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Evaluating Professional Clinical Competency Development in Doctor of Psychology Students Using Multiple Methods of Evaluation: Peer, Supervisor, and Self-Assessment

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Abstract

The United States is currently facing a shortage of mental-health providers that affects 160 million Americans. The need to empower the health system with appropriately knowledgeable, skilled, and diversely aware people mental-health practitioners is a critical necessity for current and future healthcare needs. This study aims to validate the importance of multiple methods of evaluation (self, peer, supervisor) in competency-based training of clinical psychologists. Multiple methods of evaluation offer unique contributions to competency-based education, including providing a scaffolding for building confidence and progressive alignment of evaluation of self with supervisor evaluation. Over time, students were able to better align with supervisor evaluation of strengths and weaknesses and core training competencies, while peers played an important role in scaffolding confidence. Multimodal evaluations facilitated improved self-assessment in growing clinicians' education—an important developmental competency.

Keywords: clinical psychology, competencies, training, multimodal evaluation, multiple methods of evaluation

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Chapter 1

According to the 2021 National Survey on Drug Use and Health —which provides comprehensive statistics on substance use, mental health and treatment in the U.S.—less than half of Americans with a mental-health need were able to access care; Americans with substance abuse issues have even less access to care (Substance Abuse and Mental Health Services Administration, 2023). As of March 2023, regional mental-health shortages affect 160 million Americans, with an estimated 8,000 mental-health provider deficit to meet the current mental-health needs of the population (Health Resources and Services Administration, 2024). The need to empower the healthcare system with appropriately knowledgeable, skilled, and diversely aware providers is a necessity for the current and future needs of the U.S. According to the current presidential administration, the youth of the U.S. are facing an unprecedented mental-health crisis—critical before the pandemic, escalations in care needs will exceed the currently projected deficits in access to mental-health services (US Department of Education, 2022).

Mental-Health Workforce

The mental-health workforce is composed of a broad array of professionals, ranging from lay, peer, and volunteer support professionals to licensed clinical professionals. The licensed professional workforce possesses a broad range of licenses and certifications, ranging from the associates degree level (e.g., certified drug and alcohol counselors), to the doctoral degree level (e.g., medical doctors, psychologists), each with a respective scope of practice. According to the National Alliance on Mental Illness (2020), the scopes of these practices range from the

provision of care coordination, counseling and therapy (clinical counselors and social workers); to assessment and therapy (psychologists); to prescribing authority for a range of medical interventions for mental health (psychiatric mental-health nurse practitioners, medical doctors, and primary care providers). Each license has foundational educational requirements, practical application requirements, and a series of accredited competency benchmarks that they must meet to enter the field.

In addition to the foundational knowledge, application, and competency benchmarks, the current world expects their mental-health caregivers to be trustworthy and humble. Experts must develop health care empathetically and collaboratively, acknowledging the value of unique patient needs while embracing evidence-based practices for the patient's overall well-being (Tadele & Amde, 2019). This need necessitates the ability to relate and engage in self-reflective and adaptive practice models. As stated above, the demand for care currently exceeds the available trained, licensed professionals (Drapeau et al., 2018; Wafula et al., 2023). Training these professionals to practice in a diverse world requires acknowledging cultural uniqueness and individuality. Self-reflective practice is essential to develop this understanding (Drapeau et al., 2018; Horgan et al., 2009; Ismayilova et al., 2018; Tadele & Amde, 2019; Torres et al., 2020). This paper specifically homes in on the need for mental-health professionals, and their mandatory requirement of expertise in knowledge, skill, and execution of services.

Torres et al. (2020) acknowledged the wealth of evidence-based treatments that work to improve quality of life. These theoretical advances require doctoral-level training, which incorporates evidence-based practice with rigorous research to validate and enhance clinical approaches. Ensuring that training certifies the highest level of quality care and knowing the abilities to meet the needs of patients, particularly within their communities, is a must (Wafula et

al., 2023). Establishing competency standards creates a foundation for an educational and developmental understanding of what makes a quality, capable, comprehensive mental-health professional.

Competency Benchmarks–Quality Training That Will Translate to Clinical Practice

Competent health professionals require ongoing training to meet the community's mental-health needs. Competencies within the mental-health professional services (i.e., counselors, social workers, psychologists, psychiatrists) have many commonalities. Each discipline requires high expectations of ethical and professional behavior, with its code of ethics encompassing patient safety, privacy, social awareness, diversity awareness, advocacy, and a high standard of behavior (American Board of Professional Psychology, 2024). They encompass competency in research, assessment, case conceptualization, and interventions. Counseling, psychology, and psychiatry also incorporate supervision to continue proficient development (Council on Social Work Education, 2020; Council for Accreditation of Counseling and Related Education Programs, 2023; American Board of Psychiatry & Neurology, 2011; American Board of Professional Psychology, 2024).

Furthermore, psychology and psychiatry expand the requirements into evidence-based therapies, consultation practices, teaching abilities, and understanding and supporting management and systems. The field of psychology embraces a high emphasis on reflective practice, which develops one's curiosity and instills continued training practices throughout one's professional career (Hitzeman et al., 2020).

Achieving appropriate and expected competency levels before graduation requires an intentional approach, breaking from traditional classroom teaching (Marcus, 2017). For example, methods aimed at inspiring learning through skill development and acknowledgment of

individual abilities. Consequently, competency-based education (CBE) creates the atmosphere for this approach. Additionally, CBE requires institutions to become well-informed and establish training based on the CBE to ensure instructors and staff gain appropriate training and skills (Marcus, 2017). Developing evidence-based CBEs and establishing a well-founded point of reference that logically creates a strategy for development is necessary for knowledge retention, skill honing, and aptitude refinement.

Systematic and standardized competency-driven evaluation methods with developmental trajectories anchored in foundational and practical domains, provide an anchor for the appropriate evaluation of developmental progress (Gonsalvez & Crowe, 2018). Hitzeman et al. (2020) suggest adopting evaluation methods to produce a consistent and beneficial understanding of expectations for instructors, supervisors, supervisees, and students, specifically in the clinical psychology profession.

Programs that have adopted a CBE approach have utilized some of the following assessments to assess the developmental achievements of trainees accurately. The Accreditation Council for Graduate Medical Education formed a competency-based, scaffolded, early-to-advanced-stages-of-development evaluation called the Milestone (Verderame et al., 2018). A clinical psychology practicum competencies rating scale has been designed to offer a consistent, comprehensive, and phase-based approach to evaluating a trainee's knowledge, skills, and abilities (Hitzeman et al., 2020). The 360-degree evaluation tool has years of support and turned a vertical evaluation approach into a spherical viewpoint, providing an integrated assessment of an individual's strengths and growth areas while progressing through the early stages of training to become a licensed professional (Tyson & Ward, 2004).

This study incorporated the Competency Benchmarks in Professional Psychology, established by the American Psychological Association CBE (APA, 2011) approach, which has been well utilized (Kaslow et al., 2009). The APA benchmarks model incorporates reference points for rating student progress, aiding institutions with delivering exceptional training and encouraging well-rounded learning (Kaslow et al., 2009). The benchmarks comprise 16 core competencies within six domains, including professionalism, relational, application, science, education, and systems, with a grouping of essential components (Kaslow et al., 2009). They were additionally connected through a developmental approach. The scaffolded approach includes practicum, internship, and early professional competency expectations, known as "graduated complexity," in the APA CBE model. Each level consists of behavioral anchors developed as observable behaviors for ranking (Kaslow et al., 2009). Although standardized competency benchmarks communicate expected appropriate achievement levels to become clinical psychologists, evaluations are ultimately subjective. With subjectivity errors in mind requiring an evaluation approach that remained in competency-guided principles and continued improvement on the educational system, evaluation methods have expanded (Gonsalvez & Crowe, 2018).

