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# Narrative Identity Development for Novice Psychotherapists in Clinical Training

Dana Michelle Satterlee

George Fox University, dsatterlee10@georgefox.edu

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Narrative Identity Development for Novice Psychotherapists in Clinical Training

by

D. Michelle Satterlee

Presented to the Faculty of the  
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George Fox University

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Newberg, Oregon

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D. Michelle Satterlee

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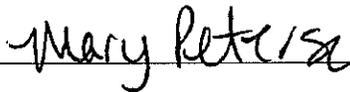
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Signatures:



Mark R. McMinn, PhD, ABPP, Chair



Mary Peterson, PhD, ABPP



Winston Seegobin, PsyD

Date: 3.19.15

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D. Michelle Satterlee

Graduate Department of Clinical Psychology

George Fox University

Newberg, Oregon

### **Abstract**

Narrative identity is “the internalized, evolving story of the self that each person crafts to provide his or her life with a sense of purpose and unity” (Adler, 2012, p. 367). This identity is distinct from the broad dispositional traits and the characteristic adaptations for contextualized behaviors. It provides the self with a sense of purpose, meaning, and unity across time and situations (McAdams & Olson, 2010). Researchers have developed ways of measuring *innovative moments* (IMs), or shifts in narrative identity that occur in psychotherapy.

Researchers have also explored *narrative identity processing* as it seems to occur across the lifespan. This study used qualitative reflective learning methods in an attempt to describe some of the narrative identity processes that may be supported during clinical training in graduate psychology programs. Eight narratives, collected from novice clinicians, revealed innovative moments occurring secondary to clinical training. Primary themes include (a) performance, (b) cultural and racial identity, and (c) emotionality, relatedness, and presence. Implications are discussed. The occurrence of these IMs, their themes, and the implications for clinical training warrant further research and exploration.

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## Chapter 1

### Introduction

Narrative identity is “the internalized, evolving story of the self that each person crafts to provide his or her life with a sense of purpose and unity” (Adler, 2012, p. 367). This identity is distinct from the broad dispositional traits and the characteristic adaptations for contextualized behaviors. It provides the self with a sense of purpose and meaning and with a sense of unity across time and situations (McAdams & Olson, 2012). Narrative identity seems to emerge in adolescence, support generativity in adulthood, and foster meaning making at the end of life (Adler, 2012; Habermas & Bluck, 2000). For evaluation and adaptation, individuals often compare their own narrative identity with the culture’s *master narrative*, which outlines the typical and expected course of an individual’s life within that specific context. Narrative identity is also used to explain the development of self over a series of events, and it provides the self with a continuous story, linking the past self with the experience of the present self and the expectation of the future self (Adler, 2012).

The broader construct of personality can be broken down into three levels, each supporting function and self-concept in different ways (Adler, 2012). The first level, the foundational signature of the personality, includes dispositional traits, such as those described by the Big Five. The second level of personality is shaped by *characteristic adaptations*. These are the components of personality that are contextually specific – adaptations used for specific times, places, or roles. These behaviors are contextually rewarded and often reflect an individual’s

primary concerns or developmental progress. Finally, the third level of personality can be described as the *narrative identity*. Of the three personological levels, it is the narrative identity that ties most closely to meaning-making and congruence. Perhaps, in clinical training, it is narrative identity that best explains the *why*. For example, it is narrative identity that tells the student's story, makes sense of the student's decision to pursue clinical training, creates meaning of difficulties or struggles during the graduate program, and reminds budding clinicians of the psychotherapists they hope to become.

The role of narrative identity can be seen in at least two ongoing branches of research: (a) therapeutic research utilizing narrative models and (b) developmental lifespan research monitoring narrative identity and personality. Research consistently demonstrates that across theoretical models, shifts in narrative identity are predictive for positive outcomes (Gonçalves, Matos, & Santos, 2009; Matos, Santos, Gonzales, & Martins, 2009; Mendes et al., 2010; Santos, 2009; Santos, Gonçalves, & Matos, 2011). Clients enter psychotherapy with strong, problem-related neural networks that have been repeatedly reinforced (Beaudoin & Zimmerman, 2011); their concepts of self are shaped by repeated patterns of behavior that are not congruent with their values. These are problematic narrative identities. During multiple forms of psychotherapy, clients are asked to describe (or imagine) moments that do not fit their expected patterns. When do they act in ways that are more congruent with their values? When do these *unique outcomes* appear? How might more unique outcomes be encouraged? By reliving the memory of these preferred behaviors – these exceptions – clients re-author and reinforce situational memories, shaping new neural pathways and new understandings of self (Beaudoin & Zimmerman, 2011). With enough momentum, their narrative identities shift to accommodate these unique outcomes or *innovative moments* (IMs; Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011).

Clinicians and researchers point to at least two ways that these narrative shifts can be supported or leveraged. First, not all unique outcome memories are equal. Affect-infused memories of unique outcomes may exert more leverage toward neurological changes (Beaudoin & Zimmerman, 2011). Secondly, narrative shifts seem to be supported by insight and meaning-making. When clients are able to reflect on changes and describe *how* these shifts occurred, they create meta-cognitions (or meta-positions) about their change, and these meta-cognitions are a strong indicator for positive outcomes and therapeutic success (Adler, Skalina, & McAdams, 2008). *Reconceptualization* IMs seem to provide the contrast necessary for sustainable change (Cunha, Spínola, & Gonçalves, 2012; Gonçalves et al., 2012; Matos et al., 2009; Santos et al., 2011), and *performing change* IMs mark the client's ability to generalize the narrative shift into other areas of life, making the new narrative even more resilient against the earlier, problematic narrative (Ribeiro et al., 2011).

