

Marriage and Family Therapy Students' Experience of Anxiety  
During the Clinical Training Process

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ABSTRACT

In this study I explored marriage and family therapy student interns' experience of anxiety during the clinical training process. Participants discussed their anxiety levels during the beginning of their clinical work and 6-22 months into their clinical training process.

Phenomenology guided the manner in which this study was conducted. Nine marriage and family therapy students from the Virginia Tech Marriage and Family Therapy program were interviewed. The last two of the nine interviews were conducted after the last two participants had read the first seven interview results. This allowed them to comment and expand upon the other participants' interviews. This study did not include post-masters students as these students have more clinical experience and may experience anxiety differently.

This study highlighted the importance of awareness and management of student intern anxiety levels. This study was conducted in an effort to help MFT programs and students understand anxiety in relation to the training experience of MFT students. The information presented here suggests that awareness and management of anxiety for trainees is important. The findings are both consistent with, and add to, the literature on anxiety and psychotherapy training.

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## CHAPTER I

### INTRODUCTION

“As I walked into the therapy room for the first time I felt like my face was bright red. I felt so nervous. I was wondering if the couple in front of me knew that this was the first time I had ever seen a client. I knew my supervisor was watching from behind the mirror and I wondered if he could tell I was nervous. Did I look nervous? Would I be able to talk to this couple? Would I be able to help them with their problems? Was my leg ever going to stop shaking?”  
Katherine McCarthy

Marriage and family therapy students face a variety of challenges during training. For many students in a marriage and family therapy program, training involves completion of course work, writing papers, completing client paper work, producing a thesis, and amassing 500 client contact hours (Wetchler & Fischer, 1991). During this stressful training period there is the additional challenge of managing the anxiety associated with starting clinical work. Throughout the training process students may experience high levels of stress, anxiety and even symptoms associated with depression (Polson & Nida 1998). A considerable amount of research has examined the experiences of marriage and family therapy students during the training process. Studies have examined stress levels, perceptions of supervision, student therapeutic skill levels, and the ways that students gain confidence during their clinical training. For example, Polson and Nida (1998) surveyed AAMFT student members to describe sources of trainee lifestyle stress. They found that sources of potential stress for graduate students were: how many hours that the student worked in and outside of school and for those students who were married, how many hours their spouses worked. In 1994, Goodman and Amatea studied MFT trainees' prior experience with therapy and their ability to achieve levels of clinical skill. They found that student therapists that had previous experience with therapy had higher levels of clinical skill

than those without prior experience during the beginning stages of training. However, the students without prior training were able to achieve similar levels of clinical skill by the end of their training. Lyman, Storm, and York (1995) examined the relationship of trainees' life experience to therapeutic outcome, finding that trainees with more life experience were not generally perceived by clients as more effective. In 2000, Anderson, Schlossberg, and Rigazio-DiGilio, surveyed MFT student interns to determine their best and worst supervision experiences. The findings suggest that students' best supervisory experiences were experiences involving respectful and open communication with their supervisors, live or video supervision, and supervisory meetings that were longer in length. Cornille, McWey, Nelson, and West (2003) examined MFT students' views of their basic therapy skills, finding that therapy students view of basic skills in clinical practice was not significantly different than experienced therapists view of basic skills.

The emotional well-being of students is seen as important to program faculty, not only for the health of the student but also for the treatment outcome of clients (Russell & Peterson, 2003). Yet, very few studies have examined the emotional elements of MFT students' training experience and the relationship it has with a student's work. A notable exception is Russell and Peterson (2003) who included this element when they explored the extent of student impairment in an MFT program. The researchers defined impairment as a student's inability to achieve acceptable levels of knowledge, training and experience, as evaluated by MFT program directors. This study included the idea of "student emotional well-being" in its investigation. The study questioned the program directors of Accredited MFT programs about the amount of time faculty spends with impaired students, how their impairment affects their work and a description of a typical "impaired student" from the directors' point of view. The results found



that program faculty spent on average 56% of their time helping “impaired students.” The most common definition of an “impaired” or “troubled student” was students with problems involving an inability to except supervisory feedback, not following ethical standards, performing poorly clinically, and identifiable mental health concerns, among others. The study also found that dismissal of these students happened quite often. Russell and Peterson went on, in their discussion, to call for the exploration of MFT students' perspective and experience of emotional distress and how they feel it affects their professional training.

Anxiety is the most common form of emotional distress people encounter when learning a new and challenging skill like becoming an MFT. When an individual encounters a stressful situation it is very normal to experience reactions that are associated with anxiety (NIMH, 2003). Abnormal or elevated levels of anxiety can impact an individual's life and emotional health in many unexpected ways (NIMH, 2003). Neuroscience researchers have found that if anxiety becomes excessive, or if the individual is unable to find ways to cope with or lessen their anxiety, the learning process can be impeded (Radulovic, Ruhmann, Liepold, & Spiess, 1999). Anxiety during the learning process may be even more prevalent for MFT student interns than other student interns in the counseling and therapy field due to the unique factors involved in MFT students' learning experience. For example, MFT students have to deal with more than one individual in the therapy room. As a student intern, attempting to manage communication between arguing family members in a session can spike anxiety levels. In addition, supervision for MFT interns usually involves being observed live, through a one way mirror, which does not allow the student a chance to reflect on their work or manage their emotional reactions before supervisory scrutiny or evaluation takes place (Wetchler & Fischer, 1991).

Studies of MFT student training experiences have been useful in developing an accurate understanding of MFT students as they work through the training process. This understanding has helped drive improvements in program and professional development of MFT's. There is a gap in the research however, as to how MFT student interns experience feelings of anxiety surrounding the beginning of their clinical work. While students' emotional well being and anxiety has been mentioned in some studies examining the MFT training process, it has not been the major focus of previous studies to date.

### Research Question

The purpose of this research was to study the anxiety that marriage and family therapy master's students experience in reference to clinical practice. More specifically, how do MFT students experience anxiety prior to, during and after beginning their clinical practice? This study aimed to understand the meaning MFT interns attach to their experience of anxiety.

### Guiding Theory

This study examined MFT student interns' experience of anxiety using the theoretical framework of phenomenology. The phenomenological theoretical perspective seeks to understand the meaning that participants give to their experience. According to this theory, meaning is explored by asking participants to define the phenomenon of which they are a part (Boss, Dahl, & Kaplan, 1996). Phenomenology assumes that the researcher is on equal if not subordinate ground as his or her participants. The participants I interviewed were the experts on their own experience.

Using phenomenological theoretical and philosophical assumptions, I sought to avoid predetermined categories, but rather to investigate MFT student interns' experience of anxiety through interviewing, using open ended questions. This conceptualization is especially

important to this study as past research has not specifically examined anxiety in MFT students, and given that this is new territory, predetermined categories would have been difficult for me to produce, as well as constricting for the participants of this study.

One core aspect of phenomenological research is that the researcher constantly and consistently flows back and forth between data collection and data analysis. This movement in the research process is important in that it helps to accurately express the whole and specific experience of participants. As a phenomenological researcher, I aimed to balance the collection of data and analysis throughout this study, to better understand the "lived experience" of student interns (Boss, Dahl, & Kaplan, 1996).

Phenomenological research examines the role of the researcher in regard to researcher bias, values and experience (Boss, et al., 1996). Being the primary researcher in this study and also an MFT student experiencing the anxiety involved in the beginning of clinical practice, I recognize the influence I had on this work and therefore discussed and examined it in depth with my committee chair prior to the research, during data collection and during data analysis. By using this method of reflection I was able to offer the participants involved, as well as future readers of this research a more accurate report of the phenomenon I studied (Boss et al, 1996).

Phenomenology is well suited for a study of the experience of MFT student anxiety as it aims to begin research with a hunch about participants' experience. My hunch involving this subject is that MFT student therapists experience some form of anxiety during the clinical training process. As data are collected and examined, the layers of the participant's past and present experiences are exposed, giving the researcher a true understanding of the experience and meaning involved in the phenomenon that is being studied (Boss, et al., 1996). One of the goals of this project was to gain an understanding of not only the experiences of anxiety of

participants during the first semester that they began seeing clients, but also the anxious feelings that MFT's experienced later on in their training.

This research study was also done qualitatively because of the nature of human anxiety. Anxiety is experienced differently by individuals. Some people experience overt symptoms of anxiety such as physiological and or psychological reactions, and some do not have a level of awareness of their feelings of anxiety (Biscoff, Barton, Thober, & Hawley, 2002). With the idea of the uniqueness and individualism involved in the experience of anxiety, qualitatively studying this phenomenon allowed the research participants to offer the true elements of their experience and not limit them to previously constructed variables (Boss et al, 1996).

### Significance

Student intern anxiety surrounding clinical training has been mentioned in the literature but has not been the main focus of any study as of yet. This is important because research has shown that heightened levels of anxiety can impede the learning process (Radulovic, Ruhmann, Liepold, & Spiess, 1999). The significance of pursuing this study was to investigate MFT student training further. This piece of the research puzzle was designed to help MFT programs and students understand one more part of the training experience of MFT students. This study was conducted in an effort to improve MFT program training.

### Rationale

The rationale for this research was developed after reviewing the literature on MFT student training. Many studies have discussed the idea of MFT student intern anxiety in their introduction and discussion section but have not explored and focused specifically on this subject. This study was conducted qualitatively as a first step in filling the gap in the research

surrounding MFT student clinical anxiety. The themes developed during this qualitative study maybe used as a base for further research.

## CHAPTER II

### LITERATURE REVIEW

#### Overview

The purpose of this study is to enhance our knowledge of the experience of anxiety that marriage and family therapist masters' students face in beginning clinical practice. Many aspects of marriage and family therapy students' experiences have been examined over the years, but there are no studies specifically focusing on their experience of anxiety as new therapists. Several studies have focused on other mental health professions, most notably psychology, and have developed a broad base of literature on new therapist anxiety. I will discuss the information and research the psychology field has done investigating anxiety and student therapists' clinical work. While the experiences of psychology students may differ in a variety of ways from marriage and family therapy students, it is my hope that the available literature will help to set the stage for this study that aimed to shed light on this facet of the marriage and family therapy masters students' experience.

In addition to discussing the experience of other mental health students and their anxiety, I will also examine anxiety and its role in learning. There are several bodies of research in the literature on anxiety; this review will provide a cursory look at several studies in an effort to set the stage for how student therapist anxiety may develop and how it may change over time.

There is a large body of literature on anxiety and students in the performing arts. Although performance is not the same as therapy, performing therapy and performance art have similar elements involved. For example, student therapists and performers both, experience being observed live, with the potential to have feelings of being scrutinized. Since several facets

of the mental health field have different names for themselves as professionals as well as their students, I will use the phrase “student therapists” through out most of this literature, often in place of therapy trainees, counseling students etc.

### Anxiety and Learning

It has long been accepted that anxiety affects a person’s ability to learn. Alternatively, there has been considerable debate about the specific ways in which anxiety levels impact and enhance one’s ability to learn. There have been arguments in favor of a certain level of anxiety, suggesting that some anxiety can be beneficial to the learning process. There have also been arguments asserting that anxiety can affect learning in negative ways. It has been suggested by many researchers that anxiety has a very large impact on learning, due to its interference with attention, working memory, and information retrieval (Mathews, Davies, Westerman, & Stammers, 2002). There have been several studies that have tried to examine this phenomenon. In this section of the literature review I will describe studies that explore the unique impact anxiety can have on the many aspects involved in learning.