Multiple Methods of Evaluation for Best Assessment of Competency in Training

Evaluations provide invaluable levels of training and direction for building upon strengths and ensuring growth to produce desired proficient outcomes. The history of evaluations aiding skills development, especially in the field of health services, has proven its importance and necessity (Cheong et al., 2023; Hitzeman et al., 2020; Liang et al., 2021; Kahnweiler, 1979). Effectively building skills and implementing training requires appropriate and accurate evaluation—specifically utilizing competency benchmarks as a standard measure of

development in ensuring student competency (Alipanga & Kohrt, 2022). Appropriate evaluation requires a level of standardizing training and developmental expectations. Accurate evaluation demands supervisor accountability, specifically to prevent the halo effect and leniency biases, which hinder accurate evaluation of student development (Gonsalvez & Crowe, 2018).

This study seeks to reduce evaluation bias and errors and present a more robust method for producing exceptionally trained clinical professionals by means of utilizing multi-method evaluations. Multi-method evaluations include individually completed assessments by two or more sources to create a more robust understanding of the question, particularly when desiring more formative evaluation. Offering different perspectives has shown loftier reliability and equality, allowing more accurate assessment and reducing incorrect assumptions and bias (Gonsalvez & Crowe, 2018; Harris & Schaubroeck, 1988; Kahnweiler, 1979; Kring et al., 2022; Odendaal et al., 2016). The study, “Multisource Feedback in Medical Students' Workplace Learning in Primary Health Care,” found that multi-leveled feedback effectively enhanced communication and clinical skill learning (Bjorklund et al., 2022). This study validated that the multi-process developed a more collaborative learning atmosphere. Instructors expressed how the feedback aided them in assessing the student's strengths and weaknesses. Intentionally encouraging self-reflection increased clinical conceptualizations and individual performances (Gonsalvez et al., 2023). Similarly, Liang et al. (2021) found that when only two methods of evaluation were used the results showed an inconsistent assessment of the trainees whereas three or more methods of evaluation increased appropriate identification of areas of growth for better trainee development. Additionally, the study showed an increase in patient satisfaction and

quality of care when multiple methods of evaluation, (trainee, peer, and supervisor) were incorporated into the hospital training (Liang et al., 2021).

Most commonly utilized—due to easy accessibility, affordability, and time efficacy—self-evaluations have been found to be subjectively limited (Liang et al., 2021). Although self-evaluations encourage multiple areas of growth alone, they have shown self-unawareness (Cheong et al., 2023). Hitzeman et al. (2020) employed the Clinical Psychology Practicum Competencies Rating Scale, a widely accepted and used tool for competency rating. They found that trainees scored themselves lower than their actual competency level. However, the study also found that trainees who under-evaluate themselves also displayed more advanced reflective abilities than their counterparts (Hitzeman et al., 2020).

Self-reflective practice has become a valuable staple in CBE in psychology trainees, including boosted career life-long development (Gonsalvez et al., 2023). Another critical aspect of self-reflection is welcoming feedback, which requires effectively incorporating given insights (Hitzeman et al., 2020). When combined with other evaluation sources, the benefits of self-evaluation increase substantially, and the shortcomings of self-evaluations find new meaning. Developing the skills to accurately acknowledge one's strengths and growth areas is essential in the mental-health profession to ensure the best client practices (Hitzeman et al., 2020). For example, self and peer observations utilize different ways of processing reflection and benefit both parties, including multiple levels of achievers (Cheong et al., 2023).

A newer instructional and efficient approach, peer assessment develops more flexible, problem-solving, and critical-thinking skills benefiting their peers and themselves (Cheong et al., 2023; Hitzeman et al., 2020). Instructional development in the skills needed to assess a peer has foundational merit (van Zundert et al., 2012). The opportunity to experience how others view

their abilities enhances individual self-image, gaining helpful insight and encouragement leading to deeper, more productive levels of learning. Moreover, peer feedback improved self-assurance and decreased imposter syndrome. Furthermore, peers' contemplation of their counterparts' experiences produces additional self-reflection, creating insights gleaned (Bjorklund et al., 2022; Cheong et al., 2023). Gonsalvez and Crowe (2018) discovered that to evaluate a peer appropriately, the evaluator needs a level of mastery of the evaluation topic. Nonetheless, even with a minimal understanding of the complex developmental stages, the benefits of peer reviews prevail, including self-reflection opportunities when assessing a peer (Bjorklund et al., 2022; Cheong et al., 2023).

Although self-assessment has been found valuable and peer review continues to increase positive growth, a third has been found for more accurate assessment and exceptional overall development (Cheong et al., 2023; Liang et al., 2021). Supervisor evaluations of trainees have been a staple approach over the years, playing a pivotal role in maintaining a high standard of care (Liang et al., 2021).

Evaluation Bias and Accuracy

Research has recognized that self-evaluators tend to underrate their abilities compared to their supervisors (Hitzeman et al., 2020; Kring et al., 2022). Kring et al. (2022) found that, due to an empathetic and close working relationship, supervisor bias and a halo effect compromised the accurate assessment of trainees. Meanwhile, Liang et al. (2021) found that supervisor ratings fell lower than self-raters. The different outcomes beg an explanation for whether higher or lower ratings from supervisors affect the developmental outcome of the trainee.

Supervisors and student ratings were most accurate when self-ratings were appropriately high (Atkins & Wood, 2002). Inversely, when self-ratings were low due to the early

development stage of training rather than their ability, supervisors underrated the students' overall performance. Although important, supervisors' evaluations of the trainees were found to be less accurate, especially in relation to moderate trainees or those with a fear of negative feedback (Gonsalvez & Crow, 2018). Fortunately, studies have proven no difference in whether supervisor ratings range higher or lower than the trainee in clinical development. Studies show that supervisor, peer, and self assessment accelerate positive clinical development (Cheong et al., 2023; Hitzeman et al., 2020; Liang et al., 2021). Remarkably, supervision incorporating observational techniques (e.g., in vivo or delayed feedback, role play) has been found to be most developmentally effective and decreased the gap in self and supervisor evaluation scores (Hitzeman et al., 2020). Moreover, observational methods utilized by supervisors facilitate more reliable, insightful self-assessment (Falender & Shafranske, 2017; Hill et al., 2016).

Additional studies have shown that multimodal evaluation initiates more accurate evaluations of trainees and reduces the effects of trainee and supervisor bias, giving a more accurate assessment of the trainee's abilities (Gonsalvez & Crowe, 2018; Harris & Schaubroeck, 1988; Kahnweiler, 1979; Kring et al., 2022), and increases trainee and peer self-reflection, which empowers individual growth (Bjorklund et al., 2022; Kahnweiler, 1979; van Zundert et al., 2012). Multimodal evaluations increase professional competency development and create a more well-rounded mental-health professional, instilling practices and skills for ongoing career development (Gonsalvez et al., 2023; Hitzeman et al., 2020).

