Development of the Self-of-the-Therapist Inventory (SOTI):

Exploratory Factor Analysis

by

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AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Couple and Family Therapy
College of Applied Human Sciences

KANSAS STATE UNIVERSITY
Manhattan, Kansas
2026

Abstract

Self-of-the-therapist work has been recognized as an important part of therapist training and development, yet empirical research remains limited, especially quantitative research. One barrier to this work has been the lack of a psychometrically developed measure for examining therapists' experiences with self-of-the-therapist work. This study developed and evaluated the Self-of-the-Therapist Inventory (SOTI), building on constructs identified in Goldberg et al.'s (2023) modified Delphi study. An initial 81-item SOTI was administered to therapists and therapists-in-training, with 285 participants included in the exploratory factor analysis. Principal axis factoring with Promax rotation and subsequent item reduction resulted in a 30-item measure with five factors: Self-of-the-Therapist Training Experiences, Perceived Value and Continued Engagement, Use of Self, Cultural Self-Awareness, and Supervision. The five-factor solution accounted for 59.10% of the variance and demonstrated strong internal consistency across the total scale and five factors. Construct validity analyses with a subsample of 199 participants showed meaningful associations with psychotherapy expertise, therapist self-efficacy, management strategies, and aspects of self-reflection. In contrast, the hypothesized relationship between SOTI scores and burnout was not supported. Overall, the findings provide initial support for the SOTI as a multidimensional measure of therapists' experiences with self-of-the-therapist work. The SOTI provides a foundation for continued psychometric evaluation and for future research examining how self-of-the-therapist work is experienced across training and clinical contexts and how these experiences may relate to therapist development and clinical outcomes.

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Acknowledgments

To my parents, thank you for your never-ending support, in all the ways. You may have had more to do with my choice of profession than you realize. And for the personal growth, insight, and understanding that have come from this journey…you're welcome.

To my boss, who was one of the first to believe in me before I believed in myself. Your directness, humor, and energy are unlike anyone else's, and I have been truly honored to work both for you and alongside you.

To my committee members, who saw me before I was able to see myself, thank you. Your encouragement and belief in me helped carry me through this process. To my advisor, thank you for your unwavering support, patience, and steadfastness through all of the curveballs thrown along the way. Your willingness to stay the course with me, even when the path was anything but straightforward, has meant more than you know.

To my colleagues and doctoral cohort members, thank you for the humor, gossip sessions, and wonderful distractions that reminded me there is more to life than academia and research. Sometimes, those moments were exactly what I needed to keep plugging away.

To my supervisees, thank you for trusting me, especially when doing so felt scary. Your willingness to be vulnerable, to explore yourselves, and to let me accompany you in that process has meant more than you know.

To my clients, past and present, thank you for trusting me with your stories, your vulnerabilities, and your journeys. I am continually inspired by your courage and hard work, and deeply proud of the ways you have grown, healed, and reconnected with yourselves.

To my Qualtrics ghost whisperer, thank you for helping me navigate the technology and for getting the research ball rolling.

To my local coven, thank you for helping me get to the finish line with amazing support, great soaps, blue tea, and a little moon magic.

To my sweet animals who started the journey with me but couldn't stay to see me finish, and to those who came along to carry their torch. Thank you for being beside me through it all.

To my best friend, there aren't words. And the ones that do come to mind are not appropriate for a dissertation.

And to anyone I may have inadvertently forgotten, thank you. Please forgive the oversight and we can thank my perimenopausal brain.

Dedication

To Sam and Julia,

As I have grown along this journey, I have had the extraordinary joy of watching the two of you grow into yourselves. Seeing you become the people you are, each in your own beautiful way, has made this journey richer, sweeter, and more meaningful than I could have ever imagined.

As proud as I am of accomplishing something I once wasn't sure was possible, that pride pales in comparison to the pride I feel for both of you. No degree, title, or accomplishment could ever compare to the privilege of being your mom.

You both are my everything, and everything is for you! Without the two of you, none of this would have the same meaning.

You are my boy, Blue!

I love you, Moster Roller Coaster!

I love you both, SO much!

Introduction

Self-of-the-therapist work has gained increasing recognition as a vital component of both clinical training and career-long development for marriage and family therapists. Yet, despite the widespread acknowledgement of its value from educators, supervisors, and clinicians, empirical research, particularly quantitative analysis, remains limited. Moreover, to our knowledge, no psychometrically validated scale exists to measure self-of-the-therapist work. This gap limits training programs' ability to systematically and empirically evaluate their self-of-the-therapist training efforts. Self-of-the-therapist work is the process involving the therapist's awareness of their own identity, positionality, personal history, emotional responses, and the intentional use of self within the therapeutic setting (Aponte & Kissil, 2016; Hardy, 2018; Watts-Jones, 2010). One of the most well-known and widely applied approaches to self-of-the-therapist training is Aponte and Kissil's (2016) Person of the Therapist (POTT) model. POTT offers a structured framework for developing self-awareness through exploration of personal themes, live and reflective supervision, and autobiographical exploration. Qualitative research supports the effectiveness of POTT in enhancing therapist empathy, self-reflection, emotional regulation, and therapeutic alliance, while also promoting growth in self-care and cultural attunement (Aponte & Kissil, 2016; Kissil & Niño, 2017; Oral et al., 2023; Sude & Gambrel, 2016).

In addition to the POTT method, researchers have explored other training models, such as those grounded in Bowenian theory and multicultural perspectives, that further highlight the value of attention to the inner world of the therapist. These other perspectives also highlight the effect of self-of-the-therapist work in deepening the therapeutic alliance, reducing emotional reactivity, and encouraging ethical, multi-cultural attuned practice. Without personal insight and emotional regulation, therapists may be more susceptible to countertransference, burnout, and

inadvertently recreating harmful relational dynamics within sessions (Glebova et al., 2022; Lum, 2002; Satir, 2013). These challenges also extend to the supervisory relationship, making supervision a vital space for fostering self-awareness and reflective capacity. Despite this, supervision more often centers developing technical skills rather than supporting the therapist's inner experiences and development (Frediani & Rober, 2016; Rober, 2017; Storm et al., 2001).

Although existing models and qualitative studies illuminate the benefits of self-of-the-therapist work, the lack of a validated quantitative measure severely limits further study and widespread implementation. This study addresses this gap by building on Goldberg et al.'s (2023) modified Delphi study, in which key constructs of self-of-the-therapist trainings were identified. By transforming these constructs into a psychometrically sound assessment tool, this study aims to advance both research and practice. A reliable and accessible scale would offer training programs, supervisors, and researchers a much-needed resource to measure, evaluate, and support the growth of self-of-the-therapist work across diverse clinical settings.

Literature Review

Understanding Self-of-the-Therapist

As mentioned, there is widespread consensus on the value of self-of-the-therapist work, not only during clinical marriage and family therapy training but across the span of the therapist's career (Goldberg et al., 2023). Self-of-the-therapist is a complex internal process involving multiple layers, such as awareness of one's biases, positionality, and clinical conceptual preferences (e.g., models, theories, and lenses), as well as how these factors impact the therapeutic process (Aponte & Carlsen, 2009; Aponte & Kissil, 2016; Claudio & Watson, 2018; Hardy, 2018; Kissil & Niño, 2017; Lum, 2002; Regas et al., 2017; Rober, 2017).

Additionally, awareness of unresolved personal issues and a commitment to personal self-growth (or congruence) are crucial components of self-of-the-therapist work. Equally important are the therapist's feelings about themselves and their therapeutic work, including the ability to acknowledge internal reactions, emotional vulnerabilities, and self-perceptions that may influence the therapeutic relationship (Aponte & Kissil, 2016; Baldwin, 2013; Satir, 2013; Frediani & Rober, 2016).