Warr and Downing (2000) studied learning strategies and learning anxiety as it applies to knowledge acquisition. They examined 288 young adults preparing for work as vehicle technicians. The participants were given learning motivation scales and anxiety scales, as well as knowledge examinations throughout a nine month course. The study found that students that were less anxious were more likely to use learning strategies such as studying with friends and motivational self-talk. It also found that students who were less anxious throughout the study, tended to score higher on their knowledge acquisition exams (Warr & Downing, 2000).

Chamorro-Premuzic and Furnham (2003) studied personality traits and academic performance. One of the core aspects involved in the researchers’ idea of student personality

traits was the students' anxiety levels. Participants were 247 undergraduate students from a college in London. Participants were screened over a three-year period, and data was drawn from student files, as well as a 240-item questionnaire, gauging personality traits, including anxiety levels. It was found that students that had a tendency to be anxious rated poorly in their academic performance. The researchers call for a deeper look in future research, investigating the inclusion of other student traits, such as student interests, study habits, or learning styles.

Fisher, Allen and Kose (1996) studied the relationship between anxiety and one's ability to problem solve. The study looked at 45 boys with learning disabilities and 45 boys without learning disabilities. The participants were given a child anxiety inventory scale as well as a problem solving scale. The researchers did not find a significant difference between the learning disabled children and the non-learning disabled children. They also discovered that the children with high anxiety were not found to score negatively on their problem solving skill levels. The principle investigators suggest that taking the research a step further and investigating the anxiety produced during the problem solving task, and not just general anxiety, might yield different and more pertinent results.

Gadzella, Masten, and Stacks (1998) conducted a study looking at student stress and its relationship with learning strategies, test anxiety and attributions. The researchers gave 126 undergraduate college students enrolled in psychology classes a 51 item student life stress inventory. The inventory gauged student stress on campus, involving academics, and in "off campus life", helping to establish a general look into student life stress. The study was divided into three areas: learning strategies, test anxiety, and attributions. The aim was to look at how each area was affected by a student's stress levels. The researchers found that when students reported high levels of stress, high levels of anxiety were often reported as well. Based on these



results, the researchers suggest that individuals who tend to be more emotionally and physiologically reactive to stress in general, also tend to experience high test and academic evaluation anxiety.

This portion of the literature review has examined how anxiety can impact the many aspects of the learning process. As described in the studies above anxiety can have a negative impact on one's knowledge acquisition, academic performance, and general student stress levels. These results are important to the focus of this research as these elements involved in learning are present and important in the process of learning to become a therapist.

### Anxiety and New Therapists

#### Developmental Stages/Learning to be a Therapist

Birk and Mahalik (1996) mention the four stages of a therapist's development originally discussed by Stoltenburg in 1981. The first stage of this developmental process incorporates the therapist's desire to discover the "right way to do things." Moreover, the therapist may lack confidence during this stage and is totally dependent on the supervisor. Counselors in stages 2-4 develop greater conceptual abilities and tend to have more of a need for autonomy, progressively through out these later stages.

Birk and Mahalik (1996) addressed therapy students' conceptual level, type of supervision environment and their anxiety level as predictors of their development as therapists. The therapy students were given an anxiety scale, a conceptual level exam that included a measurement of their cognitive complexity, and a measure to observe their developmental level in supervision. The students were divided into non-evaluative and evaluative supervision groups. The researchers found that participants' anxiety levels were directly affected by their developmental stage. Student therapists that were more anxious were found to be in the

beginning stages of developing their therapeutic skills. Those students that were less anxious were found to be at a more advanced stage of development.

Hiebert, Uhleman, Marshal and Lee (1998) looked at the relationship between anxiety, self-talk and counseling skills. Their study spanned 3 years and involved 95 participants from two master's level counseling programs. Participants were given an anxiety scale. The students were also given a scale in order to determine what their specific self-talk was. Student therapist skill was measured based on their instructors' ratings of their skill levels. During the first year, the researchers found that those participants that had high levels of negative self-talk also had high levels of anxiety. They also found that those participants with heightened levels of anxiety and negative self-talk rated poorly in their instructor's evaluations of performance.

This was a longitudinal study and during the last year of the study the researchers found that those participants that had previously had high levels of anxiety were able to lower their anxiety scores, if there was an increase in their positive self-talk. Consequently, this became a catalyst to increasing these particular students' scores in terms of instructor evaluation of performance.

The researchers suggest that the information obtained from this research, provides support for the idea that mental health training programs would be served well by training their students in the areas of positive self-talk, in addition to the traditional course work. They offer the suggestion that by teaching students to think positively, and in turn lower their anxiety levels, programs can help to produce more effective therapists.

Biscoff, Barton, Thober, and Hawley (2002) examined therapist development specifically in the area of self-confidence. They interviewed 39 recent therapy student graduates at the master's level, asking them about their opinion of their progress of development over a twelve-

month practicum course period. The participants were asked to graph their progress at certain times through out their practicum and then comment on their self-confidence and development during these times. Using their results, the researchers broke the student therapist development of self-confidence into three stages: 1) Variability of confidence, 2) Emerging confidence, and 3) Fragile stability.

Variability of confidence involves dramatic swings between feeling confident and not feeling confident. During this stage the student therapist's anxiety is experienced internally rather than projected outward toward the clinical situation. Situations of client "no shows" and "dropouts" tend to be taken personally at this stage and student therapists may see this as a reflection of their incompetence.

The second stage, Emerging confidence, involves a therapist beginning to have more experience over time and the ability to evaluate their own work, or as the authors refer to it "developing an internal gauge." This ability to evaluate allows a therapist to determine when they have done something well, thus leading to more confidence. In this stage, therapeutic situations do not always involve an anxious reaction. They begin to see their therapeutic skills in a more hopeful and optimistic light.

Fragile stability involves a more consistent level of confidence that does not change often. During this stage the therapist begins to develop autonomy. They begin to recognize how their individual skills sets are actually significant and helpful in the therapeutic process. The student therapist begins to use a guiding theory that may be recognizable to an observer. At this junction in development, the therapist begins to notice progress with his or her clients, and is able to recognize how components of clinical work fit together.

Anxiety is mentioned throughout the three stages but, the participants reporting to be in the variability of confidence stage of development mentioned anxiety most often. While anxiety was not a topic the researchers set out to examine and any implications for this theme that were woven through out their research data was not discussed, it is important to note the existence of this theme. This importance can be found in the relationship that self-confidence and anxiety have in general. Based on the Hiebert, Uhleman, Marshal and Lee's (1998) findings, one might speculate that in general, when your belief in your own ability to perform a task or do work is not strong or well developed, your anxiety levels are more likely to go up, and if your anxiety levels are high, it can be difficult to maintain confidence in your skills.

Duncan and Brown (1996) conducted a study, examining anxiety and a student therapist's development of conceptual complexity, using a repeated measures design. The study included eighteen master's students over two semesters of practicum and nineteen pre-practicum students over two semesters. Participants were given an anxiety scale throughout the two semesters. The scale was administered during peak anxiety provoking times such as beginning a new course, major examinations, and supervisory evaluations. Anxiety tests were also administered during less anxiety provoking points in the semester.

The researchers' results suggested that there was a significant difference in the time periods when anxiety was high. Both the practicum and pre-practicum students had higher levels of anxiety during the points in the semesters that the researchers deemed to be more anxiety provoking, and less anxious during the times the researchers anticipated to be the less anxiety provoking points during the semester. Duncan and Brown found no difference between the anxiety levels experienced by the practicum and pre-practicum students.

The study also looked more specifically at the practicum students and when their anxiety was the highest. They found research participants to have higher levels of anxiety in relationship to running their first counseling groups, than in relationship to their supervisory evaluations. They conclude that this may be due to the complexity of working with groups. Duncan and Brown point out the significance of these findings. They allow that it has been well researched and understood that learning events and test taking can be anxiety provoking. The idea that clinical work, where the clinician's anxiety causes him or her to view client(s) as a threat, or become immobilized, and therefore could be detrimental to the clinical process, caused the researchers to call for further investigation into this phenomenon.

Ellis, Kregel, and Beck (2002) examined student therapist anxiety through two studies. The studies were designed to examine self-focused attention. Ellis, Kregel and Beck focused upon one core idea from several self-focused attention theories: the idea that individuals direct attention in two ways: outward, toward others and events, and inward, toward themselves. Using this concept of attention direction, they speculated that if someone directs attention outward, they may be less likely to become anxious in a therapy situation, because they are keeping their focus on the client and the therapeutic process rather than internal events. However, if someone is directing their attention inward, they may be more likely to become anxious by focusing on what they are experiencing in the therapeutic process which, as a new therapist, may be nervousness or fear (Buss, 1980; Carver & Scheir, 1982; Duval & Wicklund, 1972; Schwartz & Wicklund, 1991; Ellis Kregel & Beck, 2002).

The first study was set up in an attempt to investigate not only the basics of self-awareness theories, but also how they fit in with past studies and research history's inability to find consistent answers to how student therapists are impacted by the audio or video taping that

is sometimes involved in their training. The study involved 71 doctoral, masters, and undergraduate students. The researchers touched on several levels of awareness by designing experimental groups that would make up the four independent variables: public, private, subjective, and experimental.

The public awareness group was established by informing some participants that they would be video taped and that they would review the video with a supervisor after the session. This was in an effort to prompt these participants to achieve a moderate amount of self awareness during their sessions. The private awareness group was achieved by the introduction of a one-way mirror set up in some of the participants' therapy rooms, where the mirror faced the student therapist, allowing them to view themselves in session. These participants were also instructed to audio tape the session and listen to the tapes alone, directly after the session. The subjective awareness group was instructed to try their best to "put themselves in the client's shoes" and that the session would not be video or audio taped, nor would there be a review of the session afterward. The experimental group was constructed by setting up audio tape machines in some of the participants' therapy rooms as well as large mirrors. The participants were told that the equipment was for another study and just to ignore it.

This experimental design had four dependent variables: two empathy measures and two anxiety measures. The two empathy measures were scales developed in an effort to gauge the degree at which a therapist empathetically engages in the client's experience. The two anxiety measures were an anxiety inventory, and a speech anxiety measuring technique, used to analyze audio tapes of all the sessions. The study found that there was no significant difference in the anxiety or empathy levels of any of the four established awareness variables. These findings lead Ellis, Krenzel, and Beck to perform a second study to further examine why some new

student therapists are more anxious than others. The researchers replicated the study but added a measure of the level of supervised clinical experience each participant had. Some of the participants had more supervised clinical experience than others. The researchers also added the element of a “difficult client” to the four independent variables. Their hypothesis was that people who are more skilled or experienced would tend to be less anxious.

The study involved 80 participants this time. During this second study the researchers found an increase of anxiety levels in all four independent variables. It is assumed by the researcher that the increase in anxiety levels from the first study to the second is due to the added element of “a difficult client.” However, they found no variance in participant anxiety levels in relationship to their supervised clinical experience.

Truell and the New Zealand Institute of Training researched the therapy training experience in 2001. The researcher examined the “Stresses of learning counseling” by interviewing recent therapy school graduates with a qualitative research design. This study used Grounded Theory to interview six graduates. Truell used a series of questions to investigate all aspects of stress during training. The study produced four major themes: how learning to be a therapist affected the participant’s relationships, how learning to become a therapist affected their self-expectations, what the stresses of learning to become a therapist are, and how the training provider could have helped.