Purpose of This Study

Through an evidence-based approach, the resolve of this study aims to validate support for multiple methods of evaluating students to facilitate their developmental growth in becoming exceptionally competent clinical psychologists. The following questions guide this study and

include the students', peers', and teacher's assistants' experiences utilizing multiple methods of evaluation based on competency benchmarks (Kaslow et al., 2009). Multiple methods of evaluation increase the overall training outcome by producing a more accurate evaluation, increasing self-awareness, attaining confidence in strengths and the motivation for growth (Bjorklund et al., 2022; Cheong et al., 2023; Gonsalvez & Crow, 2018; Hitzeman et al., 2020; Liang et al., 2021; Kahnweiler, 1979; van Zundert et al., 2012).

This Study

For this study, multiple evaluation methods were utilized to evaluate the professional clinical competency development of psychology students, including a self, peer, and supervisor assessment. The trainee and peer participants in this study were comprised of 1st-year graduate students, and the supervisors were composed of 4th-year graduate teacher assistants (TAs) for the clinical foundations class. These TAs engaged in layered supervision with a licensed psychologist who oversaw their training and clinical formation of 1st-year students. The self-assessment included a short answer self-report evaluation, using the competency-based APA benchmarks model and querying to recognize three areas of strength and growth (Kaslow et al., 2009). The peers and TAs gave trainees a numerical score based on the same benchmark model. Additionally, the TAs had opportunities to watch the students practice their skills through video observation and give them feedback, including their strengths and growth areas.

The hypotheses for this study are as follows:

1. Students will learn to rate themselves more accurately with time, as evidenced by greater alignment of self-ratings with those of TA supervisors in the second semester of a year-long training condition.

2. Based on available research, this study proposes that students will have greater alignment in self-ratings with peers than TA supervisors, especially earlier in training (first semester).

3. This study proposes there will be a difference between how students rate themselves, how their peers rate them, and how their TAs rate them, and that these ratings will demonstrate regression to central tendency over time.

Chapter 2

Methods

Participants

The participants in the study were doctoral clinical psychology students in an APA accredited doctoral psychology program in the Northwest region of the U.S.

Inclusion Criteria

Participants included were clinical psychology 1st-year students during their fall and spring semesters and advanced supervising teaching assistants in layered supervision during their fall and spring semesters.

Consent and Ethical Approval

Archival data was used for this study. To protect participants, all participant identifiable information was removed from the data. Participants gave written/electronic informed consent for research and data purposes. The Institutional Review Board granted permission for this study on January 16, 2024.

Study Design

The study data was collected during a 1-year, 2-semester clinical foundational training sequence. Each participant completed evaluations during the fall (pre) and spring (post) semesters using self, peer, and teacher-assistant evaluations. Multiple evaluation methods, including an open-ended questionnaire and a 5-point Likert scale, were employed. Utilizing a qualitative evaluation incorporating the competency-based APA benchmark model, 1st-year graduate-level clinical psychology students were given a self-report questionnaire asking their perceived view of their three top strengths and three areas of growth (Kaslow et al., 2009). The

competency benchmarks included in the questionnaire, appropriate for 1st-year clinical psychology graduate students, included professional values and attitudes, individual and cultural diversity, ethical legal standards and policy, reflective practice/self-assessment/self-care, relationships, scientific knowledge and methods, research/evaluation, evidence-based practice, intervention, supervision, and interdisciplinary systems.

A quantitative evaluation questionnaire was utilized by 1st-year graduate-level clinical psychology peers and 4th-year clinical psychology teacher assistants who then rated students on a 5-point Likert scale ranging from 1 (*poor*) to 5 (*excellent*) and the questions were based on the APA benchmarks model (Kaslow, et al., 2009).

The initial data analytics included demographics and trends (e.g., ages, ethnicity, gender identity, social economic status [SES]), assessing correlations, and regression. This study used frequency distribution and paired sample *t*-test to compare evaluation result similarities and differences of self, peers', and TAs' assessment ratings. A paired sample *t*-test was done to average the scores the peers and the TAs gave and to show any differences in rating between the first evaluation in the fall and the second evaluation in the spring.

The Student Evaluation Questionnaire Fall Semester–Qualitative (Appendix A)

Given to the students in the fall (pre), a qualitative, written self-reflection questionnaire encouraged a deeper understanding of their experience, and asked seven questions. The first three questions asked the students to identify three APA benchmark competency strengths they believe they embraced (Appendix C). The following three inquired about which APA benchmark competencies they believe were an area of growth for themselves (Appendix C). Lastly, students were asked how they intended to grow and develop throughout the year.

The Student Evaluation Questionnaire Spring Semester–Qualitative (Appendix B)

During the spring (post), students were given the qualitative self-reflective questionnaire based on the APA benchmarks competencies asking students to distinguish their perceived top three strengths and areas of growth (Appendix C). The third area of growth question included how they plan to incorporate the feedback for their continued developmental growth.

The Peer and Teacher Assistant Evaluation Questionnaire–Quantitative (Appendix D)

Both the peer and TA evaluation questionnaires used APA benchmark competency for professional psychology, specifically related to 1st-year clinical psychology training. The evaluation questionnaire was given in the fall (pre) and in the spring (post). The evaluation included the following categories: five professional values and attitudes, five individual and cultural diversity, three reflective practice/self-assessment/self-care, three relationships, one evidence-based practice, two interventions, three supervision, and two interdisciplinary systems focused questions. The feed-back scores included 1 (*poor*), 2 (*fair*), 3 (*good*); 4 (*very good*); and 5 (*excellent*).

Chapter 3

Results

As shown in Table 1, the groupings of the 34 participants included 27 students/peers (79%) and 7 TAs (21%). The participants had a mean age of 26.3 ± 5.6 years. The participants were composed of women, 26 (76%), and men, 8 (24%). Participant characteristics included age 26.3 ± 5.6 years, sex assigned at birth (76% female, 24% male), sexual orientation (92% heterosexual, 6% bisexual, 3% queer), race/ethnicity (74% White, 12% Asian, 9% Latinae, 6% Black/African, Hispanic [6% “yes,” 94% “no”]), highest level of education (76% bachelor's degree, 24% master’s degree), previous clinical experience (62%” no,” 38% “yes”), SES–economically disadvantaged (47% “no,” 21% “yes,” 12% declined to state, 21% not included), and disability–disability access service accommodations (76% “no,” 24% “yes”).

Table 1

Sociodemographic Characteristics of Participants (*N* = 34)

Characteristic	Student/peer (*n* = 27)		TA (*n* = 7)		Total (*n* = 34)	
	n	%	*n*	%	*n*	%
Age (*M* ± *SD* = 26.3 ± 5.6)	21–47		24–35		21–47	
Sex assigned at birth						
Female	20	74	6	86	26	76
Male	7	26	1	%	8	24
Sexual orientation						
Heterosexual	24	89	6	86	31	92
Gay	0	0	0	0	0	0
Bisexual	3	11	0	0	2	6
Queer	0	0	1	14	1	3
Race and ethnicity						
White	21	78	5	72	25	74
Asian	3	11	1	14	4	12
Latinae	2	7	0	0	3	9
Indigenous	0	0	0	0	0	0
Black/African	1	4	1	14	2	6
Multiracial	0	0	0	0	0	0
Hispanic						
No	25	93	7	100	32	94
Yes	2	7	0	0	2	6
Highest level of education						
Bachelor's degree	26	96	0	0	26	76
Master's degree	1	4	7	100	8	24
Previous clinical experience						
No	21	78	0	0	21	62
Yes	6	22	7	100	13	38
SES–economically disadvantaged						
No	16	59	NA	NA	16	47
Yes	7	26	NA	NA	7	21
Declined to state	4	15	NA	NA	4	12
Not included	0	0	NA	NA	7	21
Disability–DAS accommodations						
No	20	74	6	86	26	76
Yes	7	26	1	14	8	24

Note. TA = teacher assistant; NA = not included; DAS = disability access service.