Re-authored narrative identities can support congruence, while problematic narrative identities tend to reinforce value-incongruent behaviors and create further distress. It would seem, therefore, that a well-authored narrative identity allows individuals to experience a more congruent, more genuine expression of self. Actions and behaviors are examined in the light of values and personal history, and future plans are made to move the accepted self into whatever might be ahead. This requires supported reflection, openness to considering other perspectives, and a desire to act in ways that are even more congruent, more rewarding. At least at first glance, all of these would seem to have a beneficial effect on clinical training.

Longitudinal developmental research demonstrates that effective narrative identity processing, even outside of psychotherapy, correlates with greater life satisfaction and resiliency (Pals, 2006). When narrative identity is challenged through difficulty, positive resolution can

strengthen the sense of self, the sense of competency, and the sense of agency in one's life, while unresolved challenges to narrative identity tend to weaken the sense of self and sense of agency, lowering life satisfaction (Pals, 2006). Narrative identity processing is "the ongoing task of narrating and interpreting past experiences and incorporating them into the life story as lasting narrative products" (Pals, 2006, p. 1081), and this processing has been examined using features such as *exploratory narrative processing* (the richness and complexity of the narrative and how open the individual is to change), *coherent positive resolution* (a complete story that conveys a sense of resolution or closure), and *temporal coherence* (temporal ordering of events; sense of beginning, middle, and end to the story; Adler, 2012; Habermas & Bluck, 2000; Pals, 2006).

Although narrative identity processing is a key feature of narrative therapy, it is important to recognize its more general application to effective psychotherapy. For example, in Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2012), one of the six core processes of psychological flexibility is self-as-context. This process allows individuals to have an enduring narrative of life without being overly fused to the specific content of life experiences. Similarly, psychodynamic psychotherapists often speak of the "observing ego" (e.g., McWilliams, 1994, p. 56), which allows a person to view the self as if from an objective distance.

In narrative therapy, the work is to help clients move out of problematic self-narratives and replace them with more congruent, more functional narrative identities. Clearly, this is not the only goal for clinical training programs, but how might increasing narrative identity awareness help psychotherapists in training to be more congruent, more genuine in their work? For example, narrative identity awareness might help developing psychotherapists reflect on their own identity development, form mega-cognitions around significant changes, and develop a strong sense of unity across past, present, and future. Similarly, a psychotherapist who has

positively resolved narrative identity challenges might sit with clients – and their identity difficulties – in a more genuine way. Understanding one’s own narrative identities might allow supervisees to advocate for effective supervision experiences and allow the supervisor to guide the supervisee more effectively. For programs that value transformational learning in professional development, it seems reasonable to actively help students reflect on their own narrative identities and positively resolve narrative identity challenges, particularly those that might relate to their sense of clinical or professional identity.

This qualitative study explored narrative identity processes that impact psychotherapists in early training. New graduate students in clinical psychology were exposed to a series of writing assignments designed to promote narrative identity reflection. They were encouraged to reflect, in particular, on some of the most challenging and most rewarding clinical experiences with their simulated psychotherapy clients, and to relate those experiences to their own sense of identity. They were also asked to explain how their experiences might relate to the reasons they chose to study clinical psychology, and encouraged to consider how their future clinical self relates to the work that they are presently doing with clients. The study sought to observe (a) how psychotherapists in training explore and resolve challenges to narrative identity that might arise in early clinical work, (b) how psychotherapists in training utilize resources to make meaning of these experiences, and (c) whether or not innovative moments mark narrative identity shifts for psychotherapists early in their professional development.

## **Chapter 2**

### **Narrative Identity Study**

Data were collected from 25 PsyD graduate students, all enrolled in a first-year, clinical skills training course. The graduate students ranged from ages 22-36. Fifty-six percent of them were female; 44% were male. Seventy-two percent of the graduate students were European American, 8% identified as Asian-American, 12% identified as Hispanic, 4% as African-American, and 4% as Other.

During the course students were exposed to Rogerian clinical skills and practiced those skills with simulated psychotherapy clients who were recruited from the undergraduate student population. All of the graduate students were full-time students in a clinical psychology program and were supervised by fourth-year teaching assistants, as well as the teaching faculty member for the course.

Students submitted 10 written reflections as course assignments. They wrote weekly about their work with pseudo clients, reflecting on the process and their own questions and experiences. The primary researcher and course instructor reviewed these journal entries and used the reflections to create some specific, tailored prompts for use in the upcoming interview phase of data collection.