Interesting and important to the topic of this research project, Truell’s research results described high levels of fear and nervousness involved in the beginning of training to see clients. Most often fear and nervousness were discussed regarding supervisory relationships. Participants reported feeling stressed and anxious over the confusing relationship that they had with their teachers that were also their supervisors. Participants described difficulty with the

idea that they were being evaluated by their supervisors, and then placed in the awkward position of being asked to be open about their experiences and their insecurities with this same person in the classroom setting. The dynamic of being judged by the same person you are expected to be vulnerable with, lead several participants to describe heightened levels of anxiety.

In terms of what would have been helpful, Truell's participants described a desire to have more one-on-one contact with the supervisor. They reported that this would have lowered their anxiety. The participant's interview responses also suggest that more encouragement by the department to receive their own personal counseling would make a difference. More information in the beginning of their training, discussing how difficult and stressful it can be would have been helpful as well.

The aforementioned studies were all designed to explore student therapists' learning experiences and clinical development. There were some important elements that were discovered through the review of the literature in this section. We learned that student therapists experience anxiety to a greater or lesser degree depending on their ability to self sooth and use positive self talk; there is a direct relationship between growing self confidence in therapeutic abilities and anxiety; managing anxiety is critical to producing successful clinical work; and student therapists have concrete and informative ideas about how they are affected by their anxiety, as well as how to manage it.

### The Role of Supervision

Costa (1994) wrote a review of the literature, examining the research in how programs that involve live supervision in their clinical training could reduce the anxiety involved for their therapy students. Costa suggests that while some anxiety can be helpful, keeping a new therapist engaged and energized in order to be productive in the learning process, an extreme amount can



be detrimental to the learning experience (Costa, 1994). Costa offers six guidelines for supervisors to follow in order to promote a good balance of anxiety levels. The guidelines are: Supervisors should 1) negotiate a clear training contract, 2) directly address anxiety and fear, 3) match method to supervisory development stage, 4) develop a collaborative supervisory attitude, 5) create a positive evaluative focus, and 6) encourage independence. Costa's ideas about the management of anxiety in the supervision aspect of clinical practice are important to this research, as many of the guidelines she describes are themes that are woven through out this literature review as well as the research data produced during this study.

In 2000, Mauzey, Harris, and Trusty examined the affects of live supervision interventions on novice trainee anxiety and anger. They examined whether "call in" supervision or "bug in the ear" supervision would provoke more or less anxiety. They choose seventy master's level mental health students from several different educational years. The researchers used a quantitative approach, administering an anxiety inventory, an anger inventory, and a personality test to every participant. The researchers separated participants into two randomly assigned groups. One group was comprised of "call in supervision" participants and one group of "bug in the ear" supervision participants.

They found no difference in the amount of anxiety or anger involved in either the "call in" or "bug in the ear" supervision. They did find that individual student personality traits impacted which style was more helpful in managing anxiety and anger levels. This study is important because it revealed the need for the supervisor and the student therapist to be very aware of the personality traits the student brings to the clinical experience. Mauzey, Harris and Trusty made recommendations in their discussion and implications section of their study, calling attention to the idea that it is important for supervisors to be aware of student therapists' specific

personality traits, as well as to teach their students to be aware of their own personality traits.

With this in mind they assert that the heightened awareness of personality traits will help to tailor supervisory style (“bug in ear” or “call in”) and manage the anxiety and anger that may interfere with affective supervision and therapy.

Similarly Singo (1998) studied the effects of peer group supervision and individual supervision on the anxiety, self-efficacy, and basic skill competency of counselor trainees in practicum. The researcher used a quantitative design, using two anxiety scales and one self efficacy scale. The study divided 19 students into individual supervision and peer supervision groups. Pre-supervision and post-supervision information was collected from each participant, and the researcher collected information on the effects of the supervision through observation.

The study produced no significant difference between the anxiety or self efficacy levels of either type of supervision group. The information collected pre-test, and post-test, as well as observations of the researcher during, did not show a difference in anxiety or self-efficacy either. The lack of difference did not support the idea that one type of supervision was more effective than the other.

When learning to become a competent therapist supervision plays an important role. The above studies assert that the relationship between a supervisor and a student therapist can have a huge impact on a student’s anxiety level, and therefore their development as a therapist. The literature discussed here was unable to prove that one method of supervision was more effective than another. The research does imply that supervisory practices that identify a student’s developmental stage as well as individual personality traits will aide in the management of student anxiety and further a student’s clinical success.

## Anxiety and the Performance Arts

Stage fright can be experienced by any performer. Some say it can affect 50% of the performers in the world (Wilson, 2002). Similar to being a student therapist, observed by supervisors and peers through a one-way mirror, during a live performance, one may go through feelings of being scrutinized and likely to fail. This may involve fear, palpitations, sweaty palms, rapid respiration, dry mouth and an impaired ability to think, all common symptoms of an anxious reaction (Wilson, 2002). Performers can experience symptoms of performance anxiety outside of the performance itself including headaches, difficulty eating or sleeping, eczema, colds or other viruses, and a loss of interest in the outside world (Steptoe, Malik, Pay, Pearson, Price, & Win, 1995). Many researchers have studied when performance anxiety can arise and how some performers chose to cope with it.

Wilson (2002) in his book The Psychology of the Performing Artists, describes the importance of performers finding a balance in their anxiety levels. He asserts that a certain amount of anxiety is necessary to keep a performer emotionally aroused enough to stay engaged in the performance. Wilson describes a long standing principle called the Yerkes-Dodson Law, which maintains that a certain level of anxiety has a positive impact on one's performance but anxiety that goes beyond a certain point may not only be harmful to one's performance but detrimental to one's career, particularly if experienced for a long period of time (Duffy, 1962; Wilson, 2002). Wilson proposes three main components of a performer's level of anxiety. The first is trait anxiety. Trait anxiety is the performer's anxiety levels in general. If the performer is an anxious person in many other aspects of his or her life, he or she is more likely to have an unhelpful amount of anxiety involved in performing. This aspect of Wilson's theory is consistent with the findings presented in the Gadzella, Masten, and Stacks, (1998) study

mentioned earlier in this literature review, where the researchers found that individuals who experienced high test anxiety also tended to be more emotionally and psychologically reactive to stress in other areas of their lives.

Wilson's second component is the degree of task mastery that the performer has in terms of the kind of performance he or she is giving. If the performer is new to performing or has not attained the skill needed to perform at his or her best ability, he or she is more likely to go beyond positive levels of anxiety. This part of Wilson's description is supported by the research on self-confidence and anxiety. As discussed earlier, Biscoff, Barton, Thober, and Hawley (2002) found when someone is learning a new task and is experiencing doubt over their abilities, anxiety levels are likely to rise.

Wilson's final component is involving the actual performance. If the performer is performing for a test or being judged for some reason, the likelihood that the anxiety will be very high is good (Duffy, 1962; Wilson, 2002). This aspect of Wilson's work can be tied into the therapists experience of live supervision discussed earlier in this literature review.

Konijin (1991) studied Dutch actors in order to monitor stress and anxiety levels during performance. The study observed four participants, two female and two male. Their heart rates were monitored during a rehearsal and one main performance of a one hour play. The study also took self-report information about stress levels from each participant after each performance. There were judges present during both performances and a live audience during the main performance. The participants' heart rate information found that the average heart rate raised only minimally during the rehearsal performance and increased dramatically during the live main performance. The actors' self reported stress levels were consistent with the heart rate findings.

The judges' assessments of both the rehearsal and main performances suggested that the performances that were anxiety and stress provoking were better performances. With this element of the study in mind Konijn suggests that having some anxiety affects performance positively. While this maybe true of seasoned performers, the Konijn study fails to discuss the skill levels of the actors involved in the study or the number of years of experience they have. As discussed earlier in this literature review, the level of skill, and or experience a performer has can directly impact, not only the level of anxiety one has, but also, as we learned through Wilson's discussion and others, whether or not that anxiety will impact you negatively or positively.

Roberts (2001) described the process of learning to become a therapist in a book chapter, entitled "Stage Fright in the Supervisory Process". She discussed becoming a therapist as if it were the training of an actor. She asserts that learning to perform therapy is like learning to perform a live dramatic performance. The similarities between the two are that both involve drama, a need for a creative imagination, a good sense of timing, and sensitivity to the audience. Thus, the process of learning to become a therapist is fertile ground for the development of "stage fright" or "performance anxiety." This can be especially true when the therapists/performers have to report back to their supervisor or, as MFT's do, be observed live. Roberts goes on in her comparison of therapy to acting to describe the work of Gabbard (1979), who conducted intense research in the area of performance anxiety.

Gabbard (1979) asserts that anxiety is universal for performers. He sees anxiety on a continuum; from mild, feeling insecure about your performance, to severe, preventing one from performing. He divided the origins of performance anxiety into three major factors including shame, guilt, and separation anxiety. He describes internal conflicts that we have around "a loss

of control” during our performance lending its way to feelings of shame. Conflicts around our ability to live up to expectations can lead us to guilt, and conflict surrounding our rejection by the audience involved (i.e. supervisors, clients), can lead us to feelings of separation anxiety.

Gabbard (1997) took his look into anxiety and performance a step further developing two additional facets to anxiety and performance. The themes still include separation anxiety, shame and guilt but he developed a more detailed explanation.

For the first theme Gabbard (1997) maintained the idea of separation anxiety in that as children we are fearful that we will be rejected by our parents. We are taught that if we show any form of independence we will be reprimanded which can lead to anxiety. Gabbard asserts that during a performance one’s anxiety over separation can leave one fearing rejection from the crowd, similar to a fear a therapist might have that the supervisor will not approve of his or her work. Gabbard also asserts that separation anxiety can be a result of another cast member leaving a show or play, or even a performer moving into a new role that is different or more challenging. This can be likened to a student therapist changing supervisors, moving on to a new internship, or even when a client drops out of therapy.

For the second theme Gabbard mentioned stage fright as being an indulgence in forbidden pleasures. He describes shame that performers sometimes feel at the exhilaration of being in front of an audience. This could be compared to the high sometimes described by therapists over a session going well. Being in the role of exhibitionist, or center stage, is something we are taught we should not enjoy too much.

Another theme is the dread of success. Under this theme Gabbard discusses that often when one is successful at a performance there may be anxiety involved in that it is somehow depriving someone else of doing well. As children we are socialized to be selfless, and by

succeeding we are setting ourselves apart from others, thus not following our socialization to remain equal with others. This may be comparable to anxiety a therapist might feel in surpassing a fellow student therapist in clinical skill.

The fourth theme is exhibitionism and general inadequacy. He claims that this stems from our childhood fears that even in the face of the exhilaration of nudity as a child we are still fearful that others will laugh at our nudity and we will be ridiculed or deemed pathetic. Gabbard attaches this same fear to the anxiety that someone will laugh at one's performance and the performer may be ridiculed for exposing himself or herself, by being vulnerable during a performance. The student therapist is "exposed" in this same way. A new therapist may fear that they have to perform therapy a certain way, or they may be ridiculed or reprimanded by peers or supervisors for doing it their own way.