Student Self-Ratings

As shown in Table 2, student self-rating in pre-evaluations (fall semester) resulted in the following order: self-reflective practice (first), ethics and legal (second), professionalism (third), evidence-based practice/intervention (fourth), cultural competence (fifth), research/evaluation (sixth), scientific knowledge and methods (seventh), and relationships (eighth). Peer ratings in pre-evaluations (fall semester) showed professionalism, intervention, supervision, and interdisciplinary systems as the top strengths of the students and cultural competency (fifth), relationships (sixth), self-reflective practice (seventh), and evidence-based practice as lower levels of competency. Alternatively, TAs rated students, supervision (first), self-reflective practice (second), professionalism (third), and culture, relationships, evidence-based practice, intervention, and interdisciplinary systems as consistent areas of growth. In the post-evaluations (spring semester) students rated in the following order: ethics and legal (first), self-reflective practice (second), professionalism (third), cultural competence (fourth), scientific knowledge and methods (fifth), interdisciplinary systems (sixth), relationships (seventh) and they did not rate evidence-based practices, interventions, or supervision. Peers rated relationships (first), professionalism (second), cultural competence, intervention, and interdisciplinary systems (third), self-reflective practice (sixth), supervision (seventh), and evidence-based practice (eighth). TAs rated supervision (first), intervention (second), professionalism (third), culture (fourth), self-reflective practice (fifth), relationships (sixth), evidence-based practice (seventh), and interdisciplinary systems (eighth). Notably, TA ratings of students had far less variance in scores than the peers scores of students.

Table 2

Frequency Distribution Table

	Students self-rating order frequency (first, second, third)		Peers rating order frequency (first, second, third)		TA rating order frequency (first, second, third)	
Competency	Fall (pre)	Spring (post)	Fall (pre)	Spring (post)	Fall (pre)	Spring (post)
Professionalism	Third[d]	Third	First	Second	Third	*First (three)
Culture	Fifth	Fourth	Fifth	Third	Fourth	*First (four)
Ethics and legal	Second	First				
Self-reflective practice	First	Second	Seventh	Sixth	Second	*First (five)
Relationships	Eighth	Seventh	Sixth	First[t]	Fourth	*First (six)
Scientific knowledge and methods	Seventh	Fifth				
Research/evaluation	Sixth					
Evidence-based practice/intervention	Fourth		First intervention Eighth–EBP	Third intervention Eighth–EBP	Fourth / Fourth	*First(two) intervention *First (seven)
Supervision			First	Seventh	First	*First (one)
Interdisciplinary systems		Sixth	First	Third	Fourth	*First (eight)

Note. EBP = evidence-based practices.
* Same number placement with additional (number) means same average rating with highest to lowest variance

Observed five specific competency domains, professionalism, self-reflective practice, evidence-based practice/interventions and supervision Table 3 showed that students rated professionalism (63%) in the pre-evaluation (fall semester) and decreased during the post-evaluation (spring semester) (48%). In the pre-evaluation (fall semester), students rated self-reflective practice at 74% and rated lower in post-evaluations (Spring semester) to 52%. Conversely, during the pre-evaluation (fall semester), students rated evidence-based practice/intervention (33%) and increased ratings of (44%) in the post-evaluation (spring semester).

As found in Table 4, in the pre-evaluation (fall semester), the students most often rated strengths included self-reflective practice (25%), ethics and legal (23%), and professionalism (22%). Students most often rated growth areas included cultural competence (22%), ethics and legal (19%), and scientific knowledge and methods (19%). In the post-evaluation (spring semester), the students expressed their strengths in the areas of ethics and legal (19%), self-reflective practice (18%), and professionalism (17%). Students acknowledged their growth areas as scientific knowledge and methods (16%), research and evaluation (16%), ethics and legal (15%), and evidence-based practice and intervention (15%).

Considered five specific competency domains including professionalism, self-reflective practice, evidence-based practice/interventions, and supervision; results indicated that students rated professionalism at 63% in the pre-evaluation (fall semester) and decreased during the post-evaluation (spring semester, 48%). In the pre-evaluation (fall semester) the students rated self-reflective practice (74%) and their ratings decreased in the post-evaluation (spring semester) to 52%. Conversely, during the pre-evaluation (fall semester) students rated evidence-based practice/intervention (33%) and increased ratings of (44%) in the post-evaluation (spring

semester). Both pre-evaluation (fall semester) and post-evaluation (spring semester) did not rate supervision (0%) as a strength.

Table 3

Frequency Distribution Table

Competency	Pre	Post
	Strength rated %	
Professionalism	63	48
Self-reflective practice	74	52
Evidence-based practice/intervention	33	44
Supervision	0	0

Table 4

Frequency Distribution Table

Competency	Pre				Post			
	Strength frequency	%	Growth frequency	%	Strength frequency	%	Growth frequency	%
Professionalism	17	22	6	7	13	17	6	7
Culture	7	9	17	22	12	15	10	12
Ethics and legal	18	23	15	19	15	19	12	15
Self-reflective practice	20	25	7	9	14	18	4	5
Relationships	1	1	10	13	6	8	11	14
Scientific knowledge and methods	3	4	15	19	11	14	13	16
Research/evaluation	4	5	3	4	0	0	13	16
Evidence-based practice/intervention	9	11	6	7	0	0	12	15
Supervision	0	0	0	0	0	0	0	0
Interdisciplinary systems	0	0	0	0	7	9	0	0
Total frequency	79	100	79	100	78	100	81	100
Mean	7.9		7.18		7.8		8.1	
Median	5.5		6.5		9		10.5	
Mode	0		6, 15, 0		0		12, 13, 0	
Range	20		17		15		13	
Minimum	0		0		0		0	
Maximum	20		17		15		13	
Count *n*	10		10		10		10	
Interquartile	16		12		13		8	
Outliers	None		None		None		None	

Differences Among Ratings of Self-, Peers, and TAs

Paired samples *t*-tests were conducted to determine the effect of multiple methods of evaluation between peers and TAs on competency-based developmental trajectories for graduate level clinical psychology students. The paired sample *t*-tests, found in Table 5 were broken down into individual benchmarks appropriate to 1st-year clinical psychology students, peer combined and TA combined results. Table 6 reflects the combined measures (peer = Measure 1 and TA = Measure 2) results of individual benchmarks. Professional values and attitudes development results indicated a significant difference between peers scores (M = 4.029; SD = 0.49) and TA scores, M = 3.148; SD = .05; $t(45)$ = 7.820, p = -6.315. The 95% confidence interval between means ranged from [1.108 to 0.654] and indicated a significant difference between the means of samples (p = < .001). Therefore, we rejected the null hypothesis because there was a significant effect size between peers and TA ratings of students on professional values and attitudes development. Individual and cultural diversity development results indicated a significant difference between peers scores (M = 3.931; SD = .47) and TAs scores, M = 3.098; SD = .24; $t(45)$ = 7.610, p = -1.279. The 95% confidence interval of the difference between the means ranged from [1.053 to 0.612] and indicated a difference between the means of samples (p = < .001). Therefore, we rejected the null hypothesis because there was a significant effect size between peers and TA ratings of students on individual and cultural diversity development. Reflective practice, self-assessment, and self-care development results indicated a significant difference between peers scores (M = 3.819; SD = .29) and TAs scores, M = 3.152; SD = .29; $t(45)$ = 6.349, p = -9.456. The 95% confidence interval of the difference between the means ranged from [.0879 to 0.456] and indicated a difference between the means of samples (p = < .001). Therefore, we rejected the null hypothesis because there was a significant effect size