The bedrock of the self-of-the-therapist process is self-awareness. The concept of self-awareness in the therapeutic space is not new. Freud suggested that clinicians must address their own issues before helping others to maintain neutrality with clients (Aponte & Carlsen, 2009). However, the idea of neutrality in therapy has evolved; many in the field now recognize that achieving true neutrality is not only impossible but may actually harm clients (Baldwin, 2013; Satir, 2013). Therapist self-awareness improves client outcomes and transcends clinical training, theoretical preferences, socio-economic positionality, and personal identity (Aponte & Carlsen, 2009; Aponte & Kissil, 2016; Hardy, 2018; Rober, 2017). Self-of-the-therapist awareness also encompasses "the feelings and emotions the therapist has during a therapy session" (Frediani & Rober, 2016, p. 482), not only about the client but also about themselves. Rober (2017) identified three key aspects of self-reflection that directly impact a therapist's effectiveness. First, therapists must be aware of their experiences (thoughts, feelings, and physiological changes) while working with a client. Second, they should intentionally use self (e.g., volume of voice, physical position in chair). Third, they must trust their ability to sense what is going on at a deeper level beyond what is explicitly spoken. Learning this type of awareness is an ongoing process and developing therapists typically "do not experience our emotions in the moment but can only experience them in retrospect" (Rober, 2017, p. 494).

The importance of self-of-the-therapist work

In recognition of the importance of self-of-the-therapist work, Aponte and Kissil (2016) developed a training model for incorporating this work into clinical programs. Their Person-of-the-Therapist (POTT) approach is well documented. In short, their approach can be broken down into three main concepts: the use of self (how personal experiences shape their work as a therapist), working with identified personal "themes" (wounds from early life experiences), and belief that through reflection therapists can heal their wounds, positively impacting their clinical work. These concepts are addressed through a structured training environment with specific activities including autobiographical journaling, group work that includes self-disclosure, and identifying personal "themes." This work is done in supervision both live, where supervisors can help therapists connect their in-session reactions to clients to their own personal themes, and in weekly one-on-one supervision that allows for more reflective processing. Typically, there is also a standalone course within a training program that provides the lecture component of learning the basics.

Since the POTT model has been developed, several researchers have explored various aspects of the training such as: what is the perceived impact of POTT on clinical work, the connection of POTT to self-care, using therapist's signature themes as a tool for effective therapy, the benefits of POTT on the therapeutic alliance, developing POTT when working with couples, how POTT helps novice therapists attune to their inner conversations during sessions, as well as how POTT work can show up in supervision (Aponte & Carlsen, 2009; Aponte & Kissil, 2014; Claudio & Watson, 2018; Frediani & Rober, 2016; Kissil & Niño, 2017; Niño et al., 2016; Niño & Zeytinoglu-Saydam, 2020; Oral et al., 2023; Rober, 2017). Each of these are explored in the following sections.

Niño et al. (2016) conducted a qualitative analysis of master's students' perceptions of the effects their Person of the Therapist (POTT) training had on their therapeutic relationships with clients. The students ($N = 66$) reported improvements in their empathy, managing their emotional reactions to clients, and balancing the multiple alliances needed in couple or family work. They also reported feeling more accepting and less judgmental of clients as well as having a stronger bond with them. These findings mirror what Claudio and Watson (2018) found in their qualitative study that looked at the perceived impact of the Person of the Therapist training model on postgraduates' ($N = 20$) clinical work. In their study, they found that those who participated in POTT during their education reported enhanced self-awareness, which included a better recognition of their own values, emotional triggers, vulnerabilities, and their various attachment styles which led to the ability to improve their in-session effectiveness. These improvements, because of greater self-awareness, allowed the therapists to enhance and deepen their connections with clients.

Aponte and Kissil (2014) explored the concept of therapist "signature themes," which are the "lifelong struggles shaping the person's relationships with self and others" (p. 155). They emphasized that when therapists intentionally work through and begin to heal these "signature themes," they can become powerful tools used in therapy. These themes do not need to be fully resolved but must be sufficiently processed enough so that the therapist can access them without being emotionally triggered, which allows for a deeper therapeutic process, not one that is hindered by reactionary responses. The degree to which a therapist can access and work with their own emotional experiences influences the emotional depth they can facilitate within their clients. This concept of depth and authentic therapeutic presence was further supported by Aponte (2022). He elaborated on the significance of the therapist's own humanity and self-

awareness as a core therapeutic tool. He illustrated how intentional self-exploration, and congruence, can amplify the therapist's effectiveness in facilitating client insight and growth.

In addition to the benefits to professional work, Kissil and Niño (2017) studied the impact of Person of the Therapist (POTT) on the self-care of 70 clinical students from three consecutive cohorts. They found that increased self-compassion, stronger personal boundaries, and more effective stress management were outcomes of POTT training. These factors played a key role as protective factors against burnout. These findings are echoed in Glebova et al.'s (2022) study on burnout within MFT trainees. They found that the balance between internal resources (emotional awareness, self-care tools) and external demands (caseloads, supervision quality) significantly impacts burnout risk. Similarly, Rosenberg and Pace (2006) highlighted that MFTs may be uniquely vulnerable to burnout due to the emotional intensity of relational work. This indicates the importance of incorporating self-of-the-therapist work to mitigate risk by strengthening therapists' self-awareness and emotional regulation.

Claudio and Watson (2018) reported that incorporating cultural considerations into POTT training enhanced participants' ability to navigate personal biases and address multicultural issues in therapy sessions. Similarly, Hardy (2018), emphasized that self-of-the-therapist work is rooted in an awareness of how one is shaped not only by relationships but also by broader sociocultural contexts: "The enhanced ability to see one's world more complexly and more relationally paves the way for appreciating the subjectivity of reality, and how the what/how one sees largely depends on where one stands" (Hardy, 2018, p. 28). Understanding one's social location is fundamental to a multicultural perspective, as experience is not limited to our relationships, but extends to the "social, psychological, emotional, and cultural 'place' in which we are embedded" (Hardy, 2018, p. 27), including dimensions such as race, class, gender, etc.

Therapists must reflect on their own experiences with privilege and marginalization and how these impact the therapy process. Without such self-reflection, therapists cannot provide socially just or culturally attuned therapy.

While the majority of the empirical research on self-of-the-therapist work is centered around the Person of the Therapist training (POTT), several other approaches explore self-of-the-therapist empirically and theoretically from a different perspective. In one empirical example, Regas et al. (2017) incorporated self-of-the-therapist work into their clinical program from a Bowenian perspective. They studied graduates (n = 25) who participated in a yearlong Differentiation-Based Couple Therapy Course and found that working on self, rooted in the concept of differentiation (the ability to self-regulate while staying present and connected without becoming reactive) allowed them to "confront, understand and differentiate their own values, emotional anxieties, and reactivity from those of their clients, allowing them to guide couples in this same process towards personal recognition, responsibility, and transformation" (Regas et al., 2017, p. 28).

Shifting to more theoretical and clinically focused work, the consensus on the importance of self-of-the-therapist work is evident through the number of authors who have advocated for experiential and relational training models to deepen therapist self-awareness, emotional insight, and systemic reflection. Sude and Gambrel (2016) present an experiential exercise designed to help marriage and family therapist trainees explore the differences between individual and relational perspectives by shifting from "talking about" to "talking with" clients. Sude (2015) also developed the "Acknowledging, Name, and Giving" activity, which is a structured self-of-the-therapist training exercise aimed at increasing relational presence and self-reflection. Also focusing on intrapersonal awareness, Rober (2021) proposes a dual-process model in which

therapists engage in both intuitive responsivity and reflective self-supervision during sessions. This highlights the ongoing internal processes that shape therapeutic choices in session. On the flip side, Watts-Jones (2010) expands the topic by introducing, "location of self," a concept that situates the therapist's self-awareness within sociocultural and intersectional contexts. This encourages the therapist to examine their positionality and its subsequent impact on therapy. Oral et al. (2023) take the conversation to working with couples building on Person of the Therapist (POTT) model offering structured, identity-focused therapeutic interventions rooted in the therapist's use of self.