Less than a month after their last pseudo client session, the students then participated in recorded, semi-structured, half-hour interviews. Participants were asked what they knew about themselves that they did not know before they began clinical training. They were prompted to

reflect on how they worked to make sense of their experiences, and they were asked to elaborate on any shifts in what they perceived as their personal, clinical, or professional identity. In the end, few of the individualized prompts were needed to maintain the flow of the interviews, but several of the students mentioned the reflection assignments or specific reflection questions as sources of insight while describing narrative identity shifts-

For purposes of analysis, the primary researcher screened the interview videos according to the presence of four particular features of narrative identity processing theory: exploratory narrative processing, coherent positive resolution, temporal coherence and innovative moments. Exploratory processing was scored according to salience or time spent around new concepts of self, coherent positive resolution and temporal coherence were coded as present/not present, and IMs were identified when problematic self-narratives were replaced by new ways of conceptualizing self. Twelve narratives with higher exploratory narrative processing scores were placed on a randomized numbers list. Two of them were eventually ruled out as they explored very broad themes, including large amounts of insight that were not directly related to clinical training or doctoral experiences. The primary researcher then randomly selected eight of the remaining narratives for transcription and detailed analysis and full re-coding. Identifying markers were removed during transcription.

During the second round of coding, three raters did not re-score exploratory narrative processing, but IMs were coded as present or not present and then further identified as reconceptualization or performing change IMs. Raters also described the narrative shift involved in each IM. Additionally, researchers noted the specific ways in which participants made meaning of these significant clinical training experiences. Periodically, the raters met to discuss the coded IMs. They brought questions to the group, especially when they had the sense that

something was happening in the narrative but they were just not quite able to track it from their own reading. When this occurred, the other raters described the narrative shift or IM as they understood it, and the raters independently went back to the narrative to complete coding, incorporating the feedback from the others or not, as they saw fit.

## Chapter 3

### Findings

Reliability among the three raters ranged widely, depending on the type of data collected, with ending coherence reliability being the lowest and temporal coherence reliability being the highest. For continuous variables, reliability was assessed with the average inter-rater agreement, calculated by averaging the Pearson correlations between each pairing of the three raters (i.e., mean  $r$ ). Temporal coherence scores had a perfect correlation of 1.00 across all three raters. Four variables were coded for coherent positive resolution: ending coherence (average  $r = 0.040$ ), positive ending (average  $r = 0.700$ ), negative ending (average  $r = 0.745$ ), and emotional resolution (average  $r = .624$ ). It should be noted that a Pearson correlation for Rater 2's scores for negative ending could not be computed, as there was no variability among the scores.

For dichotomous variables, inter-rater agreement was to be computed with a Kappa coefficient. However, this could not be calculated with the binary IM scores because Raters 1 and 3 had no variability in their scores. They found performing change IMs in all eight narrative samples. Rater 2 coded IMs as present in six out of eight narratives, and performing change IMs were coded for all six. For each IM, raters wrote a brief description of the reconceptualization shift and listed or described the new behaviors that were part of performing change.

Clearly, the raters struggled to score ending coherence. The timing of the interviews, conducted before the end of the spring semester and less than a month after students terminated their work with their simulated psychotherapy clients, might have affected the sense of

completion or ending in the narratives. There were often mixed cues about the conclusion of the story, and the raters struggled to distinguish between the story of immediate change – the IM sequence that included reconceptualization of self and new behaviors – and what might eventually be a larger narrative in the life of the student, one in which they continued to work out the IM shift until it was no longer a concern or they began focusing on a new narrative trend. The sense of emotional resolution, isolated as a sense of relief or capacity to move on, was easier for the raters to find and describe in the narratives. Given the poor inter-rater reliability, no firm conclusions can be drawn regarding ending coherence.

### **Common Themes**

The eight coded narratives revealed three broad, IM themes: (a) performance fears, (b) shifts around cultural or racial identity, and (c) emotionality and its impact on presence in relationship. Though the other collected 18 interviews were not coded and may or may not have contained IMs, a quick screen suggested that these content themes were repeated frequently throughout the entire collected sample.

**Performance.** Half of the coded sample, four narratives, referenced fears and understandings of self that related to performance ability: two very directly and two with a mixed-theme presentation. One novice clinician reported pervasive doubts about her ability to perform in the program overall, which plagued her during the first semester of coursework and clinical training: “I was questioning, do I deserve to be in this program? I was always going to [TA’s name], am I going to be okay? Am I capable to learn this stuff?” As she began working with her simulated psychotherapy clients, these doubts heightened until something said in a psychotherapy course and some direct feedback about her psychotherapy work clicked: the program expected her to fail (in some sense), she had already done so because of

countertransference with a client, and she was right where the program expected her to be. No one's opinions of her had changed. No one expected perfection, faculty would not allow her to fall too far, and the only real barrier was her view of self. She was capable enough: "I think my confidence came from finally getting to a place where I'm okay with the unknown. And I'm still working on it, but it's a huge difference from before."

Ability and performance concerns plagued even the experienced clinicians in this training program. An MA psychotherapist, returning for doctoral training, was tripped up by strong countertransference with a client, and because client work was not new to her, she was doubly frustrated by her failure to connect and see clinical progress, "There was a part of me that was, like, 'You should know this. You have done the work. I should know what I'm doing.'" The more she pushed and was impatient, the more she struggled, until about session six, "I finally stopped and took a breath." What shifted? Feedback from her Teaching Assistant helped her recognize her own performance pressure and impatience to *already be* that fully capable, polished clinician, "It was a good reminder that I'm still learning and I'm still in training, and I can still be triggered." For this clinician in training, the shift in her narrative – from *inferior* to *still in process* – stretches into other areas of life as she lowers her expectations of herself and is "giving myself grace," saying "no" to some expectations and finding patience for herself *and* for her clients.