between peers and TA ratings of students on reflective practice, self-assessment, and self-care development. Relationship development results indicated a significant difference between peers scores (M = 3.944; SD = .35) and TAs scores, M = 3.173; SD = .28; t(45) = 8.270, p = -1.401. The 95% confidence interval of the difference between the means ranged from [0.958 to 0.583] and indicated a difference between the means of samples (p = < .001). Therefore, we rejected the null hypothesis because there was a significant effect size between peers and TA ratings of students on relationship development. Evidence-based practice development results indicated a significant difference between peers scores (M = 3.868; SD = .48) and TAs scores, M = 3.043; SD = .26; t(45) = 7.276, p = -3.984. The 95% confidence interval of the difference between the means ranged from [1.053 to 0.596] and indicated a difference between the means of samples (p = < .001). Therefore, we rejected the null hypothesis because there was a significant effect size between peers and TA ratings of students on evidence-based practice development. Intervention development results indicated a significant difference between peers scores (M = 3.997; SD = .42) and TA scores, M = 3.174; SD = .21; t(45) = 8.548, p = -5.566. The 95% confidence interval of the difference between the means ranged from [1.016 to 0.629] and indicated a difference between the means of samples (p = < .001). Therefore, we rejected the null hypothesis because there was a significant effect size between peers and TA ratings of students on intervention development. Supervision development results indicated a significant difference between peers scores (M = 3.910; SD = .46) and TA scores, M = 3.276; SD = .40; t(45) = 5076, p = -7.143. The 95% confidence interval of the difference between the means ranged from [0.886 to 0.383] and indicated a difference between the means of samples (p = < .001). Therefore, we rejected the null hypothesis because there was a significant effect size between peers and TA ratings of students on supervision development. Interdisciplinary systems development results

indicated a significant difference between peers scores (M = 3.934; SD = .47) and TA scores, M = 3.196; SD = .23; $t(45)$ = 6771, p = -2.233. The 95% confidence interval of the difference between the means ranged from [.0958 to 0.519] and indicated a difference between the means of samples (p = < .001). Therefore, we rejected the null hypothesis because there was a significant effect size between peers and TA ratings of students on interdisciplinary systems development. Neither peers nor TAs rated students on ethical legal standards and policy, scientific knowledge and methods, and research and evaluation benchmarks, which did not affect the outcome. As found in Figure 1, not only were there statistical differences among peers and TA scores, but peers rated students at a much higher level than the TAs. Peer ratings ranged from 3.4 to 5, whereas TA ratings ranged from 2.8 to 4.

Table 5

Paired Samples T-*Test*

Competency pre (fall semester) post (spring semester) combined	*SD*	*SE*	Two sample *t*-test	*df*	*P*-value	E	95% CI Cohen's *d*	*M* of x TA pre/post combined	*M* of y peer pre/post combined
Peer professionalism	.49	.10	7.820	45	-6.315	10	-1.108 to -0.654	3.148	4.029
TA professionalism	.24	.05							
Peer culture	.47	.10	7.610	45	-1.279	09	-1.053 to -0.612	3.098	3.931
TA culture	.24	.5							
Peer reflective	.35	.07	6.349	45	-9.456	08	-0.879 to -0.456	3.152	3.819
TA reflective	.29	.06							
Peer relationships	.35	.07	8.270	45	-1.401	10	-0.958 to -0.583	3.173	3.944
TA relationships	.28	.06							
Peer evidence-based	.48	.10	7.276	45	-3.984	09	-1.053 to -0.596	3.043	3.868
TA evidence-based	.26	.05							
Peer intervention	.42	.08	8.548	45	-5.566	11	-1.016 to -0.629	3.174	3.997
TA intervention comb	.21	.04							
Peer supervision	.46	.09	5.076	45	-7.143	06	-0.886 to -0.383	3.276	3.910
TA supervision	.40	.08							
Peer interdisciplinary	.47	.10	6.771	45	-2.233	08	-0.958 to -0.519	3.196	3.934
TA interdisciplinary	.23	.05							

Note. TA = teacher assistant.

Table 6

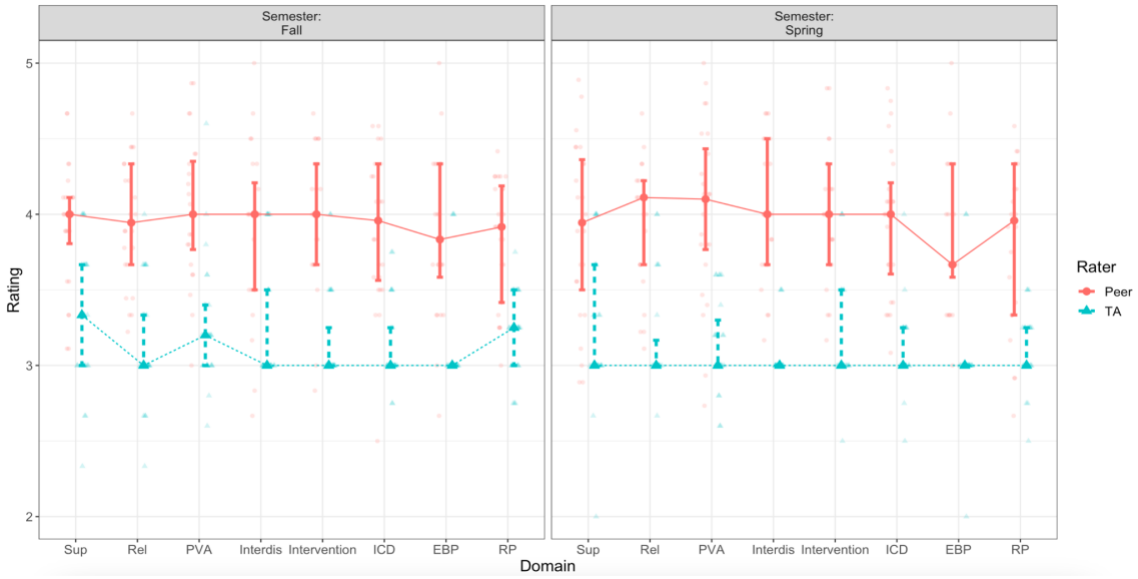
Paired Samples T-*Test*

							95% CI for Cohen's *d*	
Measure 1	Measure 2	*t*	*df*	*p*	Cohen's *d*	*SE* Cohen's *d*	Lower	Upper
Peer professionalism	TA professionalism	7.537	19	< .001	1.685	0.412	0.987	2.365
Peer culture	TA culture	7.949	19	< .001	1.778	0.404	1.057	2.480
Peer reflective	TA reflective	6.027	19	< .001	1.348	0.344	0.728	1.949
Peer relationships	TA relationships	7.806	19	< .001	1.746	0.431	1.033	2.440
Peer evidence-based	TA evidence-based	7.559	19	< .001	1.690	0.416	0.991	2.371
Peer intervention	TA intervention	8.089	19	< .001	1.809	0.436	1.080	2.519
Peer supervision	TA supervision	4.755	19	< .001	1.063	0.312	0.502	1.607
Peer interdisciplinary	TA interdisciplinary	5.687	19	< .001	1.272	0.415	0.668	1.857

Note. TA = teacher assistant.