Risks when self-of-the-therapist work is absent

Although research highlights the importance of self-of-therapist work, several issues can develop when therapists lack self-of-the-therapist awareness, one of which is being drawn into the client's system of problems. This can cause the therapist and client to repeat unhealthy patterns instead of breaking them, ultimately hindering the client's healing process (Satir, 2013). This issue may manifest in the therapy room when a client unintentionally triggers the therapist, prompting an uncomfortable reaction in the session. For example, a client might share a story about being spanked as a form of punishment as a child. If the therapist has unresolved or unprocessed memories of their own related to spanking, they may experience a physiological response such as a racing heart, shortness of breath, or jumbled thoughts. Even if the therapist can outwardly maintain composure, their inner experience may be overwhelming. Without sufficient self-work, the therapist may unintentionally try to avoid their discomfort, potentially steering the conversation toward what they perceive as a "safer" topic. This avoidance can prevent the client from exploring deeper emotional processing and leave the client feeling

unheard, invalidated, and unseen – mirroring the patterns they may have experienced growing up (Satir, 2013).

Beyond in-session experiences, unresolved self-of-the-therapist issues can affect therapists between sessions, manifesting as heightened anxiety, lack of confidence, irritation with clients, or feelings of being stuck regarding how to proceed therapeutically (Satir, 2013). Failing to explore these unpleasant feelings can result in counterproductive dynamics such as "rescuing or protecting, taking sides, or rejecting a patient and, again, putting the responsibility on the patient" (Satir, 2013, p. 21). Whether these self-of-the-therapist issues unfold within the therapy session or outside it, they perpetuate the client's internalization of the problems that brought them to therapy to resolve (Lum, 2002; Satir, 2013). This dynamic also applies to the supervision relationship. If supervisors are unaware of their own triggers, they may repeat unhealthy patterns in supervision, hindering the supervisee's growth. Thus, self-of-the-supervisor (SOS) work is just as important as self-of-the-therapist.

Self-of-the-therapist in Supervision

Supervision is a critical component of clinical development in marriage and family therapy (MFT) training (Bernard & Goodyear, 2019; Niño & Zeytinoglu-Saydam, 2020; Sutherland et al., 2013). The importance of supervision is reflected in the clinical supervision requirements established by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE, 2021), as well as in state licensure requirements that include supervised clinical experience following graduation. For example, Kansas requires 3,000 hours of postgraduate supervised clinical experience, including a minimum of 100 hours of clinical supervision, for clinical marriage and family therapy licensure (Kansas Behavioral Sciences Regulatory Board [BSRB], n.d.). Supervision has been defined as "a structured relationship

between a supervisor and a supervisee with the goal to help the supervisee gain the attitudes, skills, and knowledge needed to be a responsible and effective therapist" (Rober, 2017, p. 488).

Frediani and Rober (2016) addressed the importance of focusing on self-of-the-therapist issues and concerns during supervision. In the early stages of becoming a therapist, there are many things on the therapist's mind including managing time, keeping the client(s) on track, and applying theoretical approaches to clinical interventions. There are so many new items and tasks to be aware of, it is easy to miss things in the moment. The reflection post-session in supervision allows for this additional layer of processing. It brings things to the therapist's attention such as behaviors, thoughts, and cognitions that previously have gone undetected. In short, it brings the implicit inner workings to the forefront.

This emphasis on self-of-the-therapist does not diminish the value of clinical training or therapeutic techniques, which remain important for developing clinicians. Simon (2006) encouraged training to move beyond that of just technique and to include the therapist's presence. Echoing this stance, Virginia Satir explained, "Techniques and approaches are tools. They come out different in different hands" (Baldwin, 2013, pp. 20-21). Most research on supervision focuses on the technical aspects of therapy, such as conceptualizing cases, joining with clients, and writing case notes (Rober, 2017). However, there is less emphasis on fostering the therapist's personal development and experiences, which are equally vital for effective therapy.

The Next Step: Developing a Self-of-the-therapist Scale

Although several qualitative studies have documented the benefits of self-of-therapist work (Aponte & Kissil, 2014, 2016; Claudio & Watson, 2018; Goldberg et al., 2023; Kissil & Niño, 2017; Niño et al., 2016; Regas et al., 2017) and a well-developed and respected

implementation model exists (Person of the Therapist [POTT]; Aponte & Kissil, 2016), empirical research remains limited. This is especially true of quantitative research, where one key factor limiting this type of research is that *there is no current scale to adequately measure self-of-the-therapist work.* The absence of a validated quantitative measure of self-of-the-therapist work limits researchers' ability to systematically examine its development, impact, and association with therapy outcomes. Thus, the development a robust, generalizable evidence base for self-of-the-therapist work is severely hampered. Fortunately, recent research has provided an important foundation from which to develop a theoretically grounded self-of-the-therapist scale.

Goldberg et al. (2023) conducted a modified Delphi study to "gain consensus on some of the most important concepts, methods, benefits, and risks of self-of-the-therapist training" (p. 112). This transtheoretical approach is particularly valuable, as there is no single dominant model of self-of-the-therapist training, despite the relative prominence of Aponte's Person of the Therapist (POTT) framework. Consequently, any scale must reflect broad expert consensus rather than a model specific approach. In Goldberg et al.'s (2023) study, 18 experts who regularly integrate self-of-the-therapist methods into clinical training completed an open-ended survey that included questions such as, "What is self-of-the-therapist training/work? How is it defined?" and "How can self-of-the-therapist work be integrated into these types of trainings?" (p. 124). These qualitative responses were synthesized into a follow-up questionnaire using a 7-point Likert scale, from which 112 constructs were identified and organized into subscales addressing: (a) specific elements of self-of-the-therapist training (e.g., use of self, self-awareness and reflection, awareness of one's personal experiences and relationships, one's cultural contexts, and other elements of self-of-the-therapist training); (b) benefits and risks of self-of-the-therapist training;

(c) structure and setting of self-of-the-therapist training; (d) training for trainers and supervisors, and (e) ongoing self-of-the-therapist work.

The Present Study

Building on this expert consensus, the present study transformed these identified constructs into a new scale to empirically measure self-of-the-therapist work. Having a psychometrically sound measure of self-of-the-therapist work is essential for advancing both clinical training and supervision. Without a validated scale, it is difficult to assess the presence, depth, or developmental progression of this work across contexts, leaving programs and supervisors to rely on informal or inconsistent methods of evaluation. A standardized measure would offer the field a much-needed tool to empirically examine how self-of-the-therapist practices are integrated into training, how they evolve over time, and how they influence therapist development and client outcomes. Such a tool could also help bridge the gap between expert consensus and everyday training practices by identifying which elements are being emphasized, overlooked, or misunderstood across different settings. In doing so, it would not only support the accountability and intentionality of training programs but also empower clinicians to engage more deliberately in the personal work that underlies effective, ethical, and culturally attuned therapeutic practice.

The following hypotheses provided the guide for this study:

H1: An exploratory factor analysis will yield a multifactor solution that closely approximates the theorized seven domains of self-of-the-therapist.

H2: The self-of-the-therapist total score and the self-awareness and reflection scale of the newly developed scale will correlate moderately to strongly with the SAMS Hindering

Self-Awareness (HSA) and Management Strategies (MS) scales and their respective subscales.

H3: The newly developed total scale and the relational/reflective subscales will correlate with PEQ Subjective components (reflective capacity, empathy, therapeutic adaptability).

H4: Higher scores on the newly developed scale (overall and on the self-awareness & reflection and the perceived value/progression) will be related to lower BMS burnout scores.

H5: Higher scores on the newly developed scale, including the total score and relevant subscales, will be positively associated with therapist self-efficacy as measured by the Therapist Self-Efficacy Scale (T-SES).

H6: Higher scores on the newly developed scale, including the total score and relevant subscales, will be positively associated with self-reflection and insight as measured by the Self-Reflection and Insight Scale-Revised (SRIS-R).

Method

Positionality Statement

My interest in self-of-the-therapist work developed through my own experiences as a marriage and family therapist master's student, doctoral student, supervisor, and eventually a practicing clinician. Throughout this development, I experienced firsthand how understanding my own internal reactions could deepen my understanding of what was occurring in the therapeutic system. I learned that moments of discomfort, reactivity, or feeling triggered could provide important information about both myself and the therapeutic process. At times, these reactions reflected aspects of my own family-of-origin experiences and indicated that I had

become pulled into the client system in ways that could create blind spots and limit my clinical effectiveness. Learning to recognize and manage these responses, while also learning how to use my internal experience intentionally in therapy, became central to my development as a clinician.