The final theme discussed in Gabbard's work is looking, showing, and the primal scene. This theme is developed from the idea that anxiety can lead one to become the observer in his or her own performance. It is based in the primal scene that observing others in the dark is indulgent. With this in mind, Gabbard asserts that during a performance one can split off from one's performing self and begin to observe one's own performance. During this observation anxiety can rise due to the split and the sensation of observing oneself. This aspect of Gabbard's work might parallel therapist training when one might view one's self during therapy. This maybe a literal viewing of one's self via video tape during practicum class or a virtual experience of self consciousness during an actual therapy session.

Performance art is akin to being a student therapist: observed by supervisors and peers through a one-way mirror as the actor on stage is seen by critics and audience alike. Similarly, the literature on performance and anxiety is comparable to the findings of student therapist

anxiety research. There are many factors involved in why and how performers get anxious. The research described here reflects the similarities between the two fields and can help to develop a deeper understanding of the roots of student anxiety.

### Summary

This review has illustrated the complexity of the relationship between anxiety and learning to become a therapist. When considering the experience of anxiety that new therapists have during their education one must consider the therapist's clinical development, their learning skills, the impact that anxiety has on their ability to learn, supervisory needs of the individual, as well as the individual's predisposition to be anxious in general. Although there has been a limited amount of research conducted on anxiety and new student therapists specifically, the similarities between learning to become a therapist and learning the skill of acting allow us to consider the literature on the performing arts to guide our investigation of therapist anxiety.

This literature review looked at material from several human service fields. Its composition was in an effort to examine multiple aspects of the research helping to set the stage for the investigation into MFT student therapists' experience of anxiety.



## CHAPTER III

### METHODS

#### Design

This study used a qualitative research design. This design was chosen in order to allow the marriage and family therapy student interns to describe their experience via a qualitative interview. Qualitative methods include an open, discovery-oriented approach of collecting data (Boss et al, 1996). A qualitative research design was chosen after reviewing the literature on MFT student training. Many studies have discussed the idea of MFT student intern anxiety in their introduction and discussion section but none have explored it specifically. This study was conducted qualitatively as a first step in filling the gap in the research surrounding MFT student clinical anxiety. Studying this phenomenon using qualitative methods allowed the researcher to develop a deeper understanding of MFT student intern's experiences rather than generate generalizable data (Boss et al, 1996). The use of the qualitative, face-to face, descriptive interviews allowed for rich, meaningful data. The themes developed during this qualitative study maybe used as a base for further research.

The qualitative research questions were developed from personal experience and input from former MFT interns. This process was honed more completely with the help and input from my committee members, professors in an MFT program. Their experience as MFT students at one time, their years of experience supervising MFTs and their current interest in this project was invaluable to broadening the scope of questions used in this research (please see Appendix D). Using phenomenological theoretical and philosophical assumptions, I sought to avoid predetermined categories, but rather to investigate MFT student interns' experience of anxiety through interviewing, using open ended questions developed from past MFT experience.

The questions were tested during "mock" interviews with former marriage and family therapy students.

### Participants

Initially, the plan was to recruit MFT students from several different schools, in order to get a broader sense of MFT experiences of anxiety. Due to limited funds and time constraints I decided to focus on one MFT program. Recruitment of participants was via an email to an MFT student list from the Virginia Tech Marriage and Family Therapy Program. An email invitation was sent out, inviting students to participate in the interview (please see Appendix A). Students who responded to the email and were interested in participating were contacted via phone to set up interview appointments. Participants for the interview were chosen according to first response. Students that responded first were scheduled until 9 interviews were scheduled. Any students who inquired after this were thanked for their interest but not asked to participate. Appointments were scheduled and locations were chosen according to the participant's preference. I interviewed 9 participants who were in their second and third class years of the program. Students who agreed to be interviewed were given an informed consent form prior to the interview and assured that all information, names and identifying characteristics would be kept confidential (please see Appendix B). When he or she agreed to be a part of the study and signed the informed consent, they were given a copy of the informed consent to take home. The students were also given a brief questionnaire to collect general demographic information (please see Appendix C). Interview participants were given a list of therapists available to them at a reduced rate, in case they felt that their discussion of anxiety had brought on feelings that they might have needed help with. Interview participants were not compensated for their time. The study excluded post-masters students as most post-masters students have clinical experience

before starting the MFT program. Post-masters interns often experience anxiety during the beginning of MFT clinical work but it may be for different reasons than masters students with less clinical experience.

### Procedures

The first 7 interviews lasted 45-60 minutes each and explored the students' anxiety levels about their beginning clinical practice and their anxiety about their work now. The interviews were audio taped to make sure the researcher had a record of exactly what was said. There was a short warm up question, and a series of questions investigating each participant's experience of anxiety (please see Appendix D). The questions listed in appendix D were used as a skeleton and any additional questions were follow-up questions built upon by the researcher, in an effort to help participants expand on what they were discussing. An example of this expansion might be "Tell me a little bit more about that.", or "What was that like for you?" Another example of a follow up expansion question might be: "What is it about supervision that makes you anxious?"

The second phase of this study included 2 final interviews. The interviews were approximately 45 minutes in length and built on the themes that had already been identified in the previous 7 interviews. The themes that were identified within the initial interviews were presented to the final two interviewees by the primary researcher. This was in an effort to allow the final 2 participants to add new data to the research as well as to expand on the themes that had already been established. These themes were the main focus for the last two interviews (please see Appendix E).

### Data Analysis

The data analysis was in an effort to identify themes in the experiences of students, to gain a deeper understanding of how MFT masters students experience feelings of anxiety during

the beginning of their clinical practice. The data collected for this research was taken from the tapes, and demographic questionnaires. The information from the demographic questionnaires was used to compile a list of participant's age ranges, percentages of participants' ethnic backgrounds, gender, number of years of clinical experience, year in the program, and whether or not he or she is a full or part time student. The interview tapes were transcribed.

After the first seven interviews were transcribed, each interview was divided up according to question. Responses were cut out from each interview question and grouped with all other interviewee responses to that question in order to examine the similarities and differences of each individual response. I used open coding analysis for each question. Open coding is a method of analyzing qualitative research that allows the researcher to breakdown and examine the data, and then compare it and conceptualize it (Strauss, & Corbin, 1990). The coding and investigation of themes from the interviews was in an effort to get a "sense of the whole" (Boss et al, 1996). The themes identified for each question of the interviews began to show a repetition of major themes throughout all of the interviews. This method of coding allowed the themes initially identified to be generated into a more substantiated understanding of the themes underlying the MFT student's experience (Strauss, & Corbin, 1990).

To deepen the analysis further the preliminary themes were shared with two final interviewees. These interviewees were able to read some of the other participants' responses as well as the review the themes identified. These two interviewee participants were asked to verify and then add any additional insight as well as expand on the first seven interviews. The identification of themes throughout the data collection was used to develop insights into the experience of MFT students during the beginning of their clinical practice.

## CHAPTER IV

### RESULTS

#### Introduction

The focus of this research was to develop an understanding of the experience of MFT students, during the beginning stages of clinical training. Findings are presented here. As expected, the experience of anxiety for each participant was unique, although common themes emerged.

#### Participants

The participants for this research were chosen from the Virginia Tech Marriage and Family Therapy Program. They were drawn from the second and third class years, as these were the students in the program that were seeing clients. The participants varied in age but most were in their mid twenties. All of the participants were fulltime students and all responded that they would identify themselves as Caucasian. There were only two males that participated in the study as there are a small number of males in the program. The first seven interviewees were Alex, Sam, Mel, Jessie, Pat, Lee and Taylor. Woven through out the results are comments from two additional participants. These participants, Charlie and Terry, were able to read the results of the first seven interviews and add clarification or additional insights of their own. The names of each participant have been changed to protect confidentiality.

The interviews were interesting, enlightening and informative. Almost every participant commented at the end of the interview that they were unaware of how anxious they had been until discussing it during the interview. Almost every participant commented on how good it was for them to discuss their experience as it allowed them each to isolate and examine the progress they had made overtime.

This table represents the demographic information taken by the researcher from the first seven interview participants as well as the last two additional participants. The names of the participants have not been inserted into the table in an effort to protect confidentiality.

Number of years of clinical experience	Number of years in the MFT program	Full or Part Time	Ethnicity	Gender	Age
21 months	3 yrs.	FT	Caucasian	M	55 yrs.
7 months	2 yrs.	FT	Caucasian	F	24 yrs.
7 months	2 yrs.	FT	Caucasian	F	27 yrs.
19 months	3 yrs.	FT	Caucasian	M	26 yrs.
9 months	2 yrs.	FT	Caucasian	F	37 yrs.
7 months	2 yrs.	FT	Caucasian	F	24 yrs.
18 months	3 yrs.	FT	Caucasian	F	27 yrs.
19 months	3 yrs.	FT	Black	F	26 yrs.
19 months	3 yrs.	FT	Caucasian	F	28 yrs.

\* Throughout these research results participants' names were used in place of "he or she" or "him or her" to protect confidentiality regarding the sex of the participants.

## Beginning of Clinical Work

Participants were first asked to describe how their initial expectations of clinical work differed from the reality they encountered and how this was, or was not, a source of anxiety for them. The participants described a variety of reactions. However, most participants felt that the experience of working with clients was different from what they had expected it to be.

Alex: “The area where I was most surprised is in the area of counter transference, and the reactions that I began having during sessions of therapy. Some of them were incredibly intense and I was not prepared at all for this. So I would say that was the biggest surprise I was not expecting.”

Interviewer: “Was this anxiety provoking for you?”

Alex: “Yes. I knew about counter transference but I had no idea it was going to be that bad.”

Sam: “I expected it to be more nerve wracking then it was. I thought it would be worse then it was. I thought I would struggle more. I guess I thought I would just experience more difficulty.”

As a result, one of the first things that the participants had to deal with as therapists was that their expectations of what it was going to be like to see clients was not what they actually ended up encountering. This can be highly anxiety provoking and can leave one feeling unprepared and out of control.

To better understand the experience of anxiety, participants were asked to describe a particularly anxiety provoking incident. Several themes emerged. Some participants described anxiety due to not knowing what to do in session, or feeling like they could not live up to the supervisor’s expectations of them. For example Alex experienced anxiety when the supervisor asked Alex to use an intervention that was unfamiliar to Alex.

Alex: “I was seeing this couple and my supervisor wanted to see how they communicated, so he suggested a bit of dialog...it spiraled out of control and then the supervisor got on the phone and told me to do some “I” statements...and I didn’t know what

those were. So I really felt like a duck out of water. I was worried he would think I was doing a bad job.”

Similarly, Taylor and Sam described anxiety as a result of their relationship with their supervisors. A theme for both participants was anxiety over their supervisors’ expectations of their clinical work.

Taylor: “I think that the first time I was really anxious was when I switched supervisors in my second semester. The supervisor I had first was a lot more laid back. He seemed like he knew what was going on and was helpful and gave feedback and if I was messing something up he would jump in but for the most part he kind of let me figure out the specifics on my own. My second supervisor was a lot more involved in the moment to moment process and it became very useful for me but it made me really anxious at the beginning because it made me really conscious of all the mistakes I was making on things I had been doing for a long time. It made me doubt my abilities. I was just anxious about every movement she made.”

Sam: “My anxiety was not about ‘what is the client going to come in the room with?’ which is what I thought it would be. My anxiety in the beginning of clinical work was more about my relationship with my supervisor and feeling as if I did not live up to her expectations.....this relationship literally made me question every word I might say, it made me think there was something wrong with me. I was worried all the time.”