Figure 1

Paired Sample T-*Test*



Chapter 4

Discussion

Previous research has shown conflicting findings when self-evaluations were combined with supervisor evaluations. The close working relationship between student and supervisor has been found to produce supervisor bias and a halo effect, compromising accurate assessment of students (Hitzeman et al., 2020; Kring et al., 2022). Other studies found that supervisors ratings were often lower than self-raters (Liang et al., 2021). When student self-ratings were appropriately high, demonstrating accurate self-ratings of good skill development, supervisor ratings were shown to be most accurate. When self-raters—in the early stages of development—rated their abilities lower, supervisors also rated these moderate trainees lower and less accurately (Atkins & Wood, 2002; Gonsalvez & Crow, 2018). This research showed that supervisors rate supervisees in one of three categories: (a) too highly due to supervisor bias in favor of the student, (b) in a method that highlights student ratings, or (c) consistently lower than student ratings. Studies found that when supervision incorporates observational techniques, like watching videos or observing therapy skills live, student ratings were more reliable, and self-evaluations were more insightful (Falender & Shafranske, 2017; Hill et al., 2016 Hitzeman et al., 2020).

Results from this study demonstrated findings consistent with previous research when combining peer, supervisor, and self-assessment in a multimodal evaluation. As, the paired sample *t*-test showed a significant effect size difference between peers and TA competency benchmark ratings on student evaluations. Importantly, peer ratings were consistently higher (3.4–5) than TA rating scores (2.8–4). The considerably higher peer ratings encouraged a

decrease in student imposter syndrome, whereas the meaningful lower TA ratings gave students a more impactful ability for competency building. The students then had a stronger ability for more accurate self-reflection.

This study furthered multimodal research by incorporating lateral peer review and evaluated its relationship with supervisor review. Results showed a difference in how students rated themselves, how their peers rated them, and how their TAs rated them. Peers were more complementary in evaluations; however, they were less aligned in areas of growth and weaknesses. This suggests that peers may have viewed the evaluations as a method of boosting morale and a means for providing overall encouragement, and favored this outcome over accuracy of nuanced identification of progress. TAs gave mid-range evaluation scores, consistent with developmental models (i.e., at expected levels), and the students being evaluated aligned more closely with TAs (supervisors) in their strengths and areas of growth. Peers may not be as accurate raters, yet they provided a developmental stage of training, specifically as a supportive safety net. Peer ratings may prevent students being evaluated from internalizing at the expected level or below expected level feedback as indicative of failure. Having supportive peer feedback may allow students to be more accepting of supervisor feedback. Students could self-rate more accurately and align with supervisors because they had proof that others saw them positively, so they could acknowledge growing edges more effectively. Peers were oriented toward boosting, supporting, and lifting their peers to give them a safe space, and TAs were more aligned with training, narrowing, and focusing, which created a complementary relationship. The complementary relationships between self, peer, and TAs helped students to become more temperate in their self-evaluations and acknowledge more of what they did not know in a more

accurate representation of self. The TA's mid-range scores compared to the higher scores provided by peers, positively impacted students' abilities to rate themselves better.

A unique aspect of this study was the evidence that students learned to assess themselves over time more accurately. In the pre-evaluations (fall semester) results, students, peers, and TA ratings did not fully align with student's perceived strengths and growth areas. Though in the post-evaluation (spring semester) results, students and TAs aligned more consistently, demonstrating that students developed the ability to assess themselves over time more accurately. Contributing to this outcome was the TA's mastery-level experience—greater than that of peers and students—and their use of video observation to give students direct feedback. Even though TA ratings were, on average, moderate to low, directional guidance motivated students to improve in competency domains. Peers and students had more interaction and relationship-building opportunities (e.g., classes, projects), creating interpersonal connections and positive regard toward each other. The relational dynamic encouraged higher ratings from the peers toward each other. The triangular relationships—peer, TA, self—created safety, acceptance, and contemplation which brought a balance into self-ratings.

Limitations

The author acknowledged limitations to this study, which include a limited sample size, and limited qualitative self-evaluation in comparison to quantitative peer and supervisor evaluation. Future studies will examine the same data collection standards across populations to see both qualitative and quantitative comparisons consistently coded across groups. The author also acknowledged the lack of a control group or comparison against other programs. Providing data from other clinical psychology programs utilizing competency-based training and multi-methods of evaluation may provide diverse population information and a more robust

confirmation of the developmental value of multi-modal evaluations. Demographics of the sample, while reflective of the dominant female presentation in psychology as a discipline, also lacked greater diversity markers to demonstrate a more representative population sample, so further studies should seek to include more diverse participants from race, ethnicity, SES, and able status.

Conclusions

The goal of multiple modes of evaluation is an accurate representation of strengths and areas of growth for developmental training. The ability for training mental-health professionals to understand themselves is imperative in the context of how patients, peers, and authority figures/supervisors see them. Mental health is a human services profession deeply rooted in human relationships as a mechanism of healing. Results from this study and previous studies agreed that self-reflection competency shows troubling limitations when programs only use self-report evaluations or self and supervisor-only evaluations (Bjorklund et al., 2022; Cheong et al., 2023; Hitzeman et al., 2020; Gonsalvez & Crowe, 2018; Harris & Schaubroeck, 1988; Kahnweiler, 1979; Kring et al., 2022; Liang et al., 2021). Multimodal evaluations are a more effective method of developmental measurement of competencies because peers provide a safety net to accept more difficult ratings allowing for more mid-range ratings of self and reducing the effects of imposter syndrome (van Zundert et al, 2012). Evaluations that include the complementary relationships of self, peers, and TAs showed that students more moderately and accurately evaluated themselves over time. These best-training practices aid in developing competent clinical psychologists—able to meet the increasing demand for behavioral health professionals.

There is a significant difference in how TAs and peers rated the students. The complementary relationships significantly benefit the developmental structure of training where the peers created the support network and the TAs ensured instructional development. Over time, students had even greater alignment with TAs providing an appropriate developmental growth trajectory and becoming more able to rate themselves accurately. Gaining the ability to self-assess accurately ensures strong, competent, and well-trained clinical psychologists ready to serve their patients through the highest quality of care.

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Appendix A

The Student Evaluation Questionnaire Fall Semester–Qualitative

1) Identify 3 strengths in the areas of competency detailed above. Be specific to you.

Example:

Professional Values and Attitudes - respecting the contributions of others.

- I have welcomed the feedback from my TA and my TA group in my development.

2) Identify 3 areas for growth in the areas of competency detailed above. Be specific to you.

Example:

Relationships - empathy for people who do things I don't agree with.

- I have sometimes struggled to find and experience empathy for people when I disagree with them, or I don't find their experience as significant as they do.

3) Describe your plan for growth and development in the areas of growth you detailed in question 2. Bullet point the area of growth and identify your plan for ongoing development.

Example:

Improve understanding of cultural diversity as it relates to the humanistic approach:

- Examine literature detailing cultural factors in humanistic therapy
- Seek supervision with my TA

Appendix B

The Student Evaluation Questionnaire Spring Semester–Qualitative

1) Identify 3 strengths in the areas of competency detailed above. Be specific to you.

2) Identify 3 areas for growth in the areas of competency detailed above. Be specific to you.