These experiences also shaped my approach to supervision. As I began supervising master's students, I became increasingly interested in how helping developing therapists understand themselves might enhance their ability to integrate theoretical knowledge with their clinical work. My own experience with self-of-the-therapist work extended beyond professional development. By engaging deeply with my own history, relationships, and patterns of interaction, I was able to experience meaningful personal growth and healing that subsequently shaped how I understood and practiced therapy. These experiences reinforced my belief that therapists must be willing to explore their own difficult experiences if they are to help clients explore theirs. Consistent with Satir's conceptualization of self and congruence (Satir et al., 1991), I approach self-of-the-therapist work as a process that involves moving beneath readily observable behaviors and reactions to understand the deeper, more integrated experiences that shape how therapists enter and participate in the therapeutic process.

My personal and professional experiences with self-of-the-therapist work shaped how I approached the conceptualization of this study. I entered the research with the assumption that self-of-the-therapist work is consequential to therapist development and that it involves more than self-awareness alone. My initial interest was in qualitatively examining how and why self-of-the-therapist work contributes to therapist development through a grounded theory study. However, the absence of a comprehensive instrument for assessing self-of-the-therapist suggested that establishing a means of measuring the construct was an important preliminary step. This led to the development of the Self-of-the-Therapist Inventory (SOTI) and the present

study based on Goldberg et al.'s (2023) modified Delphi study. Because of my inherent belief in the benefits of self-of-the-therapist work, I remained attentive to the ways my own experiences and assumptions could influence decisions throughout the research process. The development and evaluation of SOTI were therefore approached with an awareness of those assumptions and a commitment to allowing the empirical process to guide decisions regarding the structure and measurement of the construct. This reflexive awareness remained important throughout the development and evaluation of the SOTI.

Procedures

Participants included licensed therapists and therapists-in-training recruited through two main avenues. The first was a multi-pronged convenience sampling approach that included posts on social media, professional therapist listservs, and snowball sampling through the authors' professional networks. At the completion of the survey, participants could register to enter a raffle to receive one of 25 gift cards for $25.

After the first survey was launched, it became clear that bots were infiltrating the survey in an attempt to register for the raffle. As a result, the survey was shut down, additional bot protections were built into the Qualtrics survey, and the second iteration of the survey was not posted on social media. Survey 1 initially included 1,324 responses. Of these, 1,271 were identified as bots and deleted based on nearly identical survey completion times of approximately seven minutes and uniform responses to open-ended questions. This left 53 participants. Two were dropped because they discontinued the survey before completing any of the study scales, and four were dropped for missing attention checks, resulting in a final sample of 47 participants for Survey 1.

A total of 105 participants completed Survey 2 using the same multi-pronged convenience sampling approach, with the exception of social media posts. Four participants did not consent to participate and were dropped, 30 were dropped for non-completion (i.e., completing only a few demographic questions and none of the central study scales), five were dropped for missing attention checks, and one was dropped for extreme straight lining. This resulted in a final sample of 65 participants for Survey 2.

In addition to the convenience sampling approach, data were collected through CloudResearch's Connect platform (Hartman et al., 2023). CloudResearch was contacted prior to data collection and reported having approximately 100 licensed therapists in its participant pool. In conjunction with Connect, recruitment was set up so that only participants who had been previously screened as licensed therapists or therapists-in-training were offered the survey (Survey 3). Participants were compensated $3.75 for their participation. A total of 96 Connect participants completed the survey. Of these, three did not consent to participate, one was not a licensed clinician or clinician-in-training, four completed only a few demographic questions and none of the central study scales, and one was dropped for missing attention checks. This resulted in a final sample of 87 participants for Survey 3.

A final sample was collected through Connect's *Managed Study* option. For Survey 4, the survey was shortened to include only the demographic questions, the Self-of-the-Therapist Inventory (SOTI), and the burnout questionnaire. The goal of this final round of data collection was to increase the sample size available for the psychometric analyses, as we determined that the existing sample was sufficient for the planned validity analyses. For the Managed Study, the Connect team sourced potential participants from its general population panel networks based on self-reported profiling information indicating that they were licensed clinicians or clinicians-in-

training. Because participants could self-select into the study based on these profiling data, there was a greater possibility that some participants would not meet the study's inclusion criteria and, therefore, an expectation that a larger number of participants would be excluded. This was the case. A total of 203 participants completed the shortened survey. Participants were dropped because they did not consent (n = 17), did not qualify as a licensed therapist or graduate student in training (n = 28), missed attention checks (n = 42), provided impossible licensure responses (n = 4), were identified as duplicate responses (n = 10), or discontinued the survey after completing the demographic questions (n = 16). This resulted in a final sample of 86 participants for Survey 4.

Across the four surveys, the final combined sample included 285 participants. The four recruitment samples were generally similar in their demographic composition. There were no significant differences in gender, sexual orientation, race/ethnicity, education, or relationship status (all $ps > .05$). There was a small difference in age across samples, $F(3, 263) = 3.19$, $p = .024$, $\eta^2 = .04$, with mean ages ranging from approximately 36 to 41 years. Differences were also found across samples on some of the study scales, with the largest difference found for one of the Self-of-the-Therapist Inventory (SOTI) factors, Perceived Value and Continued Engagement (PVCE), $F(3, 281) = 14.19$, $p < .001$, $\eta^2 = .13$. This difference did not appear to be related to age or where participants were in their careers, as PVCE was not related to age ($r = .02$, $p = .763$) and did not differ based on student/trainee or provisional licensure status. Instead, the difference appeared to be more closely tied to professional discipline. Among participants who identified with a single professional discipline, PVCE scores differed significantly across marriage and family therapy (MFT), counseling, social work, and psychology, Welch's $F(3, 102.19) = 10.14$, $p < .001$. MFTs reported the highest PVCE scores (M = 6.52), followed by counselors (M =

6.22), social workers (M = 6.15), and psychologists (M = 5.81). MFTs scored significantly higher than psychologists (d = 1.12) and social workers (d = .61). Given the substantial differences in the proportion of MFTs across recruitment samples, differences in professional training background may have contributed to the differences in PVCE scores. However, the extent to which these differences reflect professional discipline or other characteristics of the recruitment samples remains unclear.

Participants completed an online survey that included demographic and professional characteristics and the Self-of-the-Therapist Inventory (SOTI). Surveys 1–3 also included a set of established measures used to evaluate the validity of the SOTI. Survey 4 was shortened to reduce participant burden and included a shortened set of demographic and professional questions, the SOTI, and the Burnout Measure–Short Form (BMS). As a result, the full sample (N = 285) was available for the psychometric analyses, while validity analyses involving the additional measures were conducted using participants from Surveys 1–3 (n = 199).

Sample

Data from these recruitment efforts resulted in two analytic samples. The exploratory factor analysis (EFA) sample consisted of 285 participants and included responses from all four survey collections. Participants ranged from 21 to 83 years (M = 38.27, SD = 11.32), with age data available for 267 participants. The sample was predominantly women (80.4%) and White (78.9%), with heterosexual being the most frequently reported sexual orientation (75.4%). Participants represented a range of educational backgrounds, professional disciplines, licensure statuses, and levels of clinical supervision.

A validity subsample (n = 199) was drawn from the larger EFA sample. Participants in this subsample ranged in age from 21 to 83 years (M = 37.14, SD = 11.45), with age data

available for 184 participants. Clinical experience ranged from 0 to 56 years (M = 8.92, SD = 9.60), with data available for 193 participants. Because participants in Survey 4 completed only the measures needed for the psychometric analyses, validity analyses were conducted using the participants from Surveys 1–3 (n = 199). Demographic and professional characteristics for both analytic samples are presented in Table 1.