The mixed-theme narratives both blended themes of emotionality and relationship with performance. In the first, the novice clinician noted a strong "fix-it" mentality that she tended to use as a means of avoiding negative affect across contexts, and while this was something of a performance issue for her, she framed it and resolved it relationally. Her narrative focused on how this fix-it approach affected her relationships, including her work with clients, and she

found that she could behave differently by increasing her efforts to validate and understand, making that the new, more preferred performance measure. The second mixed-theme narrative described a student's struggle to engage in negative affect and a tendency to encourage and console. Once she recognized this tendency in herself and her work, she recognized it was incompatible with her growing sense of the ideal psychotherapist. She approached it as a performance question and worked to adapt to the professional identity that she valued.

**Cultural and racial identity.** Three of the student narratives directly related to diversity awareness, and particularly cultural and racial identity. In two cases, students described how their strongly developed regional and cultural norms interfered with their ability to connect to others comfortably. Their experiences in the program challenged relational and worldview expectations, often leading to a sense of isolation or frustration. Both noted this tension in course discussions. One narrative revealed how gender norms interfered with perspective taking in clinical work. The other student emphasized the ways in which regional differences made it difficult to feel connected and supported as the student faced the rigors of clinical training and supervision. In the process of moving through their work with clients and working through the first year of training, with heavy professional and interpersonal feedback, both students faced the assumptive power of their worldviews and moved toward a more diversity-flexible, culturally-aware view of self.

In the third narrative, the shift around diversity awareness was arguably much more profound. Jamie (a pseudonym) grew up in what he described as a "vibrant" cultural context: "Things like race, SES, and even regional idiosyncrasies ...played a large role in my relationships with peers." He thought he was able to be vulnerable and connect relationally, and he thought he felt relatively comfortable with his racial identity until he sat with his first client of

color. At that point, the salience of racial identity took on a whole new dimension. He felt he could not be “genuine with my client at all, and that’s originally what I thought I could be,” and “it forced these questions within myself and my own identity.” The student felt he had constructed a “temporary shell” and “been complacent” with his identity work.

I came down to, “Oh, I don’t get this! Maybe this is me. Maybe I just didn’t even take the time to access these parts of myself that I’ve been denying up until this point, or really haven’t had the opportunity to talk about them.”

To make sense of these experiences, the student committed to more racial identity work. He engaged in class presentations differently. He picked up reading resources, and he sought a psychotherapist of color to “figure out what is there.” He acknowledged that this will be an ongoing process and that he may need to do much of the work outside of the program of clinical training: “Yeah, once I piece it together, piece myself together, outside of the system, then maybe I’ll feel more confident about being here and not have to deal with all of the thoughts that cross my mind.”

Owning the salience of their own identity markers encouraged all three student psychotherapists to lean into diversity education and awareness. They expressed a stronger desire to learn about other groups who may feel misunderstood, isolated, or disenfranchised. They described ways in which humility, openness, and perspective taking were impacting their family and intimate partner relationships, as well as their experience within the doctoral program and the cohort. They all found colleagues and confidants who were open to processing their experiences and holding them accountable to their new narratives, and they described diversity awareness as a priority for their continued professional identity development.

**Emotionality, relatedness, presence.** The theme of emotionality, and its impact on the novice clinician’s ability to maintain presence, was the most common theme in the coded sample. Navigating emotional boundaries, relational norms, and their own countertransference challenged at least six of the student psychotherapists in ways that caused them to question fundamental beliefs about themselves and their life experiences prior to clinical training. Examples of these narratives are shown in Table 1.

Table 1

*Student Comments about Emotion in Pseudo Sessions*

Participant Pseudonym	Quotation
Melanie	I thought there was some defect in me. I really felt like I was missing something or didn’t have compassion. I must be defective in that way, that I have no empathy or compassion.
Trevor	...when I am alone with God, I am very expressive of my emotions, but with other people I don’t. I mean to be able to cry with someone? It’s like I’ve always wanted that, just like so many things in my life that I wanted to be able to do and haven’t been able to do. And so it made me worried, like in therapy, especially learning Rogerian, and sitting with negative affect with people. Some part of me yearned to experience that. Honestly, I had this thought, like, “If I can’t do that, then therapy’s going to be horrible, and I’ll never have clients who are able to do that.”
Elissa	I’ve been surprised because I thought I could hold emotion and negative emotion, but I had a really hard time digging for it. I didn’t want to make people uncomfortable. I didn’t want to make myself uncomfortable. ...I kind of want to be the – you know, jump on the cheerleading type wagon, “You’re doing great. You’re doing great. Yep, these things are hard, but you’re going to be awesome. We’re good.”
Tina	I see people hurting, and I’m like, “This can’t be. We can’t do this. We gotta’ fix it.”

Performance anxieties kept some students from fully engaging in the emotionality of psychotherapy. Melanie, also mentioned in the *Performance* discussion, explained how program reassurances helped her move past those constant fears of failure so that she could give her clients “their space” and be emotionally available for them, “Once I realized they are here to train us, I think that was the turning point.” As she relaxed, surprising things started to happen in the room, “I was taken off guard the first time they cried. I was like, whoa, this is huge.” Elissa, also included in the *Performance* theme, realized that her discomfort with emotion was getting in the way of taking on the psychotherapist’s role,

Ok, well, *you* feel uncomfortable. What is that coming from? That may be coming from you and not the client. They may not be going there because *you’re* not taking them there. And you’re not willing to go there. You think you are, but you aren’t.

