal adjustment as dependent variables: reciprocal filial belief, a positive variable from the interpersonal domain (Yeh & Bedford, 2003), and somatic-psychological symptoms, an intrapersonal construct with high cross-cultural validity (Lin, 1989) that are negatively associated with autonomy. The authors hypothesized that RA is more positively associated with reciprocal filial belief than IA, and IA is more negatively associated with somatic-psychological symptoms than RA.

For each sample, Yeh et al. (2009) utilized free-estimated measurement models for the two autonomies and also for the dependent variables (somatic-psychological symptoms and reciprocal filial belief). They utilized maximum likelihood for all measurement models. The results indicated sufficient fit and a medium latent correlation between the two autonomies in both samples and the results of the measurement models

28

for the outcome measures showed that the data fit satisfactorily for each sample. It is important to note, that Yeh et al. (2009) found two of the 12 factor loadings in the two autonomies model to be nonequivalent across samples. After removing the two items, equivalence was confirmed with acceptable indices of model fitness, supporting their first hypothesis that the two forms of autonomy have a medium positive correlation across individuals from both cultures.

The structural models showed that IA was significantly associated only with somatic-psychological symptoms (γ for Americans and Taiwanese were -.44 and -.22 respectively, both $ps < .01$), and not with reciprocal filial belief (γ were .05 and -.08, both $ps > .05$). RA was significantly related to reciprocal filial belief (γ for Americans and Taiwanese were .46 and .45, both $ps < .01$) but not to somatic-psychological symptoms (γ were .00 and -.05, both $ps > .05$). The results indicated that in both cultures, IA was more associated with somatic-psychological symptoms, an adjustment measure in the intrapersonal domain, than with reciprocal filial belief, an adjustment measure in the interpersonal domain. The reverse was true for RA. Their second hypothesis was supported.

Yeh et al. (2009) found that both forms of autonomy in both cultures were significantly negatively correlated with negative somatic-psychological symptoms and significantly positively correlated with reciprocal filial belief, indicating that both forms of autonomy are associated with positive outcomes. It is important to note, that Yeh and Yang (2006) found similar results among Taiwanese adolescents, in that both forms of autonomy were positively correlated with self-esteem, personal subjective happiness, and

29

social skills, and negatively associated with internalized and externalized problems. In both Taiwanese and American college samples, IA was more associated with somatic-psychological symptoms, an outcome variable of the intrapersonal domain, than with reciprocal filial belief, an outcome variable of the interpersonal domain. The opposite was true for RA. They also found cultural differences in that the extent of IA in their Taiwanese sample was lower than their American sample. Unexpectedly, RA was found to be higher in the US sample than in the Taiwanese sample. They hypothesized the unexpected finding to be due to the scale's focus on relations with parents rather than people in general. Despite the conflicting finding regarding cultural differences, Yeh et al. (2009) demonstrated the domain-superior function of each form of autonomy across cultures. As they expected, IA was more associated with intrapersonal domain outcome variables, and RA was more associated with interpersonal domain outcome variables. Both IA and RA were beneficial for intrapersonal as well as interpersonal adjustment. One process allowed for complicated cognition, emotion and flexible function within the individual, and the other allowed for greater capacity to manage thoughts, feelings, and behaviors harmoniously that conflict with others.

Autonomy and Clinical Supervision

As discussed above, the current developmental models of counselor development hypothesize that trainees become more autonomous as they gain experience. The more experienced a trainee is, the more autonomous a trainee becomes (Loganbill et al., 1982; Stoltenberg et al., 1998; Ronnestad & Skovholt, 2003). However, this rests upon a potentially, narrow and flawed definition of autonomy that may be particularly limiting

with trainees high in VC orientation. As such I will examine this experience-autonomy relation using a fuller definition of autonomy that encompasses both IA and RA (Yeh et al., 2009).

Relating autonomy (RA) from the dual autonomy model represents an orientation towards developing the capacity to act volitionally with an emphasis on harmony of self in relation to others, and the quality of interpersonal relationships (Yeh et al., 2009). In the context of clinical supervision, RA is different from IA and traditional autonomy in that it motivates actions in clinical supervision based on the importance of maintaining the quality of interpersonal relationships instead of one's personal desires. Due to the highly individualistic nature of clinical supervision and the expectation of developing traditional autonomy, a construct that highly focuses on the individual's personal volition instead of the maintenance of social harmony, RA is not specifically fostered to develop through the course of training and will unlikely increase over time and accumulated clinical experience.

Taking cultural values into account, the developmental trajectory of trainees who are high in VC orientation may differ in comparison to the development outlined by existing developmental models. For trainees imbued with the value of relatedness and high sensitivity for power differentials, it may take them a longer period of time to acculturate to the autonomous culture within clinical supervision. Advanced trainees are often expected to take the lead in clinical supervision regarding the content they would like to discuss with their clinical supervisors. Even with sufficient clinical experience, trainees may be heavily motivated to maintain relationship harmony with their supervisor

31

over discussing topics of personal interest in supervision. Additionally, trainees who are sensitive of the power differential between themselves and their supervisors may have further difficulties adjusting to taking the lead over someone who has higher power compared to them. Due to the above reasoning, a trainee's VC orientation is first likely to be positively associated with RA due to their overlapping emphases of relatedness, but not associated with IA and traditional autonomy as they focus primarily on the expression through individualistic attributes. Second, a trainee's VC orientation can potentially influence the relation between experience level and autonomy. Specifically, trainees with high VC are more likely to develop IA and traditional autonomy at a slower pace given the same amount of accumulated experience compared to those with low VC due to sensitivity to power differentials, and prioritizing social harmony and interdependence over independent pursuits. The same relationship is unlikely to exist for RA due to the sole expected growth of traditional autonomy and not of RA in trainees, emphasizing the act against social constraints and in favor of one's own self-expression. Regardless of a trainee's VC orientation, the trainee's level of RA is likely to remain stable over the course of training.

Research Questions and Hypotheses

The current study explores the application of IA and RA within clinical supervision as well as the relations between VC, experience, and autonomy. To do so, an established autonomy measure in clinical supervision from Western developmental models is needed to serve as comparison to the dual autonomy scale. The Dependency-

Autonomy subscale from the SLQ-R is used to measure the trainee's level of autonomy within the IDM framework.

The following are research questions and hypotheses for the study:

1. What are the relations among IA, RA and traditional autonomy within the context of clinical supervision?

   I hypothesize that IA and RA will be moderately correlated with each other. Despite IA and RA identified as distinct constructs, Yeh et al. (2009) found IA and RA to be positively correlated with each other for both Taiwanese and American samples. They have also specified that these constructs are not mutually exclusive and both exist within the individual. IA will likely be highly correlated with traditional autonomy, since Yeh and Yang (2006) conceptualized IA similarly as traditional Western autonomy, emphasizing the volitional capacity to achieve an independent self-identity by expressing individualistic attributes and distinctions, within the intrapersonal domain. RA will not be correlated with traditional autonomy due its focus on the self in-relation to others rather than independent self-identity. If this relation between RA and traditional autonomy is confirmed, results will imply that RA and traditional autonomy are separate, distinct constructs, and that RA has not been previously measured within the Dependency-Autonomy subscale.

2. Will VC covary with the different types of autonomy?

First, I hypothesize that VC will be positively correlated with RA. Markus and Kitayama (1991), Sato (2001), and Singelis et al. (1995) outlined cultural values between individualistic and collectivistic cultures to significantly differ. One of the primary characteristics of collectivism is interdependence among groups. This is synonymous with the concept of relatedness, the construct that RA encapsulates. Additionally, VC adds an additional layer to collectivism emphasizing the sensitivity to inequalities that exist within groups. This sensitivity to power differentials is also likely to contribute to actions leading to the successes and failures of maintaining social relationships.

Second, I hypothesize that VC will not be related to IA and traditional autonomy due to the differences in cultural values between individualistic and collectivistic cultures. As mentioned previously, collectivism highlights the importance of interdependence, relationships, group goals, and social expectations (Singelis et al., 1995). IA and traditional autonomy emphasize the importance of acting against social constraints in favor of one's own self-expression. These concepts operate among different systems (collectivism through groups, and IA and traditional autonomy through the individual), hence I hypothesize VC and IA, traditional autonomy to be unrelated.