Some participants described fear of certain situations or clients that they had not experienced themselves. Jessie described feeling high anxiety about working with individuals going through something that Jessie had never experienced personally.

Jessie: “I get the most anxious with clients that I haven’t seen. So like intakes that I have talked to on the phone but I haven’t seen their faces yet. ....I also think I get really anxious about working with people that I have never worked with before like teenagers, or couples. My heart would pound whenever I talked to my first assigned couple on the phone.”

Interviewer: “Well, what do you think that it was that made you so anxious about them being a couple?”

Jessie: “Part of it is that I’m not in a couple and I haven’t really had that experience. I haven’t been married. This couple was



separated and thinking of divorcing and I haven't experienced anything like that either so I think that is what made me super anxious. But another part of it was the idea of two people being in the room...and wondering if one would think I was aligning myself with the other and that I was against them.

For Lee, fear of the unknown, or not having a clear road map as to how the session would go, was anxiety provoking.

Lee: "I have a case where I am working with several people in the room...and this is a non-traditional case....and this one particular session involved me getting two family members that did not really want to be in the same room together in the same room together. They were so anxious about being there and I was really anxious because they were anxious. I didn't have a clear direction of where I wanted to go. I didn't know what the end result would look like. I didn't know what I wanted to achieve. They didn't know what they wanted to achieve so there was all kinds of ambiguous stuff going on and that just leaves me feeling really anxious."

Pat described a fear of being unable to maintain a professional demeanor during the session.

Pat: "The first couple that I had and the woman was a screamer. I mean, she was screaming and screaming at me but not really at me but about her husband, but I mean swearing and screaming big time.....The phone would ring and I would jump a mile."

Interviewer: "What was it about her screaming that made you feel so anxious?"

Pat: "She was really throwing me off and getting me annoyed with her screaming....and I was concerned that it was noticeable that I was bothered. I really wanted to be professional but she just got a rise out of me.....I kind of felt like I did not know how to help her settle down politely and professionally. It was different then what I would have done outside of therapy"

Interviewer: "Did you get anxious because you had to behave differently than you naturally would."

Pat: "Exactly. I had to tailor myself and I felt like I didn't know what I was doing."

Some anxious reactions were triggered by specific aspects of the clients involved. In this section of the interview Alex and Lee reported that they were aware of counter transference as a

source of anxiety. Mel did not name counter transference specifically but described anxious feelings involved in a counter transference reaction.

Alex: “Then also there was another time that I had a personal/emotional reaction to a male client that shared his experience of when he sexually assaulted his sister. It stirred up so much in me. I didn’t know how to handle it. I worried I would never be able to treat someone that I had feelings against.”

Lee: “Another case where my anxiety was high was when I had had a difficult event in my life and I was treating a client that was going through something similar.”

Interviewer: “It sounds like you were experiencing counter transference...is that what made you anxious.”

Lee: “I would say that.”

Mel: “My first client was an adolescent mother and daughter. It made me so anxious to work with them as I knew that the mom did not want to be there. Then I was also anxious just because there was an adolescent in the room. I think this particular adolescent made me anxious as she reminded me of my own little sister.”

Terry and Charlie commented on the participants’ anxiety experiences as well as their own.

Terry: “I can identify with the comments on the supervisor relationship making people anxious. During my first semester I was very anxious about my relationship with my supervisor and she was really hands on and called in a lot...it made me feel like she didn’t have faith in me that I could do it on my own. That kind of just reinforced my thoughts of self-doubt that maybe I was in the wrong field by calling in so much and being so specific...like word for word...and it took away any freedom. I felt like her puppet like she was doing the therapy for me.”

Charlie: “The section when your participants discussed counter transference really spoke to me. In the beginning of clinical practice, I felt very overwhelmed by my client’s emotions. This was highly anxiety provoking for me. I was overwhelmed with their emotions and I knew that they were overwhelmed with their emotions, and so it left me feeling incompetent. This did not feel safe to say that to anyone else...not my supervisors or my peers.” “Also the comments about supervision. It was challenging to adjust to each supervisor’s style. Some styles increased my

anxiety, while other supervisors helped me to cope with my anxiety more effectively.”

“I was surprised there was not more stuff about specific issues like, trauma. I felt very anxious about this.”

Interviewer: “What was it about these subjects that made you anxious?”

“I felt very unsure about how to apply theory to help clients with that. I felt unprepared for this. We never learned about this in class, when I first started.”

Interviewer: “Was it trauma specifically, or not knowing about a certain subject?”

Charlie: “Not knowing about a certain subject.”

The major sources of anxiety that the participants described were counter transference, supervisor’s expectations, fear of not knowing what to expect or not having a road map for doing therapy, fear of not being able to maintain a professional demeanor, and anxiety as a result of working with clients dealing with situations or problems that the participants had not experienced themselves.

People experience anxiety differently. In an effort to examine how anxiety presented itself in their experiences, participants were asked how they knew that they were anxious. Most participants described experiencing body sensations and emotional reactions.

Alex: “My heart rate increased. I just wanted to run out of the room.....mostly a very tense feeling and just not wanting to be there.”

Jessie: “Like my heart was beating. That kind of physiological thing and I was just kind of having trouble concentrating. My palms were sweaty and I was smiling a lot. I kept thinking is the 50 minutes over yet? I was focusing on it and felt kind of nervous and I couldn’t....I was thinking irrationally. I was really focused on the fact that my experience was different from the clients’ and I was not a couple and I was not going to be able to help.”

Taylor: “I identified it as performance anxiety and that is how I knew I was anxious. I didn’t really have any body cues or anything but I did notice that I was very defensive of my work....when my supervisor said anything I was ready to defend

my work and give reasons for everything. I think that is how my anxiety comes out.”

Lee: “I have body issues and I second guess myself. It kind of brings me way into my head. I get tense. My muscles tense up and I get a real tightness in my chest.”

Pat: “When the telephone rang I jumped in my seat and I answered the phone very unprofessionally like I was at home or something. It was almost like I forgot where I was. I guess I was a little disoriented.”

Mel: “I would get that nervous feeling like...not shaking but kind of hot/cold feeling and just got real nervous like there is no way that I can do this. I think it was a body feeling, you know, like butterflies in your stomach and kind of thoughts about the people behind the mirror and what they were thinking about me. I think that scared is the only word I was thinking.....it was also hard for me to focus on how to do actual interventions. I was thinking only about how to get through the 50 minutes. I was trying to do stuff to make the time pass. I did have many thoughts during the session...not about the therapy or clients but just defensively wondering if my supervisor was going to call in.”

Terry commented on the others experiences as well as Terry’s own symptoms of anxiety.

Terry: “I felt like I was going to throw up right before my very first session, I had sweating and dry mouth, and heart palpitations, and shallow breathing. The physical symptoms went away pretty fast but the dread took a long time. One of your interviewees mentioned the dread leading up to clinic night and I so felt the same way. I just wanted to get it over with.”

The major symptoms of anxiety that the participants described were difficulty concentrating, forgetfulness, emotional reactions of defensiveness, as well as traditional body cues (e.g. heart palpitations and shakiness).

The participants were asked what it was like for them to experience anxiety in an effort to examine how they evaluated or reacted to their experience. Participants reported their experience of anxiety was very uncomfortable for them. Along with their feelings of discomfort,

the participants described what the experience felt like. Pat and Sam described feeling “stuck” or feelings of “dread” involved in their experience of anxiety.

Pat: “I really dreaded clinic days. I was not looking forward to it in any way. It was just sort of knowing what is going to happen type of thing and not knowing what is going to happen is the hardest....just physically, I didn’t want to go into the clinic because I didn’t know what was going to happen. I was terrified I wouldn’t know what to say or do.”

Sam: “I felt very stuck with it. I didn’t know what to do with it. I didn’t feel comfortable talking about it.”

Some participants believed their experience of anxiety to be an indication that there was something wrong with them either personally or clinically. Alex described being very self-critical for experiencing anxiety.

Alex: “I tend to anesthetize myself so I really didn’t feel it until I was in the room. When I was in the room I felt really scared and disappointed in myself that I was experiencing this.”

Similarly, Mel’s experience of anxiety during the beginning of clinical practice resulted in feelings of incompetence. Mel described feeling unsure of whether or not to stay in the field because of the anxious feelings.

Mel: “It was weird because up until this point, you know, I had been pretty successful in everything that I tried and felt confident in my abilities. Going into the therapy room, I did not feel competent. I didn’t feel like I knew what I was doing. The anxiety made me feel like I was not successful....I began to doubt if I should stay in this department because the anxiety feelings were just so uncomfortable.”

Some participants seemed to have a more positive experience of anxiety. They described feeling uncomfortable but being able to use the anxiety to help with their learning process.

Jessie: “I was surprised at how nervous I got. I tried very hard to make sense of my anxiety and it really made me feel better about it because I expected this process to be hard. I think it made me

work harder because being a therapist is something I really wanted to do.”

Lee: “I think that the anxiety helps me to really stay aware of my own process and my own thoughts and kind of what leads up to my anxiety and leads me to feeling that way. So I take it, as uncomfortable as it is and I hate to feel that way. I mean I don’t like it. I just use it to learn.”

Some of the participants’ reactions to experiencing anxiety were negative like feeling stuck or dread, doubting their abilities, and being very self-critical. Some participants described reacting positively to anxiety by working harder or using it as a learning experience for future challenges.

The participants were asked if others were aware of their anxiety in order to explore how they dealt with their anxiety. Many participants discussed their attempts to hide their anxiety from their peers and supervisors. Alex and Taylor felt that they were able to hide their anxiety well.

Alex: “No.no.no. I just took the great anesthetize so no one could tell what was going on.”

Taylor: “No I don’t think so. My process is to look pretty together, even when I am not.”

Sam discussed trying to hide experiencing anxiety and then being confronted about it by peers.

Sam: “Yeah people said that semester I looked stressed and they said I felt distant especially around practicum class...they said that they felt I wasn’t the same right now. I was amazed that they could tell because I was working really hard at not being so obvious.”

Terry and Charlie commented on the other participants’ attempts to hide their anxiety as well as their own experiences. Both expressed that at some point during their training they felt that it was not okay for them to be anxious and that it was something that they should attempt to

hide. Charlie felt it would make Charlie seem incapable, and Terry felt that Terry was the only one who was anxious.

Terry: “It really shocked me to read that so many other students tried to hide their anxiety as well. I felt like we had to project this mask like we were fine... No one else seemed anxious so I felt like I was the only one. It didn’t feel safe to talk about it. We all did a good job of covering up our anxiety.”

Charlie: “It took a long time for me to realize that I could discuss my feelings with others and that feeling anxiety did not mean that I was not capable of doing therapy. I am not sure but maybe we all tried to hide it because we didn’t know that that was okay. No one told us.”

Other participants did not attempt to hide their anxiety. Jessie, Lee and Mel discussed their feelings of anxiety with others. These participants felt comfortable discussing their feelings with their supervisor or peers.

Jessie: “I talked with people that were in my practicum class and I still remember some of the people from my clinic night.”

Lee: “I talked about it with my supervisor. My supervisor told me that he never would have known if I hadn’t admitted my anxiety to him...but I remember my leg always used to shake.”

Mel: “I don’t know probably. I would say probably because I think that I talked about it a lot and that is how I got it out...got my anxiety out.”