3) Identify any areas of growth that you have identified, or that have been offered to you by faculty/peers related to global professional development and not necessarily an aspect of the above competencies.

4) Describe your plan for growth and development in the areas of growth you detailed in question 2. Bullet point the area of growth and identify your plan for ongoing development.

Appendix C

APA Competency

Benchmark revised by Jodi Brents

Competency Benchmarks in Professional Psychology Training	
1 - Professional Values and Attitudes: reflect the values and attitudes of psychology	
1a. Integrity	Understands professional values; honest, responsible
1b. Deportment (demeanor, attitude)	Understands how to conduct oneself in a professional manner
1c. Accountability	Accountable and reliable
1d. Concern for the welfare of others	Demonstrates awareness of the need to uphold and protect the welfare of others
1e. Professional Identity	Demonstrates beginning understanding of self as professional: “thinking like a psychologist”
2 - Individual and Cultural Diversity: Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal backgrounds and characteristics defined broadly and consistent with APA policy	
2a. Self as Shaped by Individual and Cultural Diversity and Context	Knowledge, awareness, and understanding of one’s own dimensions of diversity and attitudes towards diverse others
2b. Others as Shaped by Individual and Cultural Diversity and Context	Knowledge, awareness, and understanding of other individuals as cultural beings
2c. Interaction of Self and Others as Shaped by Individual and Cultural Diversity and Context	Knowledge, awareness, and understanding of interactions between self and diverse others
2d. Applications based on Individual and Cultural Contest	Knowledge of and sensitivity to the scientific, theoretical, and contextual issues related ICD as they apply to professional psychology. Recognizes the need to consider ICD issues in all aspects of professional psychology work.
3 – Ethical Legal Standards and Policy: ethical concepts and legal awareness regarding professional activities with individuals, groups, and organizations.	
3a. Knowledge of ethical, legal, and professional standards and guidelines	Demonstrates knowledge of the principles of the APA Ethical Principles and Code of Conduct – practice of psychology that apply to practice while placed at practicum setting.

3b. Awareness and Application of Ethical Decision Making	Demonstrates awareness of the importance of applying an ethical decision model to practice
3c. Ethical Conduct	Displays ethical attitudes and values
4 – Reflective Practice/Self-Assessment/Self-Care: Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care	
4a. Reflective Practice	Mindfulness and self-awareness; engages in reflection regarding professional practice
4b. Self-Assessment	Knowledgeable of core competencies: engages in initial self-assessment regarding competencies
4c. Self-Care: attention to personal health and well-being to assure effective professional functioning	Recognizes the importance of self-care in effective practice; demonstrates knowledge of self-care methods; attends to self-care
4d. Participation in Supervision Process	Demonstrates straightforward, truthful, and respectful communication in supervisory relationship
5 – Relational; Relationships: Relate effectively and meaning fully with individuals, groups, and/or communities	
5a. Interpersonal Relationships	Displays interpersonal skills
5b. Affective Skills	Displays affective skills
5c. Expressive Skills	Communicates ideas, feelings, and information clearly using verbal, nonverbal, and written skills
6 – Scientific Knowledge and Methods: Understanding research, methodology, data collection and analysis, biological bases of behavior, cognitive-affective and lifespan development.	
6a. Scientific Mindedness	Displays critical scientific thinking
6b. Scientific Foundation of Psychology	Demonstrates understanding of psychology as a science
6c. Scientific Foundations of Professional Practice	Understand the scientific foundation of professional practice
7 – Research/Evaluation: Generating research that contributes to the professional knowledge base and evaluates effectiveness of various professional activities	
7a. Scientific Approach to Knowledge Generation	Participates effectively in scientific endeavors when available

8 – Evidence-Based Practice: Integration of research and clinical expertise in the context of patient factors	
8a. Knowledge and Application of Evidence-Based Practice	Demonstrates basic knowledge of scientific, theoretical, and contextual bases of assessment, intervention and other psychological applications; basic knowledge of the value of EBP and its role in scientific psychology
10 – Intervention: Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations	
10a. Skills	Displays basic helping skills
10b. Intervention Strategies	Basic knowledge of intervention strategies
13 – Supervision: Supervision and training in the professional knowledge base of enhancing and monitoring the professional functioning of others	
13a. Skills Development – 1	Displays interpersonal skills of communication
13b. Skills Development – 2	Displays openness to feedback
13c. Skills Development – 3	Ability to incorporate feedback and demonstrate use of feedback in progress
14 – Interdisciplinary Systems: Knowledge of key issues and concepts in related disciplines. Identify and interact with professionals in multiple disciplines	
14a. Cooperates with others	Learning to interact with psychologist at different levels of training (within-system)
14b. Respectful and Productive Relationships with Individuals from other Professions	Demonstrates awareness of the benefits of forming collaborative relationships with other professionals (within-system)[1]

[1] Adapted from *Revised Competency Benchmarks for Professional Psychology*, by the American Psychological Association, 2011. In the public domain.

Appendix D

The Peer and Teacher Assistant Evaluation Questionnaire–Quantitative

1. Professional Values and Attitudes: as evidenced in behavior and comportment that reflect the values and attitudes of psychology [Understands professional values; honest, responsible]

2. Professional Values and Attitudes: as evidenced in behavior and comportment that reflect the values and attitudes of psychology [Understands how to conduct oneself in a professional manner]

3. Professional Values and Attitudes: as evidenced in behavior and comportment that reflect the values and attitudes of psychology [Accountable and Reliable]

4. Professional Values and Attitudes: as evidenced in behavior and comportment that reflect the values and attitudes of psychology [Demonstrates awareness of the need to uphold and protect the welfare of others]

5. Professional Values and Attitudes: as evidenced in behavior and comportment that reflect the values and attitudes of psychology [Demonstrates beginning understanding of self as professional: “thinking like a psychologist”]

6. Individual and Cultural Diversity: Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal background and characteristics defined broadly and consistent with APA policy. [Demonstrates knowledge, awareness, and understanding of one’s own dimensions of diversity and attitudes towards diverse others]

7. Individual and Cultural Diversity: Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal

background and characteristics defined broadly and consistent with APA policy. [Demonstrates knowledge, awareness, and understanding of other individuals as cultural beings]

8. Individual and Cultural Diversity: Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal background and characteristics defined broadly and consistent with APA policy. [Demonstrates knowledge, awareness, and understanding of interactions between self and diverse others]

9. Individual and Cultural Diversity: Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal background and characteristics defined broadly and consistent with APA policy. [Demonstrates basic knowledge of and sensitivity to the scientific, theoretical, and contextual issues related to ICD (as defined by APA policy) as they apply to professional psychology. Understands the need to consider ICD issues in all aspects of professional psychology work (e.g., assessment, treatment, research, relationships with colleagues)]

10. Reflective Practice/Self-Assessment/Self-Care: Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care. [Displays basic mindfulness and self-awareness; engages in reflection regarding professional practice]

11. Reflective Practice/Self-Assessment/Self-Care: Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care. [Demonstrates knowledge of core competencies; engages in initial self-assessment re: competencies]

12. Reflective Practice/Self-Assessment/Self-Care: Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care. [Understands the importance of self-care in effective practice; demonstrates knowledge of self-care methods; attends to self-care]

13. Reflective Practice/Self-Assessment/Self-Care: Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care. [Demonstrates straightforward, truthful, and respectful communication in supervisory relationship]

14. Relationships: Relate effectively and meaningfully with individuals, groups, and/or communities. [Displays interpersonal skills]