3. Will VC moderate the relation between autonomy and experience?

First, I hypothesize that VC will moderate the relation between experience and IA, and experience and traditional autonomy. Specifically, trainees with

higher VC orientation will have a slower growth rate of IA and traditional

autonomy over accumulated experience compared to trainees with lower VC

orientation. With little counseling experience, all trainees will have low IA

and autonomy specified by the Dependency-Autonomy subscale. This was

specified in Stoltenberg and colleagues' IDM (1998) as was also found by

Tracey and colleagues (1989) that beginning trainees preferred more

structured supervision and advanced trainees preferred less structured

supervision across different supervision content conditions. As trainees gain

experience, however, they are expected to become more competent clinically,

which results in an increase in autonomy level. Within clinical supervision,

seasoned trainees are expected to take leadership, and utilize the session time

based on what they need personally from their clinical supervisors. There are

two main primary components of VC that can interrupt the predicted course of

development according to counselor development models. First, for trainees

who identify highly with values of VC emphasizing interdependence,

relationship harmony, and group-oriented goals, even with accumulated

clinical experience over time, they may have difficulty being autonomous

within clinical supervision to express their personal needs. Second, VC

emphasizes sensitivity toward the inequalities that exist within groups. Given

that the clinical supervisor has an evaluative and mentoring role in clinical

supervision, trainees with high VC orientation may have more difficulty

taking leadership in clinical supervision knowing that they have less perceived

power compared to their clinical supervisors. Due to these unique cultural factors, I predict that trainees with high VC orientation will develop IA and traditional autonomy at a slower pace compared to trainees with low VC.

Second, I hypothesize no moderating effects of VC for experience and RA. Because the current supervision structure is outlined with the expectation for more experienced trainees to take leadership in supervision sessions based on their personal needs, RA is not emphasized and is not expected to increase as one accumulates clinical experience. Therefore, regardless of a trainee's VC orientation, the trainee's level of RA is likely to remain stable over time.

CHAPTER 3

METHOD

Participants

A total of 496 individuals participated in the study, and 404 completed

questionnaires were included in data analysis. All participants were aged between 21 and

68 (mean = 28.61, SD = 6.71), and all were enrolled in graduate programs across the US.

54 participants identified as male, 344 as female, and 6 as other. At the master's level, 73

participants reported being enrolled in Mental Health Counseling, 8 in Counseling

Psychology, 4 in Counseling and Counselor Education, 1 in Social Work, 2 in School

Counseling, 3 in Marriage and Family Therapy, and 8 in Forensic Mental Health

Counseling. At the doctoral level (Ph.D. & Psy.D.), 120 participants reported being

enrolled in Counseling Psychology, 165 in Clinical Psychology, 1 in Clinical,

Counseling, and School Combined, 15 in Counselor Education and Supervision, 1 in

Counseling and Human Services, 1 in Counseling and School Psychology, and 1 in

Health Psychology. One participant reported being enrolled in an Ed.S. degree in School

Counseling. All participants completed the study online.

Measures

Demographic Questionnaire – The demographic questionnaire assessed basic

demographic information (age, gender, race/ethnicity), whether one is an international

student, country of origin, first or second generation immigrant (first generation was

defined by "The first generation in your family to have moved from your country of

origin to the US", and second generation was defined by "The first generation in your

family to be born in the US"), years lived in the US, attending university, highest degree earned, name of current counseling education program, current year in counseling education program, type of accreditation (APA, CACREP, CSWE, COAMFTE, Unsure, Other), chosen counseling emphasis area (addiction, career, community mental health, college counseling, marriage and family, school, VA/hospital, unsure), current practicum setting (community mental health, university counseling center, school, VA/hospital, private practice), previous semesters of practicum completed, previous semesters of supervision received, and total years of graduate education completed.

Individualism-Collectivism Scale (INDCOL) (Singelis, Triandis, Bhawuk, & Gelfand, 1995) was utilized to measure trainees' vertical collectivism orientation. The instrument contains a total of 32 items measuring individualistic and collectivistic orientations, 8 items measuring horizontal collectivism, and 8 items measuring vertical collectivism. Horizontal collectivism (HC) emphasizes equality, and is defined by perceiving the self as a part of the collective, and seeing all members of the collective as the same. A sample item for this dimension includes: "My happiness depends very much on the happiness of those around me". Vertical collectivism (VC) is defined as perceiving the self as a part of the collective, but accepting inequalities and discrepancies within the collective. Individuals who score high on vertical collectivism tend to prioritize group goals over personal goals, but accept in-group inequality and welcome competition. A sample item for this dimension includes: "I would sacrifice an activity that I enjoy very much if my family did not approve of it".

38

All eight items specifically measuring VC orientation were used for the study. Responses were measured on a 9-point Likert scale (1 = *Never or definitely no*, 9 = *Always or definitely yes*). Higher scores indicate higher collectivistic orientation, and scores range from 8 to 72. The measure has demonstrated good internal consistency overall. Singelis et al. (1995) reported an alpha reliability of VC as .68. Chirkov, Ryan, and Willness (2005), and Na, Spanierman, and Lalonde (2017) reported internal consistencies of .75 and .74 from their respective studies.

Seeking support for convergent validity of the INDCOL, Singelis et al. (1995) found HC and VC scales to be strongly correlated ($r = .39$, $p < .001$). They also compared the dimensions of the INDCOL with the Self-Construal Scale (SCS) (Singelis, 1994), a measure designed to assess the degree to which the respondent is both independent and interdependent, among undergraduate students in Illinois and in Hawaii. They reported the HC scale to be positively related to the SCS interdependence ($r = .43$, $p < .001$), and the VC scale to be strongly correlated with SCS interdependence ($r = .50$, $p < .001$) and negatively related to SCS independence ($r = -.26$, $p < .001$), providing support for convergent and discriminant validity with another measure.

Experience level – Although clinical experience has been used as the sole criterion variable for measuring a trainee's "experience level", McNeill and colleagues (1992) recommended to include other criterion, such as supervision experience and graduate education due to their value towards a trainee's growth as a clinician. To classify their trainees' experience level, McNeill and colleagues (1992) assigned each trainee a value for each index of experience (e.g., 1, 2, 3, etc.) and summing those three

values (semesters of previous counseling and supervision experience, years of graduate education) to create a score for the trainee's experience variable. Trainees were then labeled "beginning", "intermediate", or "advanced" based on this broader experience variable. They tested the validity of the SLQ-R with their specified experience level, and found significant differences in Dependency-Autonomy subscale scores between beginning and advanced trainee groups, $t(43.4) = 2.23$, $p < .05$, and the intermediate and advanced trainee groups, $t(70.7) = 2.40$, $p <.05$. They also conducted an analysis of variance with the experience index as the independent variable, and finding that the total SLQ-R scores of the groups differed significantly, $F(2, 102) = 7.37$, $p < .001$. For this study, experience level was measured using McNeill et al.'s (1992) experience index. However, rather than categorizing trainees into three distinct experience levels, experience was measured as a continuous variable. Each trainee was assigned a numerical value specifying their experience level based on their (a) total numbers of semesters of previous counseling experience, (b) number of previous semesters of supervision experience, and (c) years of completed graduate education.

      Dual Autonomy Scale (Yeh & Yang, 2006) was utilized to measure IA and RA across the cognitive, functional, and emotional domains. The measure contains 12 total items, with 2 items targeted to measure each domain, for both IA and RA. Sample items for assessing IA include: "I always know what I want", "I always feel confident about my own decisions", and "I am always able to find the most beneficial way of doing things for myself". Sample items for RA include: "When making a decision, I evaluate the practicalities of both my ideas and my parents' suggestions", "It is meaningful for me to

fulfill my duty as a son or a daughter", and "I am always able to make things satisfactory for both parties even when my parents' expectations are different from mine". Since the study is focused within clinical supervision, modifications were made to accommodate the supervision context. The item inquiring "son or daughter" was modified to "trainee", and items inquiring "parent(s)" were modified to "clinical supervisor". Participants would rate their degree of agreement with each item on a 6-point Likert scale from 1 (strongly disagree) to 6 (strongly agree). Total scores range from 6-36 for IA and RA respectively, with higher scores reflecting higher level of autonomy. Yeh et al. (2009) reported the alpha reliabilities of the measure for American and Taiwanese college students aged 18-23 to be .71 and .80 for IA, and .80 and .77 for RA respectively. Wu and colleagues (2015) reported alpha reliabilities of .83 and .87 for IA and RA respectively among Northern and Southern Taiwanese high school students.