Interestingly, the participants seemed to be split, in that some believed that their anxiety must be hidden for reasons such as it would make them seem incapable or that they would be isolated in their experience of anxiety. On the other side, some participants were comfortable with admitting their feelings of anxiety and found it helpful to be upfront about their experience.

Participants were asked how their anxiety affected their learning in an effort to get a sense of the impact that the participants’ anxiety had on their experience of learning to do

therapy. Alex, Taylor, Lee and Mel were able to see a very positive side of being anxious during the learning process. They felt it helped to motivate them to work harder.

Alex: "I think it affected my learning a lot. I tend to take situations that are particularly difficult for me and I think that at times I over-analyze them, but I do try and work them through to the point that I can get something or some learning out of it.

Interviewer: "So you found anxiety to be useful?"

Alex: "Oh, yeah."

Taylor: "I think that it motivated me in the sense that I wanted to be competent ...so I learned and figured it out so that I didn't have to feel self-conscious. I think that it had that affect. I think it made me a little more focused, a little more motivated."

Lee: "I think if I had not been so anxious I would not have worked as hard and probably not gone back and watched my tapes or maybe not wanted to process my sessions with my peers as much."

Mel: "It discouraged me and left me feeling like I couldn't be a therapist...so I began to think that the work didn't matter. But, as the semester went on I think I began to see that I could do this and I just needed to learn more, even outside of class, and so it kind of motivated me to learn."

Jessie, Pat and Sam believed that their anxiety during the beginning of clinical practice had a negative impact on their learning. These participants discussed feeling a lack of concentration, an inability to process the information being given to them by the supervisor, and feeling like they were unable to try new things, as a result of their anxious feelings.

Jessie: "It definitely affected my learning...I couldn't concentrate on anything. I just couldn't even think of all of my clients and plan for them. I definitely had trouble focusing and concentrating. I also had trouble remembering."

Pat: "That time I was really anxious...I was barely hearing what the supervisor was saying on the phone and I would just totally repeat it and not think about how it fit or how they thought about how it fit or what he thought about how the session came to be so chaotic. I mean, I just sort of left there with no idea what they asked me or anything. So the anxiety left me doing what I was told and not really thinking about it."



Sam: “I did not feel safe to take risks. I did not feel safe to be vulnerable or try anything new. I felt scared the whole time. I felt like Oh, my God I’m going to say one thing and my supervisor will correct me. It really affected my learning and my work with clients because I just didn’t, just wasn’t, it’s almost like part of me wasn’t there.”

Participants reported being impacted by anxiety in many different ways. Some felt that it impeded their learning process in that it prevented them from concentrating well, retaining information, and prevented them from stepping up to new challenges. Some participants felt that the anxiety they experienced was almost like a tool in helping them to challenge themselves and work harder to achieve their goals of learning to become a therapist.

### Changes in Anxiety

Participants were asked about a time that they noticed that they were less anxious. This portion of the interview was designed to begin the examination of any changes in participants’ anxiety levels since they first began clinical practice. Participants’ responses were very unique. Participants seemed to gauge their own anxiety in very different ways. Jesse and Lee noticed a change in their anxiety levels when they had worked with one particular client over an extended period of time. It seems that observing their own growth helped them to feel less anxious about clinical work.

Jessie: “There is this one time I can think of right away because this has probably been one of the best experiences just because there is this one client that I pretty much have had since the beginning. I have been able to see my growth and her growth through the whole process, which I just love.

Lee: “I am not anxious with my very first client that I started out with. I don’t feel anxious with her at all because she is the best first client to have because she will work with me and she will go where I ask her to go in session and do some of the hard or harder stuff, and she doesn’t fight it.”

Interviewer: “It almost sounds like there is something about the familiarity in working with her that is keeping your anxiety down.”

Lee: “Absolutely. I have been able to watch my anxiety lessen with her over time and I really like that. I am always less anxious with clients I have had for a while.”

Pat noticed less anxiety with a certain type of client. Pat said that children and adolescents were less anxiety provoking.

Pat: “I am the least anxious around kids or adolescents and I don’t really know why. I think that as an adult I just feel a lot more comfortable. I mean, those are the two that I think about and worry about less during the course of the day.”

Interviewer: “Was that always true?”

Pat: “No. I was anxious about all of my clients at first but I have found that I am much more relaxed with kids and adolescents.”

Mel described feeling that Mel has less anxiety surrounding issues that Mel had dealt with in therapy before or a feeling of being more of an expert in a particular area. Mel described feeling competent because of Mel’s experience over time. Mel noted that this competence, along with the motivation of the client, was a good combination for reducing Mel’s anxiety.

Mel: “I have a lady or a client that is really motivated. She is really doing all of the work, but some of her issues were ADHD, depression, PTSD and I know a lot about ADHD and I know a lot about depression. The fact that she is so motivated and that I know a lot about her problems, helps me not feel anxious at all about going into sessions with her. I feel competent and if she asks me a question about one of the topics I mentioned I can answer it.”

Participants expressed less anxiety when describing clients that they had some kind of expertise with, and certain populations they just felt comfortable to work with. These examples fit in with traditional ideas of situations that would keep anxiety low such as dealing with things that are familiar, and feeling confident in one’s performance.

Participants were asked to describe the difference in their anxiety levels from the beginning of clinical practice until the time of the interview, to get a sense of any changes in

their anxiety levels. Similar to the way they described their stories of a low anxiety situation, participants described the difference in their anxiety levels in highly individualized ways. When describing the difference in anxiety levels between the beginning of clinical work and the time of the interview, Jessie described noticing forgetfulness. Jessie attributes the forgetfulness to being more relaxed. Jessie and Pat both report feeling more relaxed in session and for Pat before the session as well.

Jessie: “It has been real neat.....I know I am less anxious because I forgot something in one of my sessions, and I had to go get it later.”

Interviewee: “So you are saying you are more relaxed?”

Jessie: “Just little forgetful things let me know I am less anxious. I am not so worried about where we are going, and how things are going to go anymore.”

Pat: “I open the door without anxiety now. I am relaxed and I even joke around with my clients now. I feel more normal now....where by before my anxiety was really high. Now it feels like I am able to deal with it and before I felt like I couldn’t deal with the anxiety.....I don’t stress all day about the fact that I have clients that night.”

Lee described still feeling high anxiety. However, the difference in the anxiety for Lee was that it was no longer about self evaluation and how Lee felt. Lee noticed that now the anxiety is about the client.

Lee: “I am still anxious but it feels like a mature anxiety. Before I was anxious about being in the room and the supervisor, but now I am more anxious about where therapy is going and such.”

Interviewer: “It sounds like before your anxiety was more about you and now it is more about the therapeutic process, is that right?”

Lee: “Yes. Now I am more worried about knowing where to go with a client, wanting to make sure that we have clear goals, treatment objectives, and all that kind of stuff. In some way it is almost worse now because in the beginning I gave myself that free pass to be bad because I was new, but now I am harder on my self.

I care more about what others, mostly my supervisor, thinks of my work.”

Pat described the difference as having the ability to process the information the supervisor gives during a session, whereas Pat had difficulty with this in the past.

Pat: “I feel like if the phone rings I can actually take in what my supervisor is saying. I don’t just take it in my ear and out of my mouth and then it is gone.”

Sam described being less defensive about Sam’s work. The ability to take feedback without defensiveness and the ability to use that feedback is the difference in the anxiety for Sam.

Sam: “I feel like I can take feedback now. I am like a sponge, just absorbing everything. The feedback hasn’t changed much but I am actually able to take the content from supervisors and integrate it into something that is helpful rather than put my guard up. Also, I have a full case load right now and I do not have that much time to prepare for my clients as I did during the summer when all I had was clinic and a job, no class. I am okay with less planning time, where I don’t think I would have been before.”

Mel described what Mel felt others would be able to observe about the difference in Mel’s anxiety levels. Mel felt that an observer would be able to identify that Mel is more present in the therapy room as well as what framework Mel uses. Mel describes these two elements as major signs that Mel’s anxiety is lower.

Mel: “I have more presence in the room. I used to try and not talk or give my opinions or even when I was asked what I thought, I would not say anything or I would re-direct. So I think I have more presence in the room. I also think you would be able to identify the framework that I use, where I didn’t really have one before. I would just kind of pull things out of the air of what I could remember from class.”

Each participant had a unique way of recognizing the difference in their anxiety levels. Some of the major themes for recognizing change in participants’ anxiety are being more present

in the therapy room, being able to use a guiding theory, being more relaxed about seeing clients during the session as well as when thinking about it outside the session, being less anxious about what is going on for them and being able to transfer that energy into working with the clients, and being able to accept feedback without having a defensive anxious reaction.

Participants were asked what it is like to still be experiencing anxiety now, in an attempt to explore how they react to anxiety they may still be experiencing. Many participants were comfortable with still experiencing anxiety in relationship to clinical practice. They understand that anxiety is normal and that their anxiety levels are declining and or changing for the better overtime. Alex, Taylor and Sam felt it was not only normal for them to still feel anxiety but also helpful in some ways.

Alex: “For the most part it feels normal and comfortable. I am clearer on what I am looking for in the therapy room and the transference issues are easier to recognize. I think it is just part of the dynamics. It is my belief that if I get too distant or emotionally distant from the client, it will get to the point that we don’t even connect. I believe my anxiety level now helps me to stay connected.”

Taylor: “It increases my tolerance. It actually feels good. It feels normal. I have pretty low anxiety now. I feel like the anxiety I have now is in useful levels. I also feel that my own anxiety allows me to be more tolerant of the client’s anxiety in the room....and so that is good because I am able to be more cognitive and less reactive about how I want the response and those kinds of things that are important and useful instead of just trying to put out fires or calm things down.”

Sam: “It is still so hard for me to trust myself in certain situations but I am not surprised by that. I think that is part of the process and I think it is part of the learning curve. It doesn’t feel out of place. .It’s almost like when I get anxious I pull my own rug out from under myself....but then I need to calm down and put the rug back in place. I am in a good place. I feel more successful being less anxious now.”

Participants were asked if they felt that others are aware of their anxiety now to explore how they are dealing with or coping with any anxiety they may still be experiencing.

Participants described talking about their anxiety with their supervisors and peers more often. Jessie, Sam and Mel felt others are aware of their anxiety due to their open communication about it.

Jessie: “I talk about it often now so yeah. I think my supervisor can tell sometimes because I will still have trouble remembering what he said on the phone but that’s about it.”

Sam: “Yes. It comes up in case planning still. Sometimes when I discuss my clients my supervisors or the other students will make comments that I need to be nicer to myself or not be so goal oriented.”

Mel: “Yes I think people are because I have just learned to be more open about it. I find it helpful to be more open about it.”

Participants were asked how their anxiety still impacts their learning to further understand if and how they feel anxiety still affects them. Most participants were able to see how some anxiety is beneficial to their learning process. Pat and Mel seem to view their anxiety as helpful, keeping them motivated to learn and stay on top of things.

Pat: “I think that I am learning better now because of it.....it keeps me on the ball in planning and thinking about things still.”

Mel: “I think it helps my learning because if I feel anxious about something I have learned that it is usually because I do not know that much about it and it prompts me to go out and learn about it on my own.”

Sam was the exception and seemed to think that anxiety is still holding Sam back a bit. Sam describes having to filter everything Sam learns through what Sam calls an “anxiety filter.”