Measures

The primary measure developed and evaluated in this study was the Self-of-the-Therapist Inventory (SOTI). The initial SOTI consisted of 81 items developed from the self-of-the-therapist constructs identified by Goldberg et al. (2023) in their modified Delphi study. The 81 items were conceptually organized into seven theorized domains: (a) experience-based constructs; (b) perceived value and progression of self-of-the-therapist work; (c) use of self in therapy; (d) self-awareness and reflection; (e) personal history, relationships, and therapist development; (f) culture, spirituality, and contextual awareness; and (g) supervision, structure, and training. Items were rated on a 7-point Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*), with higher scores indicating greater endorsement of each item. The original 81-item SOTI administered in the study is provided in Appendix A.

Five established measures were administered to examine the construct validity of the SOTI. The *Psychotherapy Expertise Questionnaire* (PEQ; Gori et al., 2023) consists of 32 items rated on a 5-point Likert scale and evaluates eight subfactors related to therapeutic expertise. These are organized into two domains: subjective (performance, cognitive functioning, personal and relational qualities of the therapist, and therapist self-assessment) and objective (experience, reputation with clients and colleagues, training and professional updating, and deontological ethics and setting rules). This assessment provides an empirically grounded framework to

evaluate therapists' psychotherapy expertise across subjective and objective dimensions. Example items include "I am able to establish the therapeutic alliance," "I can make appropriate diagnostic evaluation," and "I respect the rules of the clinical setting." Evidence of validity comes from confirmatory factor analyses supporting an eight-factor structure and an alternative higher-order model, with significant associations with self-efficacy, self-esteem, insight orientation, personality traits, and years of practice (Gori et al., 2023). Internal consistency was excellent for the total score (α = .95), with subscale alpha coefficients ranging from .72 to .90 in the original validation study. Higher PEQ scores indicate greater levels of psychotherapy expertise. The PEQ demonstrated excellent internal consistency in the present sample (α = .946, *n* = 194), with the total score used in the validity analysis.

The *Self-Awareness and Management Strategies* (SAMS) scales (Williams et al., 2003) were administered. This instrument includes two scales: a 10-item Likert scale measuring hindering self-awareness (recognition of personal reactions in therapy) and a 15-item Likert scale assessing strategies for managing those reactions. For the present study, all 10 Hindering Self-Awareness items and the 12 Management Strategies items comprising the two multi-item factors were administered; the three single-item management strategies were not administered. Sample items include "How often do you become aware of feeling anxious during a session?" representing Anxious Awareness; "How often do you find that your self-awareness is hindering during a therapy session?" representing Distracting Awareness; "Engage in self-reflection (process my reactions after the session)" representing Self-Care/Self-Reflection; and "Use deep breathing techniques" representing Cognitive/Relaxation Techniques. Exploratory factor analyses supported two factors for hindering self-awareness (anxious and distracting) and two management strategy factors (self-care/self-reflection and cognitive/relaxation), with additional

single-item strategy indicators. Internal consistency was acceptable in the original validation study (hindering self-awareness α = .76; management strategies α = .73). Convergent validity was supported via positive relations with private self-consciousness, and discriminant validity via non-association with self-monitoring. Higher Hindering Self-Awareness (HSA) scores indicate more frequent experiences of hindering self-awareness during therapy sessions, whereas higher Management Strategies (MS) scores indicate more frequent use of strategies to manage self-awareness. In the present sample, internal consistency was α = .850 for HSA total, α = .782 for Anxious Awareness, α = .762 for Distracting Awareness, α = .805 for MS total, α = .634 for Self-Care/Self-Reflection, and α = .823 for Cognitive/Relaxation Techniques (*n* = 194). The Hindering Self-Awareness (HSA) and Management Strategies (MS) total scores and their respective subscale scores were used in the validity analysis.

The *Burnout Measure, Short Version* (BMS; Malach-Pines, 2005) was administered to assess therapist burnout. This 10-item measure evaluates the extent of emotional, physical, and mental exhaustion, capturing early indicators of burnout that may impair therapeutic ability. Example items include “When you think about your work overall, how often do you feel tired?”, “How often do you feel trapped in your job?”, and “How often do you feel helpless?” Responses are rated on a 7-point scale from 1 (*never)* to 7 (*always*). The BMS has demonstrated strong internal consistency across samples in the original validation study (α = .85-.92). Construct validity was supported through associations with theoretically relevant variables, including work satisfaction, work stress, and somatic complaints. Higher BMS scores indicate greater levels of burnout. The BMS demonstrated strong internal consistency in the present sample (α = .911, *n* = 193) and was administered in both the EFA and reliability and validity samples, with the BMS total score used in the validity analyses.

The *Therapist Self-Efficacy Scale* (T-SES; Gori et al., 2022) was also administered. This scale was developed to assess mental health therapists' professional efficacy. It is a 21-item scale that evaluates therapists' perceived efficacy across communicative effectiveness, clinical competence, intrapsychic competence, relational competence, affect regulation, and diagnostic skills. Items include "Be welcoming," "Promote therapeutic alliance," and "Properly manage emotions." Confirmatory factor analysis supported a single-factor structure with good internal consistency (α = .93) in the original validation study. The scale also showed positive correlations with general self-efficacy, insight orientation, and personality traits (conscientiousness and openness) (Gori et al., 2022). Higher T-SES scores indicate greater perceived professional self-efficacy. The T-SES demonstrated strong internal consistency in the present sample (α = .920, *n* = 192), with the total score used in the validity analyses.

Finally, the *Self-Reflection and Insight Scale – Revised Short Form* (SRIS-R; Banner et al., 2024) was administered. This is a 14-item measure designed to assess reflective capacity and psychological insight in psychologists. The SRIS-R has good psychometric properties in the original validation study for the total scale (α = .88), Self-Reflection subscale (α = .89), and Insight subscale (α = .83). Convergent validity was demonstrated through positive associations with self-reflection, and divergent validity was demonstrated through nonsignificant associations with perceived knowledge. Higher Self-Reflection scores indicate greater engagement in self-reflection, whereas higher Insight scores indicate greater understanding of one's thoughts, feelings, and behaviors. The SRIS-R demonstrated good internal consistency in the present sample (*n* = 193) for the total scale (α = .841), Self-Reflection subscale (α = .824), and Insight subscale (α = .852), with the total score and both subscale scores used in the validity analyses.

Analyses

An exploratory factor analysis (EFA) was conducted to examine the underlying structure of the 81 Self-of-the-Therapist Inventory (SOTI) items. Principal axis factoring with Promax rotation and Kaiser normalization was used, allowing the factors to be correlated. Factor retention and item reduction were guided by eigenvalues, examination of the scree plot, factor loadings, cross-loadings, conceptual coherence, and interpretability. Internal consistency reliability was evaluated for the final SOTI total scale and subscales using the full EFA sample. Pearson correlations were conducted to examine associations among the SOTI total score and subscales and the validation measures. Pairwise deletion was used for missing data in the correlational analyses. A confirmatory factor analysis (CFA) was originally planned. However, it was not conducted because the available sample size did not permit an adequately sized independent sample for confirmatory analysis following the EFA.

Results

Exploratory Factor Analysis

The Self-of-the-Therapist Inventory (SOTI) was originally an 81-item scale broken down into seven theoretically based domains: Experience-Based Constructs (EBC), Perceived Value and Progression (PVP), Use of Self in Therapy (UST), Self-Awareness and Reflection (SAR), Personal History, Relationships, and Therapist Development (PHRTD), Culture, Spirituality, and Contextual Awareness (CSCA), and Supervision, Structure, and Training Conditions (SSTC). These domains were developed from constructs identified through Goldberg et al.’s (2023) modified Delphi study of self-of-the-therapist training. Exploratory factor analyses were

conducted using principal axis factoring with Promax rotation and Kaiser normalization. An oblique rotation was used to permit correlations among the factors.

Before conducting the exploratory factor analysis (EFA), the suitability of the data was evaluated using the EFA sample ($N = 285$). The data were well suited for factor analysis, with a Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy of .948. Bartlett's test of sphericity was significant, $\chi^2(3240) = 18{,}241.97$, $p < .001$, indicating that the correlations among the 81 items were sufficient to proceed with the EFA.