15. Relationships: Relate effectively and meaningfully with individuals, groups, and/or communities. [Displays affective skills]

16. Relationships: Relate effectively and meaningfully with individuals, groups, and/or communities. [Communicates ideas, feelings, and information clearly using verbal, nonverbal, and written skills]

17. Evidence-Based Practice: Integration of research and clinical expertise in the context of patient factors. [Demonstrates basic knowledge of scientific, theoretical, and contextual bases of assessment, intervention and other psychological applications; demonstrates basic knowledge of the value of evidence-based practice and its role in scientific psychology]

18. Intervention: Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations. [Displays basic helping skills]

19. Intervention: Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations. [Demonstrates basic knowledge of intervention strategies]

20. Supervision: Supervision and training in the professional knowledge base of enhancing and monitoring the professional functioning of others. [Displays interpersonal skills of communication]

21. Supervision: Supervision and training in the professional knowledge base of enhancing and monitoring the professional functioning of others. [Demonstrates openness to feedback]

22. Supervision: Supervision and training in the professional knowledge base of enhancing and monitoring the professional functioning of others. [Demonstrates ability to incorporate feedback and demonstrate use of feedback in progress]

23. Interdisciplinary Systems: Knowledge of key issues and concepts in related disciplines. Identify and interact with professionals in multiple disciplines. Note: At this stage, you are learning to interact with psychologists at different levels of training, so it is within-system. [Cooperates with others]

24. Interdisciplinary Systems: Knowledge of key issues and concepts in related disciplines. Identify and interact with professionals in multiple disciplines. Note: At this stage, you are learning to interact with psychologists at different levels of training, so it is within-system. [Demonstrates awareness of the benefits of forming collaborative relationships with other professionals]

Curriculum Vitae

Jodi Brents, M.S., M.A.

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Education

Present **Doctor of Psychology, Generalist Track**

Dissertation: *Evaluating Professional Clinical Competency Development in Doctor of Psychology Students Using Multiple Methods of Evaluation: Peer, Supervisor, and Self-Assessment* (Anticipated defense date 4/2024)

Chair: Carilyn Ellis, Psy.D.

George Fox University, Newberg, Oregon

2021 **Master of Arts, Clinical Psychology**

George Fox University, Newberg, OR

2018 **Master of Science, Clinical Psychology**

Regent University, Virginia Beach, VA

2017 **Bachelor of Science, Psychology**

Regent University, Virginia Beach, VA

Professional Training

2023 – Present **Mann – Grandstaff VA Medical Center, Spokane, WA**

Predoctoral Internship, Generalist Track

Behavioral Health Services

Rotations: Posttraumatic Stress Disorder Clinical Team (PCT), General Mental Health (GMH), Acute Psychiatric Unit (APU)

2023 – 2024 Community Living Center (Hospice and Rehabilitation)

Clinical Experience

2022 – 2023 **George Fox University Health and Counseling Center, Newberg, OR**

Pre-Internship: Doctoral Psychology Trainee

Supervisors: Bill Buhrow, Ph.D. and Luann Foster, Psy.D.

Completed clinical rotation in University student counseling, including structured intakes, individual therapy, and comprehensive assessment.

2021 – 2022 **Linfield University Student Health and Wellness Center, McMinnville, OR**

Practicum: Doctoral Psychology Trainee

Supervisors: Kenneth Logan Psy.D. and Sally Godard, M.D.

Completed clinical rotation in University student counseling, including assessments, integrated reports, individual therapy, and interdisciplinary consultation

2019 - 2022 **Behavioral Health Crisis Consultation Team, Yamhill County, OR**

Supplemental Practicum: QMHP/Behavioral Health Crisis Consultant

Supervisors: Bill Buhrow, Ph.D.; Luann Foster, Psy.D.; Mary Peterson,

Ph.D.

Completed clinical rotation providing crisis consultation in emergency departments including risk assessments, diagnostic evaluations, and other behavioral health evaluations, consulted and collaborated with medical staff and other integrated health professionals, and trained new crisis consultants

2020-2021 **Cedar Hills Inpatient Hospital – Military Program, Portland, OR**

Practicum I: Doctoral Psychology Trainee

Supervisors: Jory Smith, Psy.D. and Mario Bolivar, LCSW

Completed clinical rotations in combat-related PTSD, substance use, serious mental illness, mood disorders, and serving as a member of an interdisciplinary team. Did outcome evaluations, group therapy, and inpatient individual therapy.

2020 **George Fox Graduate Department of Clinical Psychology**

Pre-Practicum: Student Therapist

Supervisors: Glena Andrews, Ph.D.

Completed clinical foundations in University student counseling and comprehensive assessment, and individual therapy.

Certifications

2022 **George Fox University Graduate School of Clinical Psychology**

Trauma Treatment in Clinical Practice & Crisis Consultation Certificate Training

Peer Consultation

present **Mann – Grandstaff VA Medical Center, Spokane, WA**

Provided peer consultation with a Master Level student provided feedback on evidence based practices (EBP) and supported their professional development.

Supervision of Students

2022 – 2023 **George Fox University, Newberg, OR**

Provided supervision for 2nd year students in the doctoral program, doing practicum training. Provided feedback on interventions and supported the professional development of the student.

Research Experience

2023 – Present **George Fox University, Newberg, OR**

Committee Chair: Carolyn Ellis, Psy.D.

Other Committee Members: Kenneth Logan, Psy.D. and Jory Smith Psy.D.

Topic: Evaluating Professional Clinical Competency Development in

Doctor of Psychology Students Using Multiple Methods of Evaluation: Peer, Supervisor, and Self-Assessment (anticipated defense date 4-2024)

Research Presentations

Brents, J.L., Godoy, S., Marler, M. & Gathercoal, K. (2021). *The Interprofessional Primary Care Institute: Easy Transition to Remote Learning.* Poster presented at the American Psychological Association Annual convention. August 2021.

Teaching Assistant

2021 **George Fox University Clinical Psychology**

Supervision Course Professor: Amber Nelson, Psy.D.

Social Psychology and Human Sexuality

Professional Affiliations

2018-Present American Psychological Association

American Psychological Association - Division 56: Trauma

Relevant Membership & Participation

2019 - 2023 **Military Psychology Student Interest Group - Member**

Graduate School of Clinical Psychology

George Fox University, Newberg, OR

References

Patrick Metoyer, Ph.D. – PTSD Clinical Team Supervisor

Chief, Behavioral Health Service (BHS)

Specialty Care (PCT and STP) Program Manger

Clinical Psychologist

Clinical Instructor, University of Washington, School of Medicine, Psychiatry and Behavioral Sciences

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Hugh Leonard, Ph.D. – General Mental Health Supervisor

DBT-Linehan Board of Certification

Diplomate, Academy of Cognitive & Behavioral Therapies

Clinical Psychologist

Behavioral Health Services

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Emily Crawford, Psy.D. – Acute Psychiatric Unit Supervisor, General Mental Health Supervisor, and Assessment Supervisor

Acute Psychiatric Unit Programming Coordinator

Co-Training Director

Clinical Psychologist

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Virginia Kleman, Psy.D – Assessment Supervisor

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Darrelle Volwiler, Ph.D. – Community Living Center Supervisor

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LuAnn Foster, Psy.D. – Crisis Consultation Team Supervisor and George Fox University Health & Counseling Center Supervisor

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Jory Smith, Psy.D. – Cedar Hills Military Program Supervisor

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Substance Use

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