At least three of the student psychotherapists came to understand their discomfort with emotion in light of family roles and rules. One tended to take on the more familiar, more comfortable “big sister” role with clients, and in this way, she found herself colluding with her clients’ own defenses against negative affect. Another student recognized how much vulnerability and struggle were discouraged in her family system, while anger and defense were more common means of relating: “I just always jumped to anger before I jumped to what I was actually feeling.” In a clinical setting, exploring negative affect felt threatening, or even unnecessary, and when initial humor was not enough, she moved into a familiar “fix-it” mode. Finally, the third student came to recognize that fulfilling certain family roles might have trumped being “completely real,” even with her family. Moving into the intimate role of psychotherapist and focusing on congruency and authenticity highlighted what she felt were “holes and gaps” in her relationship experiences, “And there’s this uncomfortable-ness that

comes with this, ‘Wow, you’re seeing me, just for me, without all this added stuff.’ And, um, I love it and hate it.”

## **Chapter 4**

### **Implications**

#### **Theoretical Implications**

**Coherence.** Narrative researchers frequently assume that coherence is a quality of beneficial narratives, and some empirical evidence appears to support that position. High levels of coherence are associated with positive outcomes (Adler, 2012; Adler & McAdams, 2007), and temporal coherence, in particular, has often been touted as the hallmark or essential feature for useful narratives (Habermas & Bluck, 2000; Ribeiro, Bento, Gonçalves & Salgado, 2010).

Some narrative authors, however, challenge these assumptions about cohesion. Freeman proposes an alternative to the potential binary paradigm of order versus meaninglessness: perhaps it is possible to move away from the “unity-harmony-closure equation” while still retaining the “sense-making binding function” served by narrative (Hyvärinen, Hydén, Saarenheimo, Tamboukou & Freeman, 2010, p. 171). To some degree, the design of this study artificially imposed temporal coherence. That is, the training cycle with simulated psychotherapy clients began and ended on a fixed schedule. Students received feedback according to pre-set, course timelines, and a uniform set of reflection questions were answered after each session. However, even with this imposed temporal frame, ending coherence and temporal coherence scores were relatively weak in two of the eight coded narratives, even though narrative identity shifts occurred. Perhaps these cohesion scores speak into the cohesion construct debate.

**Master narratives and focused contexts of training.** Master narratives, or cultural concepts of biography, are generally thought of as analogous to course descriptions. They are

normative routes of development as laid out in a particular cultural context (Adler, 2012).

Through master narratives, cultures provide a widely accepted “menu of themes, images, and plots for the psychosocial construction of narrative identity” (McAdams & Pals, 2006, p. 8), but what happens when master narratives interact with narrative identities in focused, developmental settings, like clinical training programs? Clinical training programs are not cultural vacuums. They are, however, places where culturally imposed, master narratives may be challenged, even as narrative identity formation is strongly encouraged.

To enter into most doctoral programs, students are asked about meaning making and narrative identity. *What has led them to psychology and an interest in clinical training? How will a doctoral program contribute to the future they desire?* There are implicit and explicit expectations, however, that narrative shift will occur within the context of training.

Doctoral programs encourage students to gain clinical skills *and* construct professional and therapeutic identities as they move through an educational sequence. Programs work hard to shape effective clinicians and, in doing so, they arguably craft and communicate specific, contextual narratives for development, which may or may not be in line with the broader cultural norms. Just as master narratives may broaden or limit, support or suppress various identity paths for individuals (Adler & McAdams, 2007), the master professional narratives may encourage or discourage identity options within the given professional frame. Accreditation organizations, credentialing bodies, and curriculum sequences exist within cultural contexts, yet they seek to establish their own normative routes, their own “menu of themes, images, and plots” as guidelines for a particular profession. Training programs work hard to order a specific path of normative development, but these professionally oriented narratives are not well addressed in the narrative literature. Additional studies are needed to understand how narratives shift throughout

training programs in health service psychology and related fields, and whether these narratives vary substantially from one training program to another. Similarly, it might be useful to study professional master narratives and narrative identity shifts in a wide range of professional training contexts, such as military and paramilitary programs, medical school, seminary, or athletic training.

### **Training Implications**

Clinical training programs, as outlined by competency sequences and professional ethics, hope to encourage change beyond the level of characteristic (contextual) adaptation. The term *professional identity* is widely used for a reason. Doctoral programs hope to impress ways of being and thinking on students that will last past the immediate context and will continue to impact graduates even when supervisors and ethics boards are not in the immediate vicinity. Reflective practice and self-awareness, including a willingness to employ basic mindfulness and consider one's own material, are included in the foundational competencies for professional training (Fouad et al., 2009); accrediting bodies are aware of the importance of narrative but have struggled to capture the professional narrative in a way that can be easily assessed or researched. Arguably, clinical training programs want to impact students at the meaning making, narrative identity level, and, ideally, training occurs where the professional master narrative and the individual's ever-developing narrative identity intersect.

Narrative research has long argued that narrative meaning making is collaborative and must be understood in a social context (Pasupathi, 2001). While prescribed competency markers, course sequences and practica outline the broad, normative course of development in any training program, the narrative identity shifts in this study were also all directly related to dialogue and collaborative meaning making that accounted for the student's narrative identity

*and* the intersecting professional master narrative in their clinical training context. Students moved toward the competencies (performing change IMs) when their training experiences promoted reflection and reconceptualization of self (reconceptualization or protest IMs) in dialogue with others who shared the contextual, professional narrative. Though doctoral training programs of varying sizes may face differing challenges when it comes to helping students integrate personal and professional narratives, Aponte and Kissil's work (2014) suggests that this aspect of training may be crucial, as it seems to directly benefit clients through the nature of parallel process.