Dependency-Autonomy subscale from Stoltenberg's *Supervisee Levels Questionnaire – Revised (SLQ-R)* was used to assess the development of autonomy within trainees in the Western context (McNeill, Stoltenberg, & Pierce, 1985; McNeill, Stoltenberg, & Romans, 1992; Stoltenberg et al., 1998). The original measure contained a total of 47 self-report items and was condensed into 30 items in the final version. There are ten items measuring autonomy, with five questions reverse-scored. Responses are measured on a 7-point Likert scale (1 = *Never*, 7 = *Always*). Higher scores indicate higher levels of development, and scores from the Dependency-Autonomy subscale range from 10 to 70. Stoltenberg and colleagues (1998) reported Cronbach alpha reliability coefficient for dependency-autonomy to be .64. To assess the construct validity of the

measure, 105 students from eight psychology training programs differing in clinical experience across the US were examined using the SLQ-R. Intercorrelations of the subscales were statistically significant (Self and Other Awareness and Dependency-Autonomy, $r = .53$ $p < .001$; Self and Other Awareness and Motivation, $r = .58$ $p < .001$; Motivation and Dependency-Autonomy, $r = .43$ $p < .001$), but not high enough to suggest that they were measuring the same construct (McNeill et al., 1992). Regarding the Dependency-Autonomy subscale specifically, Mirgon (2007) found within her participants, consisting of Master's of Counseling students in practicum within a Southwestern university, students on Master's-leveled internship, post-internship counselors, and licensed counselors that scores ranged between 35.0 and 62.0 with a mean of 48.29, and the shape of the distribution was consistent with practicum students scoring the lowest and licensed counselors scoring the highest with a slight decrease for post interns from the intern group.

Procedures

Participants were recruited through professional psychology listservs, connections through students and educators in counselor education programs across the United States, social media, and the researcher's native counseling program. The study is anonymous and all data provided by participants are confidential. Participants were allowed to discontinue the study at any time. Incomplete studies were not included in data analysis. Once granted online access, each participant first filled out the demographic questionnaire, which assessed their experience in semesters of clinical work, semesters of clinical supervision, and years of graduate coursework. Afterwards, participants

completed the collectivism portion of the INDCOL, the dual autonomy scale, the Dependency-Autonomy subscale from the SLQ-R and were thanked for their participation.

Analysis

To account for missing data, listwise deletion was utilized to delete all cases of missing data on any of the measured variables. 92 incomplete surveys were not included in data analysis due to missing data. Correlation analyses were conducted to assess relations between all variables for the study. Regression analyses were conducted to assess main effects of experience level and VC orientation on each form of autonomy (IA, RA, and Dependency-Autonomy from SLQ-R).

Because the dual autonomy scale has not been used in the context of clinical supervision, a confirmatory factor analysis (CFA) was conducted to assess whether the two-factor structure of IA and RA fit well within the study's sample. CFA analysis of the 12-item dual autonomy scale was conducted using SPSS Amos for a two-factor model. The model hypothesized that two co-related dimensions of individuating and relating autonomy underlie the dual autonomy scale for counseling trainees participating in the study. IA will correspond to the six items intended to measure IA, and RA will correspond to the six items intended to measure RA. To evaluate the fit of the model, statistics related to model chi square ($\chi2$) goodness of fit test, comparative fit index (CFI), and root mean-square error of approximation (RMSEA) were used. Modification indices were also examined to identify poorly performing measures.

To assess whether VC orientation moderated the relation between experience level and autonomy, a hierarchical regression was conducted for each of the three autonomy measures. Experience level and VC were entered as the first step, followed by the interaction term. If the interaction is significant, then moderation is supported.

According to Cohen et al. (2003), when the relation between two variables is dependent upon a third variable, this variable is known as a moderator. For the current study, the hierarchical regression tested whether VC orientation interacted with the experience variable in that the regression coefficients for the regression of IA and traditional autonomy on experience decreases as VC orientation increases. When experience level is low, VC orientation has little effect because trainees lack the experience to be autonomous in clinical supervision. When experience level is higher, then VC orientation will affect the relation between experience and IA, as well as experience and traditional autonomy due to differences in cultural values between the trainee and the clinical supervision setting.

CHAPTER 4

RESULTS

This chapter will involve a summary of the results and will be presented in the same sequence as the specification of hypotheses. Prior to testing the study hypotheses, a confirmatory factor analysis (CFA) was conducted to assess how well the proposed two-factor structure of individuating autonomy (IA) and relating autonomy (RA) fit among data collected from counseling trainees. This is necessary to test whether IA and RA are constructs applicable within the context of clinical supervision. The normality of data was first analyzed. Due to values of skewness and kurtosis exceeding the -1.0 and 1.0 range for several items of the measure indicating that data is not normally distributed, a more robust estimator, asymptotically distribution free (Browne, 1984), was utilized.

The values of the estimated parameters with standardized solution are shown in the model (Figure 1). All factor loadings were statistically significant ($p < .001$) and fairly strong. The correlation coefficient among the two factors (IA and RA) was .32, and was statistically significant ($p < .001$).

Based on model chi-square ($\chi 2 = 137.89$, $p < .001$), the null hypothesis of perfect fit was rejected. The value of CFI was .80, with a value closer to 1 indicating better fit (Bentler, 1990). The value of RMSEA was .06 (90% confidence interval from .050 to .076), indicating a good fit of the proposed two-factor model (Browne & Cudeck, 1993). Based on fit indices, the proposed two-factor structure of the dual autonomy scale does appear to have a fair fit. The results of this model are depicted in Figure 1.

A second CFA was conducted to assess how the two-factor structure of the dual autonomy scale compares to a single-factor structure. The values of the estimated parameters with standardized solution for the one-factor structure are shown in the model (Figure 2). All factor loadings were statistically significant ($p < .001$) and fairly strong. However, the fit indices were less strong in comparison to the two-factor structure. The null hypothesis of perfect fit based on the model chi-square was rejected ($\chi 2 = 245.27$, $p < .001$), the value of CFI was .54, and the value of RMSEA was .09 (90% confidence interval from .082 to .106). According to Browne and Cudeck (1993), this RMSEA value reflects a mediocre fit. Based on the two sets of fit indices, the proposed two-factor structure of the dual autonomy scale appeared to have better fit in comparison to the one-factor structure. A chi-square difference test was conducted to compare the difference in fit between the two models, $\chi 2_{\text{diff}}(1) = 107.38$, $p < .001$. If the chi-square difference value is significant between the two models, the larger model with more freely estimated parameters, the two-factor model, fits the data better than the smaller model, the single-factor model (Kline, 1998). Therefore, the two-factor representation of the dual autonomy scale was determined as the best fit and the two-dimensional autonomy scale scoring was deemed appropriate for use in this study.