An exploratory factor analysis (EFA) using principal axis factoring with Promax rotation was first conducted without specifying the number of factors. This initial analysis failed to converge within the maximum number of extraction iterations and did not produce an interpretable factor solution. Given the lack of convergence, subsequent EFAs were conducted specifying seven-, six-, and five-factor solutions. The final factor solution was selected based on the statistical results as well as the conceptual coherence of the factors. In the seven-factor solution, the additional factor consisted of a small group of items that did not appear to represent a conceptually distinct dimension of self-of-the-therapist development. The five-factor solution, in contrast, combined items involving Self-Awareness and Reflection and Use of Self in Therapy into a single factor despite their conceptual differences. The six-factor solution maintained these as distinct factors while producing a clearer and more interpretable factor structure. Each of the six factors included multiple conceptually related items and represented a distinct dimension of self-of-the-therapist development consistent with the framework used to develop the measure. Based on these findings, the six-factor solution was retained for further item refinement.

Scale refinement was then a step-by-step process. Items were evaluated according to their performance within the emerging factor structure. Items with weak primary factor loadings

(below .40) or cross-loadings above .30 on others were identified for further consideration, with decisions about item retention also informed by their conceptual relevance and contribution to the factor structure. Candidate items were removed one at a time, so that each time items were removed, the factor structure was reexamined. This iterative process reduced the original 81-item survey to 49 items and six factors. During this phase, Personal History, Relationships, and Therapist Development (PHRTD) did not emerge as a distinct factor. Some items originally developed for this domain were removed, while others were kept because they contributed to other emerging factors. While the six-factor solution emerged, further examination indicated that the Self-Awareness and Reflection factor (SAR) was not sufficiently stable to retain in the final solution. The factor had been reduced to five items, two of which continued to cross-load above .30 on other factors. In addition to these statistical concerns, the content of the sixth factor raised a conceptual concern. That factor contained items reflecting *how* self-of-the-therapist training affected or changed therapists, rather than characteristics of the self-of-the-therapist training and developmental experience itself. Therefore, while this sixth factor represents a meaningful domain of self-of-the-therapist work, its content was conceptually distinct from the remainder of the factors, and its empirical structure was not sufficiently stable. The five items connected with this factor were therefore removed from the developing measure.

After removing the five items from the Self-Awareness and Reflection factor, the EFA was repeated with the remaining 44 items without specifying the number of factors. Seven factors had eigenvalues at or above 1.0. However, the sixth and seventh factors had eigenvalues of only 1.103 and 1.000, respectively, and each accounted for relatively little additional variance. These factors also included a small number of items and did not represent clear or conceptually distinct domains. Based on the eigenvalues, the factor structure, and the conceptual meaning of

the factors, the EFA was rerun specifying five factors. The five-factor solution produced a clearer and more conceptually meaningful factor structure. The remaining 44 items were then examined using the same criteria for factor loadings and cross-loadings used earlier in the scale refinement process. Three additional items were removed one at a time, with the EFA rerun after each item was removed. This resulted in a 41-item, five-factor solution.

Once a stable 41-item, five-factor solution was established, the focus of item reduction shifted from factor loadings and cross-loadings to conceptual clarity and parsimony. Items within each factor were examined for clarity, breadth, and overlap with other items. Decisions about which items to keep were based on how clearly they represented the factor, whether they added something different from the other items, and whether the remaining items continued to capture the range of content represented by the factor. This process was consistent with recommendations to balance thorough coverage of a construct with the benefits of a shorter measure (DeVellis & Thorpe, 2022; Rolstad et al., 2011). Items were removed one at a time, with the remaining items reexamined after each removal. When items assessed similar content, we considered which item was clearer and which combination of items provided the best coverage of the factor. This process continued until each of the five factors contained six items, resulting in a final 30-item measure. This allowed us to shorten the measure and reduce redundancy while still representing the range of content within each factor.

A final EFA was conducted on the final 30 items using the EFA sample ($N = 285$). Principal axis factoring with Promax rotation and Kaiser normalization was used. The KMO measure for the final item set was .932, and Bartlett's test of sphericity was statistically significant, $\chi^2(435) = 5317.06$, $p < .001$, supporting the factorability of the final 30-item correlation matrix. Five factors had initial eigenvalues greater than 1 (11.520, 3.204, 2.238,

1.423, 1.335). Prior to extraction, these factors accounted for 38.40%, 10.68%, 7.46%, 4.74%, and 4.45% of the variance. Following extraction, the five-factor solution accounted for 59.10% of the variance. Promax rotation converged in six iterations. The final structure contained six items on each of the five factors and represented these conceptual labels: Self-of-the-Therapist Training Experiences (SOTTE), Perceived Value and Continued Engagement (PVCE), Use of Self (UST), Cultural Self-Awareness (CSA), and Supervision (SUP).

The *Self-of-the-Therapist Training Experiences* factor consisted of six items addressing the therapist's experiences of self-of-the-therapist training, including the integration of self-of-the-therapist work within training, developmental appropriateness of training, experiential learning, emotional safety, structured opportunities for self-examination, and coherence of self-of-the-therapist training experiences. Together, these items reflected how self-of-the-therapist work was incorporated into training and the conditions that supported therapists' engagement in that work. Primary factor loadings ranged from .519 to .765. The *Perceived Value and Continued Engagement* factor also had six items. This domain reflected therapists' continued engagement with self-of-the-therapist work and the perceived value of it across professional development. These items addressed the continuation and deepening of self-of-the-therapist work over time and the perceived importance of self-of-the-therapist work to therapist development and subsequent clinical practice. This factor captured both ongoing engagement in the work and therapists' beliefs about its importance to ethical practice and client outcomes. Primary factor loadings ranged from .641 to .847. The *Use of Self* factor contained six items that reflected the therapist's understanding and intentional use of self within clinical practice. These items addressed how training helped therapists recognize the influence of personal experiences, emotional responses, and unresolved issues on their clinical presence and decisions. This factor

included items originally developed within the Use of Self, Self-Awareness and Reflection, and the Personal History, Relationships, and Therapist Development domains. Primary factor loadings ranged from .611 to .714. The fourth factor was *Cultural Self-Awareness* and also contained six items. These items dealt with the cultural and contextual aspects of self-of-the-therapist work. Specifically, they reflected opportunities to examine personal and social identities, privilege and marginalization, power, and the sociopolitical contexts that influence therapists' perceptions and clinical work. These items were originally part of the Culture, Spirituality, and Contextual Awareness domain, with additional items originally developed within the Use of Self and Self-Awareness and Reflection domains. Primary factor loadings were between .564 and .893. The final factor was *Supervision*. These six items addressed the role that supervision and supervisory relationships have in self-of-the-therapist work and development. These items emphasized supervisory relationships characterized by trust, vulnerability, and openness, as well as opportunities to explore personal reactions, biases, and parallel processes and apply self-of-the-therapist learning to clinical practice. These items were originally developed within the Supervision, Structure, and Training Conditions and Self-Awareness and Reflection domains. Primary factor loadings ranged from .550 to .911.

In short, the EFA provided partial support for the hypothesized multidimensional structure of the Self-of-the-Therapist Inventory (SOTI). Though the original scale's theoretical seven domains were not reproduced empirically, the final five-factor structure contained items from all seven domains presented in a reorganized format. The final five-factor structure reflected both reduction and reorganization of the original theoretical model.

Internal Consistency Reliability

Internal consistency reliability of the final 30-item Self-of-the-Therapist Inventory (SOTI) was calculated for the total SOTI and for each of the five six-item factors. The number of valid cases varied slightly across factors due to missing responses. Cronbach's alphas for the five factors were as follows: Self-of-the-Therapist Training Experiences (α = .860, *n* = 284), Perceived Value and Continued Engagement (α = .886, *n* = 285), Use of Self (α = .870, *n* = 285), Cultural Self-Awareness (α = .882, *n* = 284), and Supervision (α = .915, *n* = 283).

The reliability of the individual items within each factor was also examined. Corrected item-total correlations showed that the retained items were consistently related to the overall score of their respective factors. Additionally, removing individual items did not meaningfully improve Cronbach's alpha for any of the five factors. Therefore, the reliability results supported retaining all six items within each factor. Reliability was also examined for the complete 30-item SOTI using the full EFA sample. Of the 285 participants, 282 had complete responses across all 30 items. The total SOTI demonstrated strong internal consistency (α = .943, *n* = 282).