### **Research Implications**

**Innovative moments.** Using IMs as markers for clinical training, intentionally intervening and collaborating where students find their narrative identities intersecting with the professional master narrative, may have several advantages for clinical training programs. For years, doctoral programs have been moving toward competency-assessment based models that satisfy accreditation demands (American Psychological Association, 2013; Kamen, Veilleux, Bangen, VanderVeen, & Klonoff, 2010). While competency markers provide a broad course or pattern for change, they often struggle to fully address the mechanisms of change. Focusing on IMs in clinical training may be a way to help students and trainers navigate the professional master narrative in tailored, effective ways. Supportive IM targeting would openly encourage diversity and multicultural awareness. Common themes or domains of challenge might be anticipated, even while specific points of intersection might be addressed as they occur, in whatever order that might be. The recurring question would be: how will you, given all you know about yourself and all that you hope to be (your narrative identity), intersect with this master professional narrative? Interventions might be uniquely fit to the type or degree of

challenge any particular identity shift entails, and the student's ability to engage in the process, when well supported, would seem to be a valid marker of responsiveness to training.

This is the first study to explore innovative moments and narrative identity shifts that occur as part of clinical training, and this study only coded for reconceptualization and performing change IMs, as these are the IMs most closely associated with positive outcomes in psychotherapy (Ribeiro et al., 2011). It should be noted, however, that reconceptualization and performing change IMs generally occur in the middle and later stages of clinical work (Ribeiro et al., 2011). What about points of intervention that may be significant even earlier in the training process? *Action*, *reflection*, and *protest* IMs, which tend to occur earlier in therapy and recycle until a reconceptualization IM forms (if that happens), may also be worth attending to as part of clinical training and supervision. Repeatedly, the raters in this study encountered these other IM forms, including protest IMs, where students were moving away from one way of understanding self without yet replacing that strand of narrative identity, and it seems that these protest windows might also be critical moments for supervision intervention or program scaffolding. Subsequent researchers may want to examine all five types of IMs as they relate to clinical training.

The IM coding system, developed by Gonçalves, Ribeiro, Mendes, Matos, & Santos (2011) for use in psychotherapy research was used in later studies (Gonçalves et al., 2012), but this is the first attempt to apply their coding criteria to IMs that might occur outside of psychotherapy. The interview narratives may not have fully captured data necessary for IM discrimination in the same way that psychotherapy might provide, and though the raters attempted to be true to the coding descriptions provided by Gonçalves et al. (2012), it is important to note that the coding may not be completely consistent with their original IM work.

Even with these limitations, the findings of this study seem to suggest that using IM constructs to study narrative shifts outside of psychotherapy might have practical and theoretical benefit.

Researchers will likely need to adapt and refine the methodologies, but it appears that the attempts might be worth the effort.

**Diversity and experience.** If future researchers want to understand narrative shifts in relation to training, varying levels of expertise and a range of diversity markers among raters may be critical. The coding triad in this study found that their cultural and racial differences, gender and linguistic differences, differences in socioeconomic background, and differences in experience and educational levels all played important roles while working with these narratives, particularly when trying to understand the innovative moments. While individual raters were often stumped by layered meanings or nuanced language – particularly involving profound shifts in cultural or racial identity – other members of the group were often able to offer insight from their own perspectives and experience. In the same way that purely quantitative methods might never have caught the wealth of data that the narrative interviews provided, a less diverse group of raters might have missed much of its significance.

## **Conclusion**

The results of this study suggest that narrative identity shifts not only occur in clinical training, but that they occur early, are observable, and offer significant opportunities for intervention by trainers and students alike. This appears to be an opportune area for research and for training development. If doctoral programs can find ways to understand and track innovative moments in the training of novice clinicians, perhaps they can even more effectively scaffold and leverage these moments of significant change, enhancing skill development and the growing sense of professional identity which they hope to inspire.

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## Appendix A

## Curriculum Vitae

**D. Michelle Satterlee**

422 N. Meridian – GFU V316 – Newberg, OR 97132  
 (971) 400-9933 – satterleemichelle@gmail.com

***Education***


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2011-2013	<b>Master of Arts in Clinical Psychology</b> George Fox University, Newberg, OR
1999-2001	<b>Master of Arts in Counseling</b> MidAmerica Nazarene University, Olathe, KS
1992-1996	<b>Bachelors of Arts in Communications/Public Relations &amp; English Literature, Minor in Psychology, <i>Summa cum laude</i></b> MidAmerica Nazarene University, Olathe, KS

***Clinical Experience***


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Aug 2014 - Present	<b>Health and Counseling Center, George Fox University, Newberg, OR</b> <b>Title:</b> Student Therapist <b>Treatment Setting:</b> University Counseling Center <b>Supervisor:</b> Dr. William Buhrow, Psy.D. – 503-554-2340 <ul style="list-style-type: none"> <li>• Intelligence, Learning Disability, Risk, and Personality Assessments</li> <li>• Individual Counseling</li> </ul>
2013 - 2014	<b>Evergreen Clinical, Portland, OR</b> <b>Title:</b> Practicum Student Therapist <b>Treatment Setting:</b> Private Practice, ACT-based <b>Supervisor:</b> Brian Goff, Ph.D. – 503-236-6218 <ul style="list-style-type: none"> <li>• Provide low-cost, weekly, ACT-based therapy for individuals and couples.</li> </ul>
2013 - 2014	<b>Behavioral Health Crisis Consultation Team</b> <ul style="list-style-type: none"> <li>• Providence Newberg Medical Center , Newberg, OR</li> <li>• Willamette Valley Medical Center, McMinnville, OR</li> </ul>