Figure 1. Two-Factor Model with Standardized Parameters from the Confirmatory Factor Analysis of the Dual Autonomy Scale.
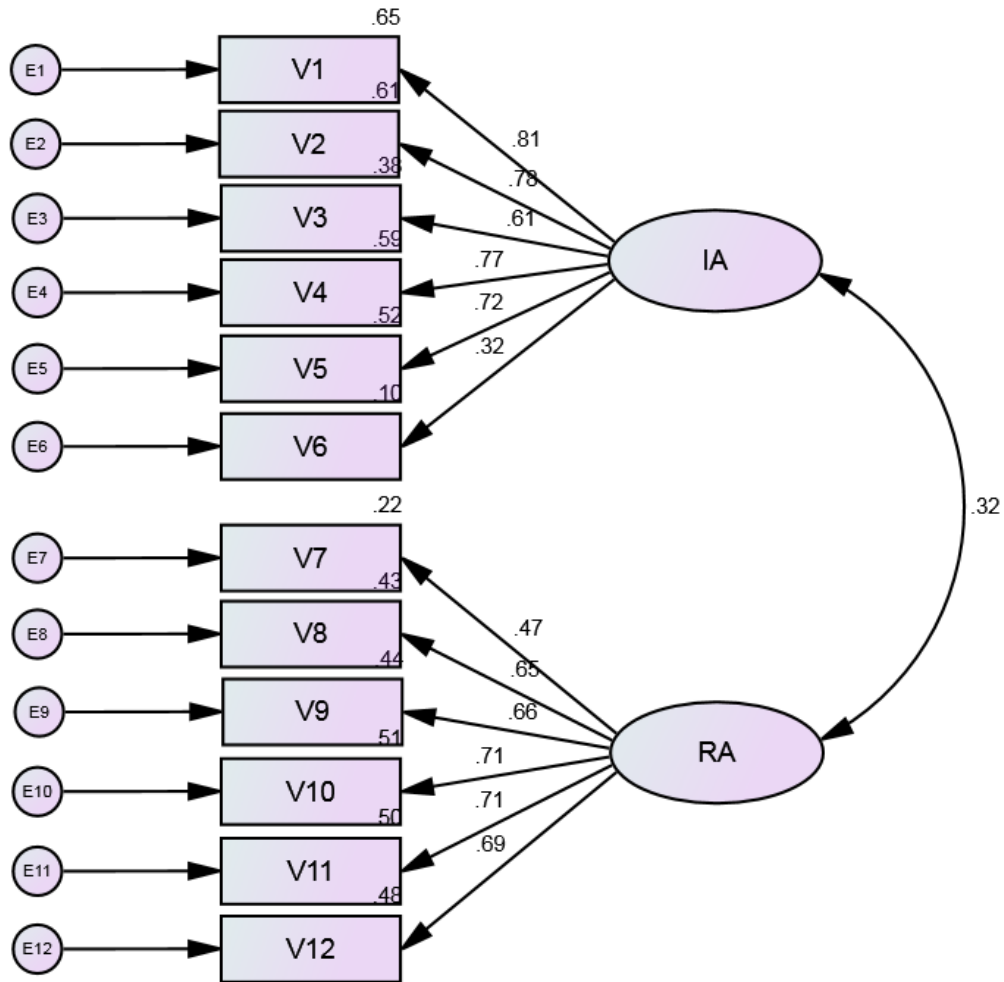
Note. All parameters were statistically significant at the α = .001 level.

Figure 2. One-Factor Model with Standardized Parameters from the Confirmatory Factor Analysis of the Dual Autonomy Scale.
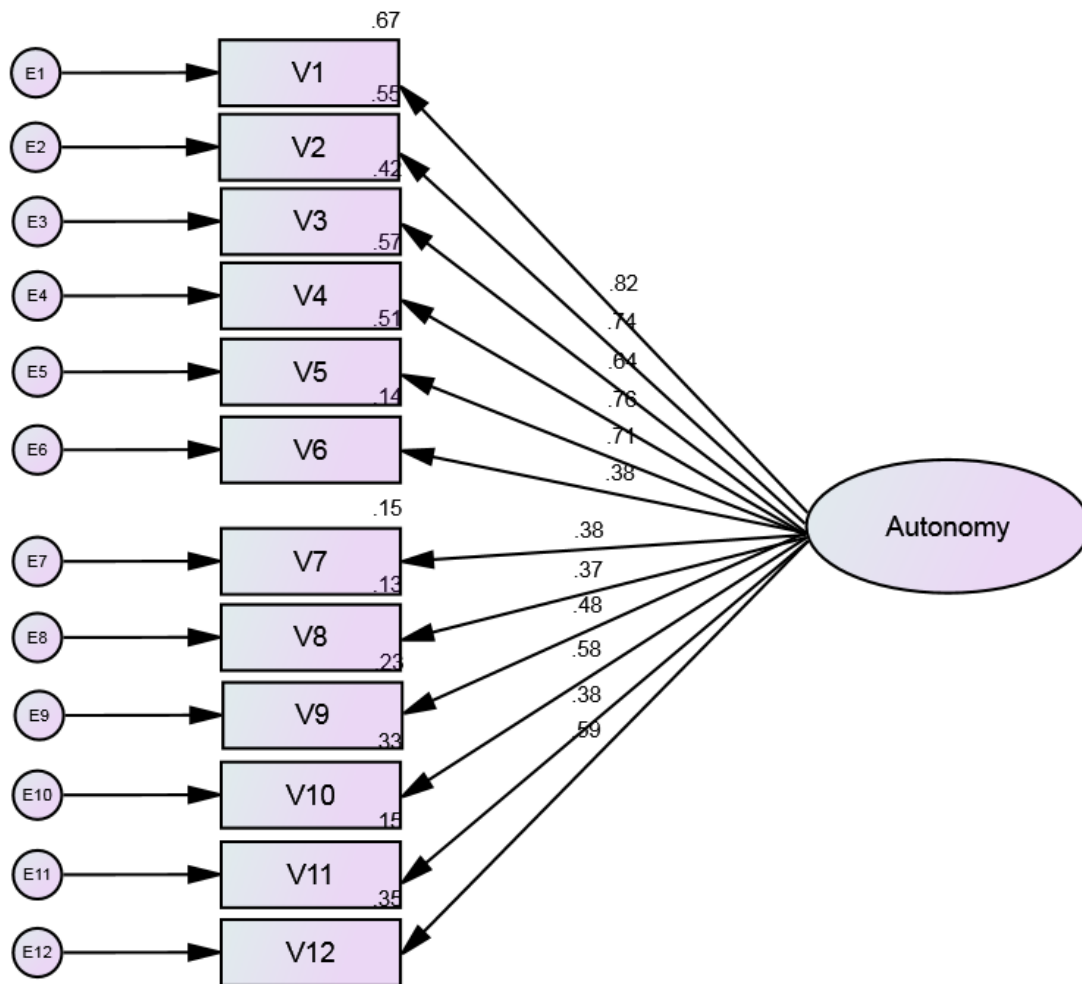
Note. All parameters were statistically significant at the α = .001 level.

The first hypothesis concerned the relations between different forms of autonomy within clinical supervision. The second hypothesis concerned the relations between vertical collectivism and the three forms of autonomy. These relations were examined using the correlations among the variables which are summarized in Table 1. Correlations among vertical collectivism (VC), experience level, IA, RA, and traditional autonomy were examined. IA was significantly correlated with RA ($r = .26$, $p < .01$) and traditional autonomy ($r = .24$, $p < .01$), and RA was not significantly correlated with traditional autonomy ($r = .07$, $p > .05$). VC was not significantly correlated with RA ($r = .08$, $p > .05$), and was significantly correlated with IA ($r = -.12$, $p < .05$) and with traditional autonomy ($r = -.16$, $p < .01$). Experience level was significantly correlated with traditional autonomy ($r = .41$, $p < .01$), and not with other variables. These results indicated that hypothesis 1, which stated that IA and RA will be moderately correlated with each other, IA and traditional autonomy will be highly correlated with each other, and RA will not be correlated with traditional autonomy, was generally supported. Hypothesis 2, which stated that VC will be positively correlated with RA and not be correlated with IA and traditional autonomy was not supported.

Hypothesis 3 predicted that VC will moderate the relation between experience and IA, and experience and traditional autonomy, such that trainees with higher VC orientation will have a slower growth rate of IA and traditional autonomy over accumulated experience compared to trainees with lower VC orientation. The same moderation effect of VC was not predicted for experience and RA. To test whether VC moderated the relation between experience level and autonomy, hierarchical regressions

were conducted and these results are summarized in Table 2. VC (β = -.13, t = -2.83, $p <$ .01) and experience level (β = .40, t = 8.75, $p < .01$) significantly predicted traditional autonomy. In the second step, the interaction term for VC and experience level was entered, but no significance increase in R^2 was detected, ΔR^2 = .000, $\Delta F(1, 400)$ = .00, p > .05. Moderation effects of VC were also tested for the relations between experience level and IA and RA, and no significance was found. VC and experience level did not significantly predict IA together, $F(2, 401)$ = 3.00, $p > .05$, R^2 = .015, but VC did predict IA as a single predictor (β = -.12, t = -2.43, $p < .05$), while experience level did not (β = .01, t = -.29, $p > .05$). On the second step, the interaction term for VC and experience level was entered, but no significance increase in R^2 was detected, ΔR^2 = .002, $\Delta F(1, 400)$ = .91, $p > .05$. VC and experience level did not significantly predict RA, $F(2, 401)$ = 1.45, $p > .05$, R^2 = .007, VC (β = .08, t = 1.69, $p > .05$), experience level (β = .02, t = .35, $p > .05$). On the second step, the interaction term for VC and experience level was entered, but no significance increase in R^2 was detected, ΔR^2 = .003, $\Delta F(1, 400)$ = 1.18, p > .05. These results did not support hypothesis 3, postulating VC to be a moderator of experience level and any of the autonomy measures.