Sam: “I still believe it hurts my learning because with my anxiety high I don’t get to just learn. I still have to filter everything through a filter of self-doubt.”

## Managing the Anxiety

Participants were asked what was helpful in an effort to explore some of the tools that they employed to manage their anxiety, as well as to pin point some of the program elements that may have been helpful in managing student anxiety levels. When asked about this, the themes of informal peer supervision and formal clinical supervision seem to be woven throughout each participant's interview response. Alex believes that peer supervision and the aspect of being observed live were helpful.

Alex: "Peers. Talking about what is going on in your theories class is really helpful. I think being in the clinic with other students is the best thing. I would talk to other therapists that I was interning with and we would talk about cases. Also live supervision. I like that they can watch everything and not just go by my description of the session."

Jessie described feeling that watching Jessie's own video tapes as well as the video tapes of other students was very helpful.

Jessie: "Being able to watch my tapes. I also think it was helpful to watch everyone else's too. It helped me to see when I had done a good job."

Jessie and Taylor both described feeling that two aspects of their supervisee experiences were very helpful. Having particular supervisors at particular times, as well as their supervisors' availability to consult with them on cases, not only helped in their development as therapists but also in keeping their anxiety in check.

Jessie: "My supervisors are a big one. I feel like I had the right supervisors at the right time. My supervisor had the perfect balance of helping me but not interfering and letting me build my own confidence. He was also very soothing. My supervisor now is more directive and I think that is exactly what I need now."

Interviewer: "So what would it be about the supervision that was so helpful in lowering your anxiety?"

Jessie: "The difference between them. Having a variety of skills just made me feel like I was getting the best education which

makes me feel like I know what I am doing which lowers my anxiety. I also think it is the fact that the supervisors I have had here are always available to talk to and that is very comforting.”  
“My peers and other interns were helpful too. Whenever I needed someone to talk to there were there. I kind of feel like we are in it together and that feels good.”  
“I think the reflection papers in some of our techniques class were helpful. They worked to help me to recognize my anxiety right in the beginning.”

Taylor: “The differences in supervision. I like the fact that they are all so different. My first supervisor allowed me a lot of space, which increased my self-confidence and being on my own. My second supervisor helped me to have a more critical eye and also to be more communicative. Developmentally, that was helpful.”

Lee felt that Lee’s first supervisor was important in keeping anxiety down. Lee described feeling that it was helpful being told anxiety was normal by the supervisor and being able to talk about symptoms of anxiety. Like Alex, Lee also described that live supervision was a positive experience in helping maintain healthy anxiety levels.

Lee: “My first supervisor was so helpful in alleviating my anxiety. He actually told me I was going to be anxious and it was normal. That heads up made me feel okay. I also think my peers were amazing. I could tell me clinic peers and my supervisor that my leg was shaking and that was okay....they didn’t think I was a moron. I actually found the mirror with live supervision helpful. I thought I wouldn’t but it was nice to know I would get feedback right away.”

Pat described that peers were very helpful in keeping anxiety low. Pat learned from classmates ahead of Pat in the program that anxiety was normal and that it eventually will get better. Pat used this information to self sooth and found this helpful in managing anxiety.

Pat: “My peers. Talking to people going through the same experience was very helpful. I also think just knowing and telling myself that they anxiety would get better was helpful.”  
Interviewer: “It sounds like you did some self-soothing, self-talk, how did you know it would get better?”  
Pat: “I had talked to the people the year ahead of me....so I guess it was my peers again.



Similar to Pat, Mel described being a graduate assistant and discussing anxiety with peers as being helpful in managing anxiety levels. Mel also hit on the theme of supervision being a key anxiety lowering element.

Mel: “The supervisor. Which is interesting because it was the supervisor that made me so anxious for so long? But getting the ideas on what else to try, you know...and then recognizing when I have had progress really lowered my anxiety. I believe that supervision is both anxiety lowering and provoking because I think that it can really push you to take on your own cases and plan them yourself and know what you want to do but also back you up if you really need it.”

“It was also really helpful to be a Graduate Assistant. When we were at work we would case plan together. The non-GA’s did not get to do that.”

When answering questions about what would have helped all of the participants had very individualized ideas. Most of what participants identified as potentially helpful seemed to relate back to specifics about what made each participant anxious as individuals. Alex who discussed having problems with counter transference issues desired guidelines that would help Alex with this counter transference in clinical work.

Alex: “I think our program lacks a focus on emotional guidelines that go into the therapy room. I really think we are lacking training on how our emotions can play out during training as well as in the therapy room.”

Jessie who had anxiety involved in what might happen in therapy, or a fear of the unexpected, desired a techniques course or a course that would teach Jessie what to expect before starting clinical work.

Jessie: “I wish we had more of a class that was teaching the logistics of therapy. That got into some of it. We had one like it but I had already been seeing clients and I felt like it was too late. I also think that it would be helpful if we had a wide variety of clients so we felt more prepared for the future.”

Many participants had some specific ideas about what would have helped.

Lee: “I think it may have been helpful to have a course or something on the paperwork well before you start clinic. It is difficult to learn so much new stuff all at once and to deal with your anxiety as well.”

Pat: “I think it would have been helpful to observe the other students more before you begin.” I think if I had seen more sessions first hand I would have been less anxious.”

Sam: “I would have really liked someone to tell me that I was going to flop in the beginning and that that was okay.”

Mel: “I think it would have been helpful to have a class of specifics about what clinical work would be like personally so that you could really relate to it. It also would have been helpful to have our theories class while we were seeing clients.”

Charlie and Terry commented on the other participants’ ideas for what would have been helpful and offered their own ideas.

Charlie: “I think that everyone’s ideas are good and all would have been very helpful for me, especially the class about specifics. I also think that there should have been a peer group where you could talk about what you were going through with out the faculty involved.”

“Terry: “I think case planning should have used some time to discuss what was going on for us...were we anxious?...How are we doing?...there was no where that I felt that it was okay for me to talk about how I was feeling and how difficult the anxiety and the over whelming it can be. There was nothing like that at all.”

Many of the participant responses of what would be helpful consisted of specific elements that they felt could have been added to their clinical education. Some of these ideas involved more or different supervision such as peer supervision, a space in supervision where students can discuss their feelings about doing clinical work. Other responses involved changes in course work such as the addition of a theory or techniques class, conducted before ever

beginning to see clients, and a course requirement of many observations of other students' therapy before ever starting therapy work.

### Summary

I have presented the findings of my seven initial and two final interviews. The unique personalities of the participants involved in this work were revealed during discussions of what they were anxious about and how they dealt with it. Each of the experiences of anxiety that the participants had were individualized but some major themes did occur. I would summarize the commonalities through several major themes:

- 1) Student therapists tend to be anxious about their supervisory relationship, but it is often the supervisory relationship that helps to lower anxiety levels as clinical experience progresses.
- 2) There seems to be an equal divide between student therapists that believe that their anxiety should be hidden from peers and supervisors and those who do not.
- 3) There seems to be an equal divide in the participants' belief that anxiety is helpful in their learning process and those that believe that it impedes their learning in some way.
- 4) Student therapists tend to feel less anxious when they have seen growth in their therapeutic abilities.
- 5) Student therapists tend to cope with their experience of anxiety by talking to peers and supervisors.
- 6) Student therapists believe that specific courses on therapeutic techniques and theory, as well as open communication within their program about anxieties involved in clinical practice, would be helpful in managing anxiety.

- 7) As student therapists experience less anxiety, they report more confidence in their clinical abilities.

In presenting these findings I hope to have given shape to the feelings and experiences of my participants, and through them perhaps illuminate the feelings and experiences of MFT students in general.

## CHAPTER V

### DISCUSSION

The purpose of this research study was to help MFT programs and students understand anxiety in relation to the training experience of MFT students. The findings are both consistent with, and add to, the literature on anxiety and psychotherapy training. The results of this research suggest that the relationship between a student therapist and his or her supervisor is a vital, yet delicate one. We can use the information from the experiences and beliefs of the participants to ensure that this relationship is the most productive and helpful it can be. Costa (1994) suggests, and this study confirms, that while some anxiety can be helpful, an extreme amount can be detrimental to the learning experience. Costa offers six guidelines for supervisors to follow in order to promote a good balance of anxiety levels: Supervisors should 1) negotiate a clear training contract, 2) directly address anxiety and fear, 3) match method to supervisory development stage, 4) develop a collaborative supervisory attitude, 5) create a positive evaluative focus, and 6) encourage independence.

Mel described what was helpful in managing anxiety:

Mel: “The supervisor. Which is interesting because it was the supervisor that made me so anxious for so long. But getting the ideas on what else to try, you know...and then recognizing when I have had progress really lowered my anxiety. I believe that supervision is both anxiety-lowering and provoking because I think that it can really push you to take on your own cases and plan them yourself and know what you want to do but also back you up if you really need it.”

Supervision was a pronounced theme throughout this research. I would like to examine the data collected from these interviews pertaining to supervision and anxiety, by discussing

them in relationship to the work of Gabbard (1997). Gabbard studied anxiety and performance art. Conducting therapy as a student and performing live have many similar facets. Similar to performing live, therapists are observed by supervisors and peers through a one-way mirror and may feel as if they are on stage. The discussions of supervision and anxiety fit well with the work of Gabbard. While these results may not fit with all of Gabbard's themes, at least two of his five themes showed parallels with the research findings.

Gabbard's first theme of separation anxiety asserts that as children we are fearful that we will be rejected by our parents. We are taught that if we show any form of independence we will be reprimanded which can lead to anxiety. This portion of Gabbard's research fits well with the participants' discussions of the supervisory relationship. Fear that the supervisor is judging your work is in a sense a fear of being rejected by your supervisor. As revealed through the participants' discussion, many student therapists are anxious about what their supervisor expects from them, as well as anxious that their supervisor does not like their work. This plays into the idea that a supervisor acts almost like a parent, and if a student therapist does not perform a certain way or live up to their parent's (supervisor's) ideas of good therapy they will be rejected. This rejection could come in the form of a supervisor calling in often because a student's therapy is not good enough, or feedback about what he or she could have done differently after the session.

Terry described this experience:

Terry: "During my first semester I was very anxious about my relationship with my supervisor and she was really hands on and called in a lot...it made me feel like she didn't have faith in me that I could do it on my own. That kind of just reinforced my thoughts of self-doubt that maybe I was in the wrong field by calling in so much and being so specific...like word for word...and it took away any freedom. I felt like her puppet like she was doing the therapy for me."

Gabbard's fourth theme is exhibitionism and general inadequacy stemming from our childhood fears that even in the face of the exhilaration of nudity, as a child we are still fearful that others will laugh at our nudity and we will be ridiculed or deemed pathetic. This theme ties in well to the participants' reports of anxiety created by supervisor expectations to perform therapy a certain way or possibly face being ridiculed or reprimanded by peers or supervisors for doing it their own way.

Sam described this experience:

Sam: "I did not feel safe to take risks. I did not feel safe to be vulnerable or try anything new. I felt scared the whole time. I felt like 'Oh, my God I'm going to say one thing and my supervisor will correct me.' It really affected my learning and my work with clients because I just didn't, just wasn't, it's almost like part of me wasn't there."