**Treatment Setting:** Hospitals

**Title:** Behavioral Health Intern, QMHP

**Supervisors:** William Buhrow, Psy.D., Joel Gregor, Psy.D., & Mary Peterson, Ph.D, ABPP

- Conduct risk assessments, cognitive evaluations, and other assessments of patients of varying age, gender, sexual orientation, ethnicity, and socioeconomic status for the Emergency Department, Intensive Care Unit, and Medical/Surgical Unit at local hospitals.
- Consult with physicians and other staff, provide recommendations regarding patient risk and discharge plan, document evaluations in electronic medical charts, and coordinate resources with county mental health employees.

2012 - 2013

**George Fox University Behavioral Health Clinic,** Newberg, OR

**Title:** Practicum Student Therapist & Management Student

**Treatment Setting:** Low-Cost Community Health Clinic

**Supervisor:** Joel Gregor, Psy.D. – 503-554-2368

- Provide weekly therapy in a solution-focused model for low income and uninsured community members. Work with individuals, couples, families, and children. Plan and facilitate an 8-week skills class. Conduct intake interviews, develop treatment plans, write formal reports, and conduct assessments.
- Conduct semester chart reviews for 6 practicum students and 4 interns. Perform administrative duties and assist in program development.

2000-2002

**Community Counseling Center,** Grace Church, Overland Park, KS and **Rose Brooks Domestic Shelter & Outreach Counseling Center,** Kansas City, MO (Summer 2000)

**Title:** M.A. Therapist Intern

**Treatment Setting:** Community Counseling Center

**Supervisor:** Cayla Bland, Ph.D., LCPC, LCMFT

- Serve families, couples, and individuals in short-term therapy. Work independently and with a co-therapist.

**Treatment Setting:** Domestic Violence Shelter & Outreach Center

**Supervisor:** Cayla Bland, Ph.D., LCPC, LCMFT

- Assist with children's groups, parent groups, DV groups and children's residential activities. Completed intakes for women admitted to emergency shelter.

- Provide individual counseling for children and adults in an outreach location.

### *Additional Clinical Experience*

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- 2003-2011      **European Nazarene College**, Büsingen, Germany  
**Title:** College Counselor, Dean of Students  
**Treatment Setting:** International Residential College Campus
- Serve multi-site college community (student, faculty, and staff) through basic risk and personality assessments, consultation services, and short-term counseling for individuals, groups, couples, and some children. Network with physicians and psychiatrists in region for referrals.

### *Research Experience*

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- 2013-2015      **Doctoral Dissertation**  
*Narrative identity development for novice therapists in clinical training.*
- The purpose of this study was to explore narrative identity processes that impact therapists in early training.
  - **Current Status:** Data analysis; anticipating defense in March/April 2014.
  - **Committee Chair:** Mark McMinn, Ph.D.
- 2011-2015      **Research Vertical Teams**  
Meet twice monthly to discuss, collaborate, and evaluate the design, methodology, and progress of research projects
- Jan 2012 – June 2014
    - Team Emphasis: Diversity and process-oriented learning
    - Faculty Advisor: Carlos Taloyo, Ph.D.
  - July 2014 – Graduation
    - Team Emphasis: Integration and qualitative research
    - Faculty Advisor: Mark McMinn
- 2013-2014      **Richter Scholar Program Grant Recipient**
- Awarded an independent research grant from a national grant fund to conduct dissertation research investigating the narrative identity processes of novices during early clinical training.

2013

**Poster Presentations**

- Snider, J., Gregor, J., Satterlee, M., & Payne, T. *Effects of strength-based feedback at intake on therapy outcome measures*. Poster session presented at the American Psychological Association Convention, 2013.
- Taloyo, C., Payne, T., Satterlee, M., & Nelson, A. *The real relationship in training pre-practicum students*. Poster session presented at the Midwinter Conference of the National Council of Schools and Programs of Professional Psychology, Nassau, Bahamas, 2013.

1998-1999

**Jackson Foundation**, Rockville, MD

*Full-Time Psychometric Research Assistant for VBIP project, USDB, Leavenworth, KS*

- Interview and test military inmates, collecting data for the Violence and Brain Injury Project, a collaborative endeavor between the National Head Injury Foundation and the Department of Defense.
- Conduct file reviews, administer and score a wide battery of neuropsychological tests and assessments to inmates, secure inmate cooperation and participation, and maintain custody and control of inmates as per the regulations of the disciplinary barracks.