Based on the results, the first hypothesis was supported. IA was positively correlated with RA as well as traditional autonomy, and RA was not correlated with traditional autonomy. Results did not support the second hypothesis in relation to VC, IA, RA, and traditional autonomy. VC did not significantly correlate to RA, and was negatively correlated with IA and traditional autonomy. Lastly, results did not support the

third hypothesis postulating moderation of VC on IA and experience. No significant

moderation effects were detected for either IA or traditional autonomy.

Table 1. Correlations among All Autonomy Variables, Vertical Collectivism, and Experience Level.

Variable	1	2	3	4	5
1. Vertical Collectivism	1.00				
2. Experience Level	-.08	1.00			
3. Individuating Autonomy	-.12*	.00	1.00		
4. Relating Autonomy	-.08	.01	.26**	1.00	
5. Traditional Autonomy	-.16**	.41**	.24**	.07	1.00
Mean	39.36	12.74	23.99	30.34	44.94
SD	8.57	7.59	4.82	3.81	6.33

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*p < .05 **p < .01

Table 2. Summary of Hierarchical Regressions Analyzing the Relation between Vertical Collectivism, Experience Level, and Different Forms of Autonomy.

	β	t	r	R^2	df	F	ΔR^2	ΔF
Criterion = Individuating Autonomy								
Step 1			.12	.015	2, 401	3.00		
Vertical Collectivism	-.12	-2.43*						
Experience Level	-.01	-.29						
Step 2			.13	.017	3, 400	2.28	.002	.91
Vertical Collectivism	-.13	-2.54*						
Experience Level	-.01	-.28						
Interaction Term	.05	.95						
Criterion = Relating Autonomy								
Step 1			.09	.007	2, 401	1.45		
Vertical Collectivism	.08	1.69						
Experience Level	.02	.35						
Step 2			.10	.010	3, 400	1.36	.003	1.18
Vertical Collectivism	.09	1.83						
Experience Level	.02	.34						
Interaction Term	-.06	-1.09						
Criterion = Traditional Autonomy								
Step 1			.43	.178	2, 401	44.68**		
Vertical Collectivism	-.13	-2.83**						
Experience Level	.40	8.75**						
Step 2			.43	.176	3, 400	29.71**	.000	.001
Vertical Collectivism	-.13	-2.79**						
Experience Level	.40	8.74**						
Interaction Term	-.00	-.04						

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

53

CHAPTER 5

DISCUSSION

The application of the dual autonomy scale, as well as how collectivism is associated with autonomy and experience within clinical supervision were examined in this study. Results supported previous findings regarding the relation of experience level and traditional autonomy. As outlined by existing counselor development models, trainees are expected to become more autonomous within clinical supervision as they gain experience.

Results from the current study support previous findings regarding the relation of experience level and traditional autonomy. Experience level significantly predicted traditional autonomy ($\beta = .40$, $t = 8.75$, $p < .01$). Despite the finding not being ground-breaking, it does contribute to existing literature. Not many studies have previously utilized the Dependency-Autonomy subscale from the SLQ-R as a specific measure of traditional autonomy. The study's finding provides further support for the validity of the subscale, reinforcing it as a dependable measure for traditional autonomy. Additionally, the current study utilized an experience level index consisting of (a) previous semesters of counseling experience, (b) previous semesters of supervision received, and (c) total years of graduate education completed, encapsulating multiple elements contributing to a trainee's growth as a clinician. McNeill and colleagues (1992) mentioned that multiple criteria including graduate education, as well as previously received supervision, are valuable toward the trainee's growth as a clinician. This more cohesive experience index has not been utilized in previous studies. Furthermore, the current study included

54

graduate trainees from both master's as well as doctoral programs, indicating that the

relation between experience level and autonomy apply for all trainees in counseling, even

for those who may not professionally pursue clinical work post-graduation.

Consistent with the study's hypothesis, a moderate positive correlation was found

between individuating autonomy (IA) and traditional autonomy. Yeh and Yang (2006)

believed in the positive attributes of both traditional autonomy in Western cultures as

well as relatedness from non-Western cultures, and incorporated both cultural constructs

into their conceptualization of autonomy. IA was conceptualized based on how autonomy

was traditionally defined by the self-determination theory (SDT), operationalizing

autonomy as self-governance and the ability to make choices based on the individual's

internal motivations rather than external controls. This definition overlaps with how

autonomy was defined in clinical supervision, referring to the degree of independence

demonstrated by trainees over time (Stoltenberg et al., 1998). Results imply that the

adapted version of the IA subscale in clinical supervision did load in the expected

direction and presents potential as an alternative autonomy measure in clinical

supervision that distinguishes autonomy based on its traditional, individualistic

conceptualization. However, because this is only a moderate correlation, there is still

much improvement for the IA subscale to become a stronger autonomy measure. For

instance, Item 6, "Trying new things is not difficult for me", had a considerably lower

factor loading, indicating that the item has a weaker association with IA than the other

items. Having a more refined measure that specifically assesses IA within the context of

clinical supervision may lead to an increase in the positive correlation between IA and traditional autonomy.

In regards to relating autonomy (RA), Yeh and Yang (2006) defined the construct as the volitional capacity to act based on the concept of relatedness, emphasizing social harmony and the self in relation to others. Results did support the hypothesized relation between RA and traditional autonomy, that the two constructs will be unrelated to each other. RA was hypothesized to not correlate with traditional autonomy due its focus on the self in-relation to others rather than independent self-identity. Results did support that RA and traditional autonomy are unrelated among counseling trainees, and can be considered as distinct constructs. However, because the correlation coefficient only indicates the relation of two variables, whether the current adaptation of RA in clinical supervision is successful cannot be assessed purely based on this statistic.

Consistent among the hypothesis, a positive correlation between IA and RA was found for the adapted dual autonomy scale. Yeh et al. (2009) found IA and RA to be positively correlated with each other for both Taiwanese and American high school and college samples. They specified that the two forms of autonomy are not mutually exclusive and that both are essential for human function. Results indicate that the same relation of IA and RA across cognitive, functional, and emotional domains of high school and college students (Yeh & Yang, 2006; Yeh et al., 2009; Wu et al., 2015) applies to counseling trainees within the context of clinical supervision as well. IA and RA are not mutually exclusive concepts, may operate in conjunction with one another, and the development of one may not hinder the development of the other.

Collectivism, more specifically, vertical collectivism (VC), was hypothesized as a cultural construct that is related to the development of autonomy among counseling trainees. First, VC was hypothesized to be positively correlated with RA. Triandis (1995) identified four distinguishing characteristics among collectivists: (1) collectivists define themselves as aspects of a group, (2) personal goals of collectivists overlap with goals of their in-group members, (3) behavior among collectivists is best predicted from social norms, perceived duties, and obligations, and (4) relationships are of the greatest importance among collectivists. Because RA was conceptualized based on the concept of relatedness, characterized as being "at one with others", or having a sense of communion or affiliation (Markus & Kitayama, 1991), there is considerable overlap between collectivism and RA, given that both constructs heavily emphasize interdependence. Additionally, Singelis et al. (1995) specified that VC adds another layer to general collectivism, in that it highlights sensitivity to inequalities and power differentials that exist within groups. Individuals high on VC orientation are more sensitive to these power discrepancies. This sensitivity to power dynamics is also likely to contribute toward how individuals maintain social harmony within their in-groups. However, results did not support the hypothesis. No relation between VC and RA was found. The result indicates that VC and RA are two distinct constructs among counseling trainees in the clinical supervision setting. There are three likely explanations of this unexpected outcome. First, it is possible for VC and RA to be unrelated constructs among counseling trainees in clinical supervision. Second, it is possible that the current adaptation of the RA subscale to accommodate clinical supervision was unsuccessful in that the measure lost its salience

57

of relatedness in the adaptation process. Third, it is possible that the limited range of scores for VC caused attenuation effects on the relation between VC and RA. Based on prior literature regarding VC and RA, I do believe that the two constructs are related. However, results have led me to question whether the adaptation of RA was successful within the context of clinical supervision in the current study.