Construct Validity

Construct validity of the final 30-item Self-of-the-Therapist Inventory (SOTI) was examined using the validity sample (*n* = 199). Pearson product-moment correlations were conducted to examine relationships between the SOTI total score, the five SOTI factors, and the external measures included for validation: Psychotherapy Expertise Questionnaire (PEQ; Gori et al., 2023), Self-Awareness and Management Strategies (SAMS; Williams et al., 2003), Therapist Self-Efficacy Scale (T-SES; Gori et al., 2022), Self-Reflection and Insight Scale-Revised (SRIS-R; Banner et al., 2024), and Burnout Measure-Short Version (BMS; Malach-Pines, 2005) (see

Table 3). Pairwise deletion was used for missing responses. As a result, the number of valid cases varied slightly across the correlation analyses.

Because the final factor structure differed from the originally hypothesized seven-domain structure, some of the factors specified in the original hypotheses were not retained as independent factors in the final SOTI. Therefore, construct validity analyses examined relationships between the external validation measures and the final SOTI total score and five empirically derived factors.

Before examining the relationships with the previously listed external validation measures, correlations among the five SOTI factors and the total SOTI score were examined. All five factors were positively and significantly related to one another, with correlations ranging from $r = .321$ to $r = .687$, all $p < .001$. The strongest relationship was between Self-of-the-Therapist Training Experiences and Use of Self ($r = .687$), followed by Self-of-the-Therapist Training Experiences and Supervision ($r = .683$) and Use of Self and Supervision ($r = .615$). Each of the five factors was also positively and significantly related to the total SOTI score. Correlations with the total score were Self-of-the-Therapist Training Experiences ($r = .865$), Perceived Value and Continued Engagement ($r = .599$), Use of Self ($r = .817$), Cultural Self-Awareness ($r = .699$), and Supervision ($r = .813$), all $p < .001$.

Convergent Validity

Evidence of convergent validity was examined through relationships between the Self-of-the-Therapist Inventory (SOTI) and measures of psychotherapy expertise, self-awareness and management strategies, therapist self-efficacy, and self-reflection and insight. Relationships with burnout were also examined based on the hypothesized inverse relationship between self-of-the-therapist development and burnout.

Psychotherapy Expertise. The SOTI total score was positively associated with psychotherapy expertise as measured by the Psychotherapy Expertise Questionnaire (PEQ; Gori et al., 2023), $r = .302$, $p < .001$. All five SOTI factors were also significantly and positively associated with PEQ scores, with correlations ranging from $r = .184$ to $r = .308$. The strongest factor-level relationship with psychotherapy expertise was found for Perceived Value and Continued Engagement ($r = .308$, $p < .001$).

Self-Awareness and Management Strategies. Self-Awareness and Management Strategies (SAMS; Williams et al., 2003) include two primary scales, Hindering Self-Awareness (HSA) and Management Strategies (MS), each with two subscales. HSA includes Anxious Awareness (awareness of anxiety during therapy sessions) and Distracting Awareness (self-awareness experienced as distracting or hindering during sessions). MS includes Self-Care/Self-Reflection (strategies involving self-care and reflection after therapy sessions) and Cognitive/Relaxation Techniques (strategies such as reframing thoughts and using relaxation techniques during or after therapy sessions). Relationships between the SOTI and the SAMS measures were mixed. The SOTI total score was not significantly correlated with the Hindering Self-Awareness (HSA) total score, $r = .133$, $p = .064$ nor to the HSA Distracting subscale ($r = .033$, $p = .645$). The SOTI total score was significantly and positively correlated with the HSA Anxious subscale, $r = .180$, $p = .012$. The SOTI total score was positively associated with the Management Strategies total score ($r = .327$, $p < .001$), Self-Care/Self-Reflection ($r = .338$, $p < .001$), and Cognitive/Relaxation Techniques ($r = .233$, $p = .001$). At the factor level, relationships with the HSA measures were less consistent, although Cultural Self-Awareness ($r = .150$, $p = .037$) and Supervision ($r = .143$, $p = .046$) were positively associated with the HSA total score and four of the five SOTI factors were positively associated with HSA Anxious (rs =

.148-.192), with Perceived Value and Continued Engagement being the only factor that was not significantly associated with HSA Anxious. Perceived Value and Continued Engagement was negatively associated with HSA Distracting (r = -.188, p = .009); none of the other SOTI factors were significantly associated with HSA Distracting. More consistent relationships were found with the Management Strategies portion of the SAMS. All five SOTI factors were positively and significantly associated with the Management Strategies total score *(rs* = .211–.318, *p*s ≤ .003) and the two subscales, Self-Care/Self-Reflection (*rs* = .200–.355, *p*s ≤ .005) and Cognitive/Relaxation Techniques (*rs* = .146–.213, *p*s ≤ .042).

Therapist Self-Efficacy. The SOTI total score was positively associated with therapist self-efficacy as measured by the Therapist Self-Efficacy Scale (T-SES; Gori et al., 2022), r = .299, p < .001. All five SOTI factors were also positively and significantly associated with therapist self-efficacy, with correlations ranging from *r*s = .172–.312, *p*s ≤ .017. Perceived Value and Continued Engagement demonstrated the strongest factor-level relationship with therapist self-efficacy (r = .312, p < .001).

Self-Reflection and Insight. The SOTI total score was positively associated with the Self-Reflection and Insight Scale-Revised (SRIS-R; Banner et al., 2024) total score (r = .175, p = .015) and the Self-Reflection subscale (r = .250, p < .001). The SOTI total score was not significantly associated with the Insight subscale (r = .050, p = .487). Factor-level relationships varied across the SRIS-R measures. Perceived Value and Continued Engagement (r = .315, p < .001) and Cultural Self-Awareness (r = .195, p = .007) were significantly associated with the SRIS-R total score whereas Perceived Value and Continued Engagement (r = .287, p < .001), Use of Self (r = .202, p = .005), and Cultural Self-Awareness (r = .266, p < .001) were

significantly associated with Self-Reflection. Perceived Value and Continued Engagement (r = .225, p = .002) was the only SOTI factor significantly associated with Insight.

Burnout. The hypothesized inverse relationship between self-of-the-therapist development and burnout was not supported. The SOTI total score was negatively associated with burnout, but the association was not statistically significant, as measured by the Burnout Measure-Short Version (BMS; Malach-Pines, 2005), r = -.078, p = .281. Each of the five SOTI factors was also negatively associated with burnout, however, none of these achieved statistical significance.

Summary of Hypothesis Outcomes

Overall, the findings provided varying levels of support for the six study hypotheses. H1 was partially supported. The exploratory factor analysis resulted in a multidimensional structure. However, the originally hypothesized seven-domain structure was not reproduced. Instead, the final Self-of-the-Therapist Inventory (SOTI) consisted of 30 items organized into five factors: Self-of-the-Therapist Training Experiences, Perceived Value and Continued Engagement, Use of Self, Cultural Self-Awareness, and Supervision.

H2 was partially supported. Because Self-Awareness and Reflection did not remain as independent factors in the final SOTI, the hypothesis was evaluated using the SOTI total score and the five empirically derived factors. Relationships with the Self-Awareness and Management Strategies (SAMS) were mixed. The SOTI demonstrated more consistent positive relationships with Management Strategies and its subscales than with Hindering Self-Awareness and its subscales.

H3 was partially supported. The relational/reflective subscales specified in the original hypothesis were not retained as independent factors in the final SOTI, and the Psychotherapy

Expertise Questionnaire (PEQ) total score rather than the proposed subjective components were used in the final analyses. The SOTI total score and all five final factors were significantly and positively associated with psychotherapy expertise as measured by the PEQ.

H4 was not supported. The SOTI total score and each of the five factors demonstrated negative relationships with burnout. However, none of these relationships were statistically significant. The hypothesized relationship between greater self-of-the-therapist development and lower burnout was not supported.