***Additional Professional Training and Education***

June 2014

**Northwest Psychological Assessment Conference**

WISC-V: Overview and Demonstration of the Upcoming Revision

**Presenter:** *Patrick Moran, PhD*

Woodcock-Johnson-IV: A New Era of Assessment and Interpretation

**Presenter:** *Stephanie Rodriguez, Ed.S.*

Assessing Therapeutic Outcome: Improving Your Effectiveness (and Satisfaction?) in Clinical Practice

**Presenter:** *Carlos Taloyo, PhD*

November 2013

**African American History, Culture and Addictions & Mental Health Treatment**

**Presenters:** *Danette C. Haynes, LCSW and Marcus Sharpe, Psy.D.*

- March 2013                    **ACT Boot Camp**, Reno, NV  
*Presenters: Steven C. Hayes, Robyn Walser, Louise Hayes, Louise McHugh, Matthieu and Jennifer Villatte, Jason Luoma and Jenna LeJeune*
- November 2012                **Sexual Identity**  
*Erika Tan, Psy.D.*

### *Assessments Administered*

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16 Personality Factors Questionnaire (16PF)  
 Millon Clinical Multiaxial Inventory-III (MCMI-III)  
 Clinical Multiaxial Inventory-III (MCMI-III)  
 Go-No-Go Response  
 Mini-Mental State Examination (MMSE) and 2<sup>nd</sup> Edition (MMSE-II)  
 Minnesota Multiphasic Personality Inventory-II (MMPI-II)  
 Minnesota Multiphasic Personality Inventory-II, Restructured Format (MMPI-II-RF)  
 Peabody Picture Vocabulary Test, Fourth Edition (PPVT-IV)  
 Personality Assessment Inventory (PAI)  
 Stroop (computer administration)  
 Test of Variable Attention (TOVA)  
 Tower of Hanoi  
 Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)  
 Wechsler Individual Achievement Test, Third Edition (WIAT-III)  
 Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV)  
 Wide Range Assessment of Memory and Learning, Second Edition (WRAML-II)  
 Wide Range Achievement Test, Fourth Edition (WRAT-IV)  
 Wide Range Intelligence Test (WRIT)  
 Wisconsin Card Sort, Double Stack  
 Woodcock-Johnson III Achievement

### *Related Teaching & University Experience*

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- 2014-2015                    **Clinical Foundations Teaching Assistant**  
*George Fox University Graduate Department of Clinical Psychology*
- Supervise and teach 1<sup>st</sup> year PsyD students basic client-centered therapy concepts and skills, lead weekly small groups to facilitate skill development, evaluate therapy video submissions and provide feedback on student papers.

- Receive weekly group supervision with five other teaching assistants to facilitate supervision skills.
- **Supervisor:** Glenna Anderws, Ph.D.

2012 – 2015

**Theories of Personality and Psychotherapy Teaching Assistant***George Fox University Graduate Department of Clinical Psychology*

- Assist with preparation of course materials, course design, and grading. Guest lecture. Prepare weekly tutoring session and supplementary course materials. Mentor successor.
- **Supervisor:** Winston Seegobin, Psy.D.

Spring 2012

**General Psychology Adjunct Faculty***George Fox University Undergraduate Department of Psychology*

- Full responsibility for an undergraduate section of Gen. Psych.

2003-2013

**Faculty Member and Dean of Students***European Nazarene College, Buesingen, Germany*

- *Dean of Students, 2003-2011*
- *Member of Curriculum Committee, 2003-2013*
  - Cohort chair, Social Sciences course cluster
  - Faculty member, Ministry Specialties course cluster
  - Assist with the development of outcome assessment measures.
  - Assist with faculty development.
- *Lecturer, 2003-2013*

Develop and teach a variety of courses in multiple countries and in multiple contexts (traditional classroom, online, mixed).

  - Abnormal Psychology (directed studies)
  - Cultural Anthropology
  - Human Growth & Development
  - Introduction to College Studies
  - Language & Written Expression
  - Ministry Integration
  - Pastoral Care & Counseling
  - Research Methodology
  - Vocation & Personal Ministry

1999 – 2003

**Resident Educator and Adjunct Instructor**

*MidAmerica Nazarene University, Olathe, KS*

- *Resident Educator, Student Development, 1999-2003*
- *Adjunct Instructor, Behavioral Sciences, 2002-2003*
  - *Human Growth & Development, 2002-2003*
  - *Microcounseling, 2002-2003*

1996 – 1998

**Church of the Nazarene, Bucharest, Romania**

- *Teacher and Program Director for English as a Foreign Language, Volunteer*

***Professional References***

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**Dr. William Buhrow, Psy.D.**

Supervisor, Health and Counseling Center, George Fox University

E-mail: [bbuhrow@georgefox.edu](mailto:bbuhrow@georgefox.edu)

Telephone: 503:554:2340

**Dr. Brian Goff, Ph.D.**

Supervisor, Evergreen Clinical

E-mail: [briangoffphd@me.com](mailto:briangoffphd@me.com)

Telephone: 503-236-6218

**Dr. Carlos Taloyo, Psy.D.**

Assistant Professor of Clinical Psychology and Director of Clinical Training

E-mail: [ctaloyo@georgefox.edu](mailto:ctaloyo@georgefox.edu)

Telephone: 503-554-2383

**Dr. Winston Seegobin, Psy.D.**

Director of Diversity and Associate Professor of Clinical Psychology

E-mail: [wseegobin@georgefox.edu](mailto:wseegobin@georgefox.edu)

Telephone: 503-554-2381

**Dr. Joel Gregor, Psy.D.**

Director, George Fox University Behavioral Health Clinic

E-mail: [jogregor@georgefox.edu](mailto:jogregor@georgefox.edu)

Telephone: 503-554-2368