Because the dual-autonomy subscale was originally created for adolescents then adapted for use with general adults, it is not a measure for a specialized population such as counseling trainees. Modifications were made to the original measure in order to accommodate counseling trainees in the clinical supervision setting. The item inquiring "son or daughter" was modified to "trainee", and items inquiring "parent(s)" were modified to "clinical supervisor". After adapting the measure, some of the previous items that assessed RA for the general adolescent and adult population may have lost meaning within the context of clinical supervision. For instance, item 1 previously stated: "It is meaningful for me to fulfill my duty as a son or daughter." After adapting the item, it states: "It is meaningful for me to fulfill my duty as a trainee." Despite the item still encapsulating relatedness in the sense of seeing the self in relation to others, the same sense of relatedness one may identify with one's parents or guardians may not be as applicable to one's clinical supervisor. Therefore, I suspect that the adaptation of the measure was unsuccessful in capturing RA in the clinical supervision context the same way that the measure did for the general adolescent and adult population.

Additionally, the study lacked participants scoring on the higher range of VC. The maximum range of VC from the participant pool was 66, with a possible maximum score

of 72. Although the correlation between VC and RA was obtained from this sample, the correlation for the population of trainees who are highly vertically collectivistic remains unexamined.

Future studies may examine how to incorporate relatedness into an autonomy measure in clinical supervision and how RA would specifically impact trainee attitudes and behaviors. For instance, trainees highly motivated by RA may be more inclined to apply supervisory feedback with their clients even if the feedback goes against the trainee's own clinical judgement due to prioritizing the relationship between trainee and supervisor over one's internal motivations, whereas trainees who are less motivated by RA would more likely dismiss the supervisory feedback and choose not to apply it in their own clinical work. Specific supervision scenarios such as these that contextualize RA within the supervision setting would be helpful in establishing RA a relevant and observable construct within clinical supervision.

In relation to VC and IA, as well as traditional autonomy, VC was hypothesized to be unrelated to IA and traditional autonomy. Collectivism highlights the importance of interdependence, relationship harmony, group goals, and social expectations (Singelis et al., 1995), while IA and traditional autonomy both emphasize self-expression through individualistic attributes. Because these concepts operate among different systems (collectivism through groups, and IA, traditional autonomy through the individual), VC was hypothesized to be uncorrelated to IA and traditional autonomy. Results did not support this hypothesis, and a small significant negative correlation was found between VC and IA, as well as between VC and traditional autonomy. Additionally, regression

analyses confirmed that VC significantly predicted IA, as well as traditional autonomy. These results indicate that VC is related to both IA and traditional autonomy, and as VC increases, IA and traditional autonomy decrease. Because the correlation coefficients as well as the standardized beta weights for these relations were quite low, VC can only be considered as a weak predictor of IA and traditional autonomy. The results did not support the previous hypotheses that VC and IA, as well as traditional autonomy as distinct, unrelated constructs, but rather VC does influence IA and traditional autonomy. Despite collectivism heavily emphasizing interdependence, group goals and relationship harmony, it does appear to directly affect self-expression through individualistic attributes. If trainees are more group-oriented, they are more likely to think and act on behalf of their in-group members (co-trainees, supervisors, professionals of the agency they are a part of, clients) rather than their own innate preferences. I suspect that VC, which emphasizes the sensitivity toward power differentials and inequalities also contributed to this effect. If trainees are highly sensitive toward power differentials, they are less likely to act based on their own volitions knowing the lack of power they possess in their clinical setting.

In terms of the direct implications of these results, because the correlation coefficients and standardized beta weights reflect only a weak relation between VC and IA as well as traditional autonomy, I can only conclude that a relation between these variables exist. For supervisors who suspect their trainees to be highly collectivistic and sensitive towards being evaluated, it may be beneficial to initiate a discussion to address cultural concerns in the beginning of a supervisory relationship to prevent potential rifts

60

and misunderstandings. These results, combined with finding a positive correlation between IA and traditional autonomy provides further support for the adapted IA subscale to serve as a possible alternative traditional autonomy measure within clinical supervision.

The last hypothesis of the study entailed testing for moderation effects of VC on experience level and autonomy. More specifically, I hypothesized that there were two primary components of VC that can disrupt the predicted course of IA and traditional autonomy development outlined by counselor development models. First, VC emphasizes interdependence, relationship harmony, and group-oriented goals. These may serve as competing forces for expressing personal concerns in clinical supervision. Second, VC highlights sensitivity toward inequality and power differentials within groups. Because supervisors have an evaluative role, trainees with high VC orientation may have difficulty taking leadership in a situation when they perceive as having less power. No moderating effects of VC was found, however. Results indicate that VC does not influence the regular developmental trajectory of autonomy among counseling trainees. As outlined by counselor developmental models, autonomy within clinical supervision develops as a function of accumulated experience. As trainees become more experienced, they gain a sense of clinical competency, and become more autonomous in clinical supervision as a result (Stoltenberg et al., 1998). Despite there being a cultural discrepancy between collectivism and the individualistic clinical supervision culture, all trainees appear to follow the predicted trajectory in IA and traditional autonomy

development. A trainee's collectivistic orientation does not appear to influence the relation between experience and IA, as well as traditional autonomy.

Given that IA and traditional autonomy were significantly correlated with each other, and the Individualism-Collectivism Scale being a well validated measure (Singelis et al., 1995), I do believe that the unexpected results were not due to issues regarding measurement. It is possible, however, that because the maximum range of VC from the participant pool was slightly low (maximum range = 66 out of a possible value of 72), the hypothesized moderation effect was not captured among highly vertically collectivistic trainees.

Overall, the study further supported what we know regarding experience and traditional autonomy. The more experienced a trainee is, the more autonomous the trainee becomes in supervision. This is a key takeaway for clinical supervisors. Based on established developmental models outlining counselor development, supervisors are advised to adjust their supervisory styles based on where the trainee is developmentally (Loganbill et al., 1982; Stoltenberg, McNeill, & Delworth, 1998; Ronnestad & Skovholt, 2003; Rigazio-Digilio et al., 1997). Beginning trainees lack the expected autonomy level to take initiative in clinical supervision and would prefer more structured instruction, whereas advanced trainees are able to take initiative in supervision and discuss their topics of interest with their supervisors. It may be developmentally inappropriate for clinical supervisors to expect novice trainees to lead their own supervision sessions while employing an unstructured supervisory style, and have routinely structured sessions with

advanced trainees who may be more interested in discussing topics and cases of personal interest.

The adapted version of the IA subscale also loaded in the expected direction in respect with traditional autonomy, and was found to be negatively correlated with VC, along with traditional autonomy. Similar loading patterns with traditional autonomy provided support for the adapted IA subscale to serve as a comparable autonomy measure within clinical supervision. Further refinement of the IA subscale could lead to a stronger positive correlation with traditional autonomy.

The adapted RA subscale did not load in expected directions for counseling trainees, and most likely did not retain relatedness the same way it did for the general adolescent and adult population. As stated previously, there were two primary limitations for the study. First, the adapted version of the RA measure did not incorporate specific supervision scenarios which would demonstrate the impact of relatedness within clinical supervision. Second, the study lacked participants who scored high on VC. Future direction may focus on specifically examining the experiences of trainees who possess high values of VC as well as scale development for an autonomy measure that encapsulates how relatedness may specifically impact trainee mentality and behavior within supervision.

REFERENCES

Asch, S. E. (1951). Effects of group pressure upon the modifications and distortion of judgments. In H. Guetzkow (Ed.), *Groups, leadership, and men* (pp. 177-190). Pittsburgh, PA: Carnegie Press.

Bakan, D. (1966). *The duality of human existence: An essay on psychology and religion.* Chicago: Rand McNally.

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin, 107*(2), 238-246.

Bernard, J., & Goodyear, R. K. (2014). *Fundamentals of Clinical Supervision.* (5th ed.). Columbus, OH: Pearson.

Bontempo, R., & Rivero, J. C. (1992, August). *Cultural variation in cognition: The role of self-concept in the attitude behavior link.* Paper presented at the meetings of the American Academy of Management, Las Vegas, Nevada.

Brown, G. W., Harris, T., & Copeland, J. R. (1977). Depression and loss. *British Journal of Psychiatry, 130,* 1-18.

Browne, M. W. (1984). Asymptotically distribution-free methods for the analysis of covariance structures. *British Journal of Mathematical and Statistical Psychology, 37*(1), 62-83.