Gabbard's exhibitionism theme about making yourself vulnerable fits in well with a student therapist's reluctance to reveal their own emerging therapeutic skills. This can provoke intense anxiety that their skills will be ridiculed and in essence they will be ridiculed. This theme also ties to participants' reports of trying to hide their experiences of anxiety. They fear that revealing this vulnerable (naked) part of themselves would make them seem "incompetent" or lead them to be more self-critical, thus opening themselves up to supervisor, peer or self-rejection.

Terry: "It really shocked me to read that so many other students tried to hide their anxiety as well. I felt like we had to project this mask like we were fine... No one else seemed anxious so I felt like I was the only one. It didn't feel safe to talk about it. We all did a good job of covering up our anxiety."

However, in performance, and in learning therapy, taking the risk of revealing oneself leads to better performance. Both must find the balance between protection and revealing oneself.

In a further examination of the effects of anxiety Biscoff, Barton, Thober, and Hawley (2002) examined therapist development and broke the student therapist development of self-confidence into three stages: 1) Variability of confidence, 2) Emerging confidence, and 3) Fragile stability. The relationship between anxiety and confidence is a unique one. I do not wish to draw parallels between my work and theirs in reference to that relationship. Rather, the research data collected from this work on the reports about participant anxiety and their experiences, allows us to ascertain where my participants would fall in terms of their self confidence in Biscoff, Barton, Thober, and Hawley's stages.

Variability of confidence involves dramatic swings between feeling confident and not feeling confident. During this stage the student therapist's anxiety is experienced internally rather than projected outward toward the clinical situation. Student therapists may begin to believe that any failures during this time, even their own nervousness and anxiety, are a reflection of their own incompetence. The elements of this stage of clinical confidence emerged often in my results:

Mel: "It was weird because up until this point, you know, I had been pretty successful in everything that I tried and felt confident in my abilities. Going into the therapy room, I did not feel competent. I didn't feel like I knew what I was doing. The anxiety made me feel like I was not successful....I began to doubt if I should stay in this department because the anxiety feelings were just so uncomfortable."

The second stage, Emerging confidence, involves a therapist beginning to have more experience over time and the ability to evaluate their own work, or as the authors refer to it



“developing an internal gauge.” This ability to evaluate allows a therapist to determine when they have done something well, thus leading to more confidence. Supervision tends to take on a different function. During this stage Biscoff, Barton, Thober, and Hawley state that supervision begins to be less of a threat and more of a validation. The participants described the difference in their anxiety levels of when they first began and when the interviews took place. Through their descriptions of lower anxiety their stage (Emerging Confidence) became apparent:

Sam: “I feel like I can take feedback now. I am like a sponge, just absorbing everything. The feedback hasn’t changed much but I am actually able to take the content from supervisors and integrate it into something that is helpful rather than put my guard up.”

Fragile stability involves a more consistent level of confidence that does not change often. During this stage the therapist begins to develop autonomy. The student therapist begins to use a guiding theory that may be recognizable to an observer. At this junction in development, the therapist begins to notice progress with his or her clients, and is able to recognize how components of clinical work fit together. Similar to the above description of the difference in Sam’s anxiety, Mel describes lower anxiety levels and the development of clinical confidence:

Mel: “I have more presence in the room. I also think you would be able to identify the framework that I use, where I didn’t really have one before. I would just kind of pull things out of the air of what I could remember from class.”

One participant discussed the use of positive self-talk as a helpful tool in managing anxiety. Hiebert, Uhleman, Marshal and Lee (1998) looked at the relationship between anxiety, self-talk and counseling skills. Their study found that those participants with heightened levels of anxiety and negative self-talk rated poorly in their instructor’s evaluations of performance. The researchers suggest that mental health training programs would be served well by training

their students in the areas of positive self-talk, in addition to the traditional course work. This element was present for Pat when Pat was discussing what was helpful in managing anxiety:

Pat: “My peers. Talking to people going through the same experience was very helpful. I also think just knowing and telling myself that they anxiety would get better was helpful.”

Interviewer: “It sounds like you did some self-soothing, self-talk, how did you know it would get better?”

Pat: “I had talked to the people the year ahead of me....so I guess it was my peers again.

It is easy to see that this research is validated by several important previous studies. I believe however, that it is an important first step in exploring an avenue that has tremendous import to the success of MFT programs.

### Limitations

There are many limitations to consider when reviewing this research. One of the most obvious and important things to recognize is the limited number of participants. A higher number of participants could have strengthened some of the major themes identified and added more to the results. A second limitation is the fact that only one MFT program was incorporated in this study. Some of the emerging themes might not have come up in schools where there are different styles of supervision, or different courses offered. This may limit some of the usefulness of the insights from this research for some programs. A third limitation to consider is the demographic characteristics of the participants. Since I did not wish to skew the results by actively seeking out a population of more varied participants, I was limited to the participants that responded first. These participants consisted of mostly female, almost all Caucasian, all full time students, with an average age of 28.2 years. It is my suggestion that future research look at a broader spectrum of students and programs.

### Implications for Training

There are several major implications for MFT program training that can be drawn from this research. The first is overall awareness for MFT students, faculty and supervisors of the MFT student experience of anxiety. MFT students may find that this study and its findings normalize their own experiences. It may also help them in finding ways to manage their anxiety. I would suggest that students that find their experience of anxiety in training to be unmanageable seek out their own therapy.

For faculty the findings presented here may be helpful in developing courses and program practices that help their students manage anxiety. More specifically, I would appeal to program faculty and supervisors to discuss student anxiety directly with their students. Programs may weave an open discussion of anxiety into one of the classes of a course or a seminar discussion that is offered pre-practicum. This open discussion would even benefit from the inclusion of a handout of the results of this research project. As suggested above, offering these findings to students and giving them an idea of what to expect has the potential to act as a normalizing experience

For supervisors the experiences described here regarding supervision and anxiety are especially important. These findings may help to further educate supervisors as to how delicate the supervisor/supervisee relationship is and how the supervisor's opinion of their work can be so important to student anxiety levels. I would suggest that supervisors offer time to their practicum students to discuss student anxiety one-on-one. In addition, I would suggest that supervisors encourage their students to discuss anxiety openly with peers. According to my findings this was the most helpful way to manage anxiety.

This study was conducted in an effort to help MFT programs and students understand anxiety in relation to the training experience of MFT students. The information presented here suggests that awareness and management of anxiety for trainees is important. The findings are both consistent with, and add to, the literature on anxiety and psychotherapy training.

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Dear Second and Third Year MFT Students,

I am writing to invite you to be a part of my thesis research:

Marriage and Family Therapy Students'

Experience of Anxiety During

the Clinical Training Process

I am recruiting participants for a 1 hour interview on this subject. I will be interviewing 8-10 participants and the first 8-10 students to respond to this email will be included. Interviews will be scheduled and location will be chosen at the potential participants' convenience. There will be no compensation given to participants, but participation will be greatly appreciated by the researcher. Please contact me via email if you are interested and include a phone number where you can be reached.

If you have any questions or concerns about the project, you can email me at [Kamccart@vt.edu](mailto:Kamccart@vt.edu) or call (703) 623-2285.

Thank you in advance for your consideration!

Sincerely,

Katherine M. McCarthy  
MFT Student Intern

Informed Consent for Research Project

Project Title: Marriage and Family Therapy Students' Experience of Anxiety During the Clinical Training Process

Researchers: Katherine M. McCarthy, M. S. Candidate, Department of Human Development, Virginia Polytechnic Institute and State University  
Karen Rosen, Associate Professor, Department of Human Development, Virginia Polytechnic Institute and State University

What is the purpose of this study? The purpose of this study will be to understand how marriage and family therapy master's students experience anxiety in reference to clinical practice

What will I be asked to do? You will be asked participate in a 1 hour interview. During this interview you will be asked about your experience of feelings of anxiety before, during and after beginning your clinical training. The interview will be scheduled at your convenience in a mutually agreed upon location. The face-to-face interview will be audio-taped to make sure we understand exactly what was said. After completing your interview you may be contacted to participate in a focus group with other research participants.

Are there any risks to me? The researchers anticipate that there will be no risk to you as a result of your participation in this research study. We will ensure that your information will be kept confidential. In an effort to really understand all the components of your experience, the interview will include some questions about emotional issues, however you may decline to answer any question at any time.

Are there any benefits to me? As a result of participating in this study you may feel empowered and feel a sense of satisfaction because you have contributed to an important study that may benefit MFT programs in the future.

Are my responses confidential? Every effort will be made to keep all information you provide in the strictest confidence. Any specific identifying information will be omitted from your transcript (e.g., name changes, age). Your responses will be kept locked for the duration of the project and access will only be allowed to the researcher. After the study has been completed your name and any other identifying information will not be reported in any publications or presentations, and audiotapes will be destroyed. Once the data collection is complete and the interviews are transcribed, a copy of your interview transcription will be sent to you via email. If there are any portions of the interview you wish to change in order to protect your confidentiality, you may do so and send it back to the researcher by the date designated in the email. You may also highlight any portion of your transcription that you do not wish to be quoted later when the research project data analysis is reported. These highlights can be sent back to the researcher via email as well. If you do not respond to the interview transcription

email by the designated date, the researcher will assume that you do not wish to make any changes.

Will I be compensated for my participation? Your participation is completely voluntary and there will be no compensation other than the researcher's appreciation for your time.

Do I have the freedom to withdraw? You have the right to refuse to participate in this study. You also have the right to refuse to answer any questions and you may drop out at anytime.

Approval of Research: This project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University.

If you have any questions about this research project, please feel free to contact:

Katherine M. McCarthy, Principal Researcher  
703-623-2284, Kamccart@vt.edu

Karen Rosen, Ed.D., Committee Chair  
703-538-8761 Krosen@vt.edu

Dr. David Moore, IRB Chair  
540-231-4991, moored@vt.edu

Participant's Permission:

I voluntarily agree to participate in this research project. I have read and understand the Informed Consent and the conditions of this project. I hereby acknowledge the above and give my voluntary consent for participation in this project by signing my name on the line below. I realize that, although I choose to participate right now, I have the right to withdraw from this study at any time without any penalty.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Interviewee#

Demographic Questionnaire

Gender:      male              female

Ethnicity:

Age:

Number of years of clinical experience:

Number of years in the program:

Are you a full time or part time student:

Are you/were you a graduate assistant      Yes              No

Interviewee#:

Interview Questions

Warm Up

What made you want to become a therapist?

When you think about doing clinical work what comes to mind?.....Is this experience what you expected?

Experience of Anxiety

Tell me about a time during your clinical experience that made you really anxious.

How did you know you were anxious?

On a scale of 1-10 (one being not anxious at all and ten being extremely anxious) how anxious would you say you were when you first started seeing clients? \_\_\_\_

What was that like?

What was it like for you to experience this (anxiety/lack of)?

Do you think other people were aware of your anxiety/lack of?

How do you think it affected your learning (anxiety/lack of)?

On a scale of 1-10 (one being not anxious at all and ten being extremely anxious) how anxious would you say you are now involving clinical work? \_\_\_\_

What is that like?

What is it like for you to experience this (anxiety/lack of)?

Do you think other people are aware of your anxiety/lack of?

How do you think it affects your learning (anxiety/lack of)?

Tell me about a time when you noticed that you less anxious during your clinical work.

How would you describe the difference in your anxiety level between when you first started and now if (if there is a difference)?

What would have been helpful?

What if anything has been helpful?

Final Two Interviews

Presentation of the themes identified in the first 7 interviews.

Discussion of the themes identified in the interviews.