Browne, M. W., & Cudeck, R. (1993). Alternative ways of assessing model fit. In K. A. Bollen & J. S. Long (Eds.). *Testing structural equation models* (pp. 136−162). Newbury Park, CA: Sage.

Carlson, H. M., & Baxter, L. A. (1984). Androgyny, depression, and self-esteem in Irish homosexual and heterosexual males and females. *Sex Roles, 10,* 457-467.

Chirkov, V. I., Ryan, R. M., & Willness, C. (2005). Cultural context and psychological needs in Canada and Brazil testing a self-determination approach to the internalization of cultural practices, identity, and well-being. *Journal of Cross-Cultural Psychology, 36,* 423– 443.

Cho, S. (2000). Selflessness: Toward a Buddhist vision of social justice. *Journal of Buddhist Ethics, 7,* 76-85.

Chu, H. (2007). *Autonomy and well-being: Self-determination in Chinese students in the United States.* Available from PsycINFO. Retrieved from

http://login.ezproxy1.lib.asu.edu/login?url=https://search-proquest-com.ezproxy1.lib.asu.edu/docview/622012590?accountid=4485

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences* (3rd ed.). Lawrence Erlbaum Associates Publishers, Mahwah, NJ.

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior.* New York: Plenum Press.

Deci, E. L., & Ryan, R. M. (1991). A motivational approach to self: Integration in personality. In R. Dienstbier (Ed.). *Nebraska Symposium on Motivation: Vol 38. Perspectives on motivation* (pp. 237–288). Lincoln: University of Nebraska Press.

Deci, E. L., & Ryan, R. M. (2000). The "what" and "how" of goal pursuit: Human needs and the self-determination of behavior. *Psychology Inquiry, 11,* 227-268.

Deci, E. L., & Ryan, R. M. (2008). Self-determination theory: A macrotheory of human motivation, development, and health. *Canadian Psychology/Psychologie Canadienne, 49*(3), 182-185.

Falender, C. A., Cornish, J. A. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., . . . Grus, C. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology, 60*(7), 771-785.

Gagné, M. (2003). The role of autonomy support and autonomy orientation in prosocial behavior engagement. *Motivation and Emotion, 27*(3), 199-223.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine Publishing Company.

Gudykunst, W. B. (1998). Individualistic and collectivistic perspectives on communication: An introduction. *International Journal of Intercultural Relations, 22*(2), 107-134.

Henderson, S., Byrne, D. G., Duncan-Jones, P., Scott, R., & Adcock, S. (1980). Social relationships, adversity and neurosis: A study of associations in a general population sample. *British Journal of Psychiatry, 136,* 574-583.

Holahan, C. K., & Spence, J. T. (1980). Desirable and undesirable masculine and feminine traits in counseling clients and unselected students. *Journal of Consulting and Clinical Psychology, 48,* 300-302.

Hmel, B. A., & Pincus, A. L. (2002). The meaning of autonomy: On and beyond the interpersonal circumplex. *Journal of Personality, 70*(3), 277-310.

Iyengar, S. S., & Lepper, M. R. (1999). Rethinking the value of choice: A cultural perspective on intrinsic motivation. *Journal of Personality and Social Psychology, 76,* 349-366.

Janis, I. L. (1982). *Victims of groupthink* (2nd ed.). Boston: Houghton Mifflin.

Johnson, W. B. (2007). Transformational supervision: When supervisors mentor. *Professional Psychology: Research and Practice, 38*(3), 259-267.

Kim, U., Triandis, H. C., Kagitcibasi, C., & Yoon, G. (Eds.) (1994). *Individualism and collectivism: Theoretical and methodological issues.* Newbury Park, CA: Sage.

Kitayama, S., Markus, H. R., & Kurokawa, M. (1994). *Cultural views of self and emotional experience: Does the nature of good feelings depend on culture?* Unpublished manuscript, Kyoto University, Kyoto, Japan.

Kline, R. B. (1998). *Principles and practice of structural equation modeling.* Guilford Press, New York, NY.

Koestner, R., & Zuckerman, M. (1994). Causality orientations, failure, and achievement. *Journal of Personality, 62*(3), 321-346.

Leung, J. P. (1998). Emotions and mental health in Chinese people. *Journal of Child and Family Studies, 7*(2), 115-128.

Lin, N. (1989). Measuring depressive symptomatology in China. *Journal of Nervous and Mental Disease, 177,* 121–131.

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

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*(2), 224-253.

McCurdy, S. J., & Scherman, A. (1996). Effects of family structure on the adolescent separation-individuation process. *Adolescence, 31,* 307–319.

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

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

Mirgon, T. L. (2007). *The relationship of supervisory working alliance and counselor self-efficacy to supervisee development: An exploratory study*. Available from PsycINFO. Retrieved from http://login.ezproxy1.lib.asu.edu/login?url=https://search-proquest-com.ezproxy1.lib.asu.edu/docview/622025440?accountid=4485

Na, S., Spanierman, L. B., & Lalonde, C. E. (2017). Exploring moderators to understand the association between vertical collectivism and psychological well-being among Asian Canadian students. *Journal of Diversity in Higher Education, 10*(3), 288-300.

Nezu, A. M., & Nezu, C. M. (1987). Psychological distress, problem solving, and coping reactions: Sex role differences. *Sex Roles, 16,* 205-215.

Norcross, J. C., Hedges, M., & Castle, P. H. (2002). Psychologists conducting psychotherapy in 2001: A study of the Division 29 membership. *Psychotherapy: Theory, Research, Practice, Training, 39*, 97-102.

Rankin-Esquer, L. A., Burnett, C. K., Baucom, D. H., & Epstein, N. (1997). Autonomy and relatedness in marital functioning. *Journal of Marital and Family Therapy, 23,* 175–190.

Rigazio-DiGilio, S., Daniels, T. G., & Ivey, A. E. (1997). Systemic cognitive-developmental supervision: A developmental-integrative approach to psychotherapy supervision. In C. E. Watkins Jr. (Ed.), *Handbook of psychotherapy supervision; handbook of psychotherapy supervision* (pp. 223-245). John Wiley & Sons Inc, Hoboken, NJ.

Ronnestad, M. H., & Skovholt, T. M. (1993). Supervision of beginning and advanced graduate students of counseling and psychotherapy. *Journal of Counseling and Development: JCD, 71*(4), 396.

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*(1), 5-44.

Roos, P. E., & Cohen, L. H. (1987). Sex roles and social support as moderators of life stress adjustment. *Journal of Personality and Social Psychology, 52,* 576-585.

Sato, T. (2001). Autonomy and relatedness in psychopathology and treatment: A cross-cultural formulation. *Genetic, Social, and General Psychology Monographs, 127*(1), 89-127.

Schwartz, S. H. (1990). Individualism-collectivism: Critique and proposed refinements. *Journal of Cross-Cultural Psychology, 21,* 139-157.

Singelis, T. M. (1994). The measurement of independent and interdependent self-construals. *Personality and Social Psychology Bulletin, 20,* 580-591.

Singelis, T. M., Triandis, H. C., Bhawuk, D., & Gelfand, M. J. (1995). Horizontal and vertical dimensions of individualism and collectivism: A theoretical and measurement refinement. *Cross-Cultural Research: The Journal of Comparative Social Science, 29*(3), 240-275.

Stoltenberg, C. D., & McNeil, B. W. (2010). *IDM supervision: An integrative developmental model for supervising counselors and therapists* (3rd ed.). New York, NY: Routledge/ Taylor & Francis Group.

Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists.* San Francisco, CA: Jossey-Bass.

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

Triandis, H. C. (1995). *Individualism and collectivism.* Boulder, CO: Westview.

Triandis, H. C., Leung, K., Villareal, M. J., & Clack, F. L. (1985). Allocentric versus idiocentric tendencies: Convergent and discriminant validation. *Journal of Research in Personality, 19*(4), 395-415.

Wageman, R. (1995). Interdependence and group effectiveness. *Administrative Science Quarterly, 82,* 145–180.

Wallach, M. A., Kogan, N., & Bem, D. J. (1964). Diffusion of responsibility and level of risk taking in groups. *Journal of Abnormal and Social Psychology, 68,* 263-274.

Wang, Y., & Ollendick, T. H. (2001). A cross-cultural and developmental analysis of self-esteem in Chinese and western children. *Clinical Child and Family Psychology Review, 4*(3), 253-271.

Williams, G. C., & Deci, E. L. (1996). Internalization of biopsychosocial values by medical students: A test of self-determination theory. *Journal of Personality and Social Psychology, 70*(4), 767-779.

Wu, C., Guo, N., Hsieh, Y., & Yeh, K. (2015). The facilitating effect of need-supportive parenting on the change rate and adaptation of dual autonomy among Taiwanese adolescents. *Swiss Journal of Psychology, 74*(4), 181-195.

Yeh, K., & Bedford, O. (2003). A test of the dual filial piety model. *Asian Journal of Social Psychology, 6,* 215–228.

Yeh, K., Bedford, O., & Yang, Y. (2009). A cross-cultural comparison of the coexistence and domain superiority of individuating and relating autonomy. *International Journal of Psychology, 44*(3), 213-221.

Yeh, K., & Yang, Y. J. (2006). Construct validation of individuating and relating autonomy orientations in culturally Chinese adolescents. *Asian Journal of Social Psychology, 9,* 148–160.

Zhang, J., & Jin, S. (1998). Interpersonal relations and suicide ideation in China. *Genetic, Social & General Psychology Monographs, 124,* 79-84.

APPENDIX A

RESEARCH SURVEY

Informed Consent Form

Hello! Thank you very much for your interest in the current research study. My name is Yue Shi and I am a graduate student at Arizona State University under the direction of Dr. Terence Tracey conducting research regarding clinical supervision. Your help is needed to better understand how supervisors can facilitate the development of trainees from diverse cultural backgrounds.

The study will take roughly 10-15 minutes to complete. There is minimal risk of your participation to the best of our knowledge. Your participation is voluntary and you can withdraw at any time without penalty. We would appreciate you answering all questions as openly and honestly as possible. All participants of the study will remain anonymous and no personally identifiable information will be requested from any part of the study. The results of this study may be used in reports, presentations, or publications, but your name will never be known.

You must be a current graduate student in Clinical/Counseling Psychology, Social Work, and Marriage and Family Therapy programs (including those on internship) who is currently being supervised by a licensed mental health professional OR has had at least one quarter/semester of clinical supervision experience. Your responses will be collected through this encrypted online survey website and downloaded into computers protected by passwords. Only Yue Shi and Dr. Terence Tracey have access to the data. If you have any questions regarding this research project, you can contact Yue Shi at yshi2418@gmail.com or Dr. Terence Tracey at Terence.Tracey@asu.edu. If you have concerns about your rights as a participant in this study, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. The Email address is research.integrity@asu.edu.

If you have read through this letter, understand your rights, fit the participant criteria, and agree to participate voluntarily, please click the "Yes" button at the bottom of this page. It will be considered as your consent to participate in this study. Thank you for your participation!

Demographic Questionnaire

Age:

Gender:

Race/ethnicity:

International Student? Yes/No

Country of origin:

First generation (the first generation in your family to have moved from your country of

origin to the US), second generation (the first generation in your family to be born in the

US) immigrant, or neither?

Years lived in the US:

Highest educational degree obtained:

Current university attending (optional):

Name of current graduate program (e.g. Counseling Psychology, Ph.D., Marriage and

Family Therapy, M.A.):

Type of accreditation (APA, CACREP, CSWE, COAMFTE, Unsure, Other):

Current year in your program:

Your overall area of clinical emphasis (addiction, career, community mental health,

college counseling, marriage and family, school, VA/hospital, unsure):

Your current practicum setting (community mental health, university counseling center,

school, VA/hospital, private practice):

Previous semesters of practicum completed:

Previous semesters of supervision received:

Total years of graduate education completed:

Individualism-Collectivism Scale (INDCOL) (Singelis, Triandis, Bhawuk, & Gelfand, 1995)

Instructions: Please answer the following items on a 9-point scale where 1 = never or definitely no and 9 = always or definitely yes. After each item, there is a scale for you to circle a number between 1 and 9 that corresponds to your sense of the event's frequency or your degree of agreement with the statement.

1   2   3   4   5   6   7   8   9

Never or Definitely No   Always or Definitely Yes

1. The well-being of my co-workers is important to me

1..........2..........3..........4..........5..........6..........7..........8..........9

2. I would sacrifice an activity that I enjoy very much if my family did not approve of it

1..........2..........3..........4..........5..........6..........7..........8..........9

3. If a co-worker gets a prize, I would feel proud

1..........2..........3..........4..........5..........6..........7..........8..........9

4. I would do what would please my family, even if I detested that activity

1..........2..........3..........4..........5..........6..........7..........8..........9

5. If a relative were in financial difficulty, I would help within my means

1..........2..........3..........4..........5..........6..........7..........8..........9

6. Before taking a major trip, I consult with most members of my family and many

friends

1..........2..........3..........4..........5..........6..........7..........8..........9

7. It is important to maintain harmony within my group.

1..........2..........3..........4..........5..........6..........7..........8..........9

8. I usually sacrifice my self-interest for the benefit of my group

1..........2..........3..........4..........5..........6..........7..........8..........9

9. I like sharing little things with my neighbors

1..........2..........3..........4..........5..........6..........7..........8..........9

10. Children should be taught to place duty before pleasure

1..........2..........3..........4..........5..........6..........7..........8..........9

11. I feel good when I cooperate with others

1..........2..........3..........4..........5..........6..........7..........8..........9

12. I hate to disagree with others in my group

1..........2..........3..........4..........5..........6..........7..........8..........9

13. My happiness depends very much on the happiness of those around me

1..........2..........3..........4..........5..........6..........7..........8..........9

14. We should keep our aging parents with us at home

1..........2..........3..........4..........5..........6..........7..........8..........9

15. To me, pleasure is spending time with others

1..........2..........3..........4..........5..........6..........7..........8..........9

16. Children should feel honored if their parents receive a distinguished award

1..........2..........3..........4..........5..........6..........7..........8..........9

Dual Autonomy Scale (Yeh & Yang, 2006)

Rate the following items based on the following scale:

   1_____2_____3_____4_____5_____6

Strongly   Strongly

Disagree   Agree

Individuating autonomy items (IA):

I always feel confident about my own decisions. (E)

I always know what I want. (C)

I am highly capable of controlling the immediate environment around me and thus am able to achieve my goals. (F)

I am always able to find the most beneficial way of doing things for myself. (F)

It is easy for me to make a decision advantageous to myself. (C)

Trying new things is not difficult for me. (E)

Relating autonomy items (RA):

It is meaningful for me to fulfill my duty as a trainee. (E)

I try to coordinate with my clinical supervisor to resolve things even when we disagree. (C)

My clinical supervisor and I can smoothly discuss the way we interact with each other. (F)

When making a decision, I evaluate the practicalities of both my ideas and my clinical supervisor's suggestions. (C)

I feel more confident about a decision when taking my clinical supervisor's suggestions into consideration. (E)

I am always able to make things satisfactory for both parties even when my supervisor's expectations are different from mine. (F)

C = cognitive, F = functional, E = emotional

Dependency-Autonomy Subscale from Supervisee Levels Questionnaire – Revised

Answer the items that follow in terms of your own current behavior. In responding to these items, use the following scale: Never Rarely Sometimes Half the Time Often Most of the Time Always 1 2 3 4 5 6 7

1. I am able to critique counseling tapes and gain insight with minimum help from my supervisor. 1 2 3 4 5 6 7

2. I lack self-confidence in establishing counseling relationships with diverse client types. 1 2 3 4 5 6 7 *

3. I tend to get confused when things don't go according to plan and lack confidence in the ability to handle the unexpected. 1 2 3 4 5 6 7 *

4. I depend on my supervisor considerably in figuring out how to deal with my clients. 1 2 3 4 5 6 7 *

5. At times, I wish my supervisor could be in the counseling/therapy session to lend a hand. 1 2 3 4 5 6 7 *

6. Although at times I really want advice/feedback from my supervisor, at other times I really want to do things my own way. 1 2 3 4 5 6 7

7. It is important that my supervisor allow me to make my own mistakes. 1 2 3 4 5 6 7

8. Given my current state of professional development, I believe I know when I need consultation from my supervisor and when I don't. 1 2 3 4 5 6 7

9. Regarding counseling/therapy I view my supervisor as a teacher/mentor. 1 2 3 4 5 6 7 *

10. Regarding my counseling/therapy, I view my supervisor as a peer/colleague. 1 2 3 4 5 6 7