H5 was supported. The SOTI total score and all five final factors were significantly and positively associated with therapist self-efficacy as measured by the Therapist Self-Efficacy Scale (T-SES). These findings supported the hypothesized positive relationship between self-of-the-therapist experiences and therapist self-efficacy.

H6 was partially supported. The SOTI total score was significantly and positively associated with the Self-Reflection and Insight Scale-Revised (SRIS-R) total score and the Self-Reflection subscale, but not the Insight subscale. Factor-level relationships also varied across the SRIS-R measures. These findings provided partial support for the hypothesized relationship between self-of-the-therapist experiences and self-reflection and insight.

Discussion

The development of the Self-of-the-Therapist Inventory (SOTI) began with an effort to identify measurable components of self-of-the-therapist work and to examine how self-of-the-therapist work itself is conceptualized. The initial 81-item survey was developed from constructs identified in Goldberg et al.'s (2023) modified Delphi study and was organized into seven theoretical domains developed from those constructs. The final factor structure did not reproduce

those seven domains exactly. Instead, five factors emerged: Self-of-the-Therapist Training Experiences, Perceived Value and Continued Engagement, Use of Self, Cultural Self-Awareness, and Supervision. Although this structure differed from the one hypothesized, the five factors reflect themes consistently discussed in the self-of-the-therapist literature, including experiential training, ongoing therapist development, intentional use of self, attention to cultural context, and the role of supervision (Aponte & Kissil, 2016; Hardy, 2018; Rober, 2017; Watts-Jones, 2010). The final structure also supports the idea that self-of-the-therapist work is not a single skill or activity but a multidimensional construct whose factors represent different but related aspects of the therapist's development and experience. This is consistent with descriptions of self-of-the-therapist as occurring through multiple pathways (Aponte & Kissil, 2016; Goldberg et al., 2023; Hardy, 2018; Rober, 2017).

Self-Awareness and Personal History

Beyond the reduction from seven domains to five factors, individual items were also redistributed across the new structure. The Self-Awareness and Reflection (SAR) domain illustrates this most clearly. Several SAR items were absorbed into the Use of Self, Cultural Self-Awareness, and Supervision factors. Other SAR items were eliminated during scale refinement, as discussed below. This finding is notable given the prominent role that self-awareness has held in the self-of-the-therapist literature, where it is considered a key component of self-of-the-therapist work requiring therapists to recognize their thoughts, emotions, physiological reactions, biases, and other internal experiences that may affect their clinical work.

This reorganization does not diminish the importance of self-awareness and reflection. It suggests instead that awareness and reflection *may* operate within broader aspects of self-of-the-therapist work rather than as a separate component, serving as a foundation for other aspects of

self-of-the-therapist work. For example, awareness of one's beliefs, biases, or reactions becomes clinically relevant to the self-of-the-therapist process when it informs how the therapist uses self, understands cultural and contextual influences, or processes experiences within supervision. The self-of-the-therapist literature similarly treats awareness as necessary but not sufficient. Aponte and Kissil (2014), for example, emphasized not simply identifying therapists' personal themes but processing them sufficiently so they can be accessed without creating reactionary responses in therapy. Hardy (2018) also connected awareness of social location, privilege, and marginalization to therapists' understanding of how these experiences influence their clinical role. Thus, both the literature and the SOTI factor structure point to a process that starts with awareness and reflection but then moves towards understanding and using that awareness intentionally in clinical work.

A somewhat different pattern emerged with the Personal History, Relationships, and Therapist Development (PHRTD) domain. PHRTD never emerged as a distinct factor, and all but one of its items were eliminated during scale refinement. The one PHRTD item that remained loaded on the Use of Self factor and addressed how experiences of trauma or loss may affect the therapist's presence. This result stands in contrast to the literature that informed the original domain. Personal history has been central to several approaches to self-of-the-therapist, particularly Aponte and Kissil's (2016) Person of the Therapist (POTT) model, which incorporates personal themes, autobiographical exploration, and examination of how early experiences shape the therapist's work. Aponte and Kissil (2014) also described the importance of therapists working with personal "signature themes" so that these experiences can ultimately be used rather than become barriers within therapy.

The absence of a specific factor for Personal History may suggest an important distinction between knowing or exploring one's personal history *and doing* self-of-the-therapist work with that history. Because the surviving item specifically connects personal experience to therapist presence, personal history may become relevant to self-of-the-therapist when the therapist explores what that history means for how they enter and participate in the therapeutic process. Rather than suggesting that personal history falls outside of self-of-the-therapist work, this finding may indicate that its relevance is reflected in *how* therapists understand and *use* their personal experiences in clinical practice. This interpretation is preliminary because the present study was designed to develop a measure rather than to test this conceptual distinction. It does, however, offer one possible explanation for why personal-history items did not remain together despite the importance placed on personal history in parts of the self-of-the-therapist literature. An alternative explanation is that the original items may not have adequately operationalized SAR and PHRTD as distinct constructs. Item wording that referenced supervision or culture may have also contributed to some items aligning more strongly with those factors rather than remaining together as separate constructs. Together, the reorganization of SAR and PHRTD may begin to distinguish what appears to constitute self-of-the-therapist work and what may instead support or influence that work.

How the Components of Self-of-the-Therapist May Work Together

The items in the final five factors primarily describe therapists' reported experience with self-of-the-therapist training, their continued engagement in self-of-the-therapist work, and their perceptions of its value. Although these factors provide an initial framework for understanding the components of self-of-the-therapist work, they should not be understood as representing all aspects of this work. However, the SOTI does not independently establish changes in therapists,

their clinical practice, or client outcomes. This distinction became clear during item reduction when a sixth factor, Self Awareness and Reflection (SAR), emerged consisting of items describing *how* self-of-the-therapist training had affected or changed therapists. This content represents a meaningful area of the broader self-of-the-therapist literature, but the factor was not stable (it had been reduced to five items, two of which cross-loaded above .30) and was conceptually different from the remaining factors. Removing these items improved the structure and clarified what the final SOTI measures. What constitutes self-of-the-therapist work and what may happen as a result of that work appear to be related but distinct questions that warrant additional investigation.

Although the present study did not examine this process directly, the literature reviewed previously repeatedly describes movement beyond awareness toward processing and clinical integration, as seen in Rober's (2017) link between awareness and intentional use of self and in Aponte and Kissil's (2014) emphasis on processing signature themes. Work on culture and positionality similarly moves from recognizing aspects of the self to understanding how they shape the therapist's clinical lens (Hardy, 2018; Watts-Jones, 2010). Both the literature and the SOTI findings therefore point to an open question about *how* the components of self-of-the-therapist work become integrated into clinical practice.

The relationships among the five SOTI factors also suggest one possible way these components may operate together. Self-of-the-Therapist Training Experiences and Supervision may represent contexts in which self-of-the-therapist work occurs, while Cultural Self-Awareness may reflect how therapists examine the influence of cultural experiences on themselves and their clinical work. Use of Self may reflect how therapists apply this awareness in clinical practice, while Perceived Value and Continued Engagement may reflect therapists'

perceptions of the value of this work and their continued engagement with it over time. The positive correlations among all five factors suggest that these components are interconnected, with the relationships among Self-of-the-Therapist Training Experiences, Supervision, and Use of Self raising questions about how training and supervision experiences may relate to therapists' developing use of self in clinical practice. However, the cross-sectional design of the present study cannot establish an ordering among these components or determine whether they represent a developmental sequence. Longitudinal research is needed to examine how these components relate to one another over time and whether their relationships reflect a developmental process.

Supervision may be one place where this integration occurs. Supervision emerged as a distinct and internally consistent factor, and its items describe more than exposure to self-of-the-therapist content. They describe a supervisory relationship in which therapists felt safe enough to be vulnerable, a supervisor who modeled openness, exploration of moments when therapists' reactions to clients affected their personal lives, and support in applying self-of-the-therapist learning to clinical practice. One SAR item, which asked whether therapists explored in supervision how their beliefs, feelings, biases, and blind spots could affect their clinical work, also became part of this factor. This suggests that, in supervision, self-awareness is examined in direct connection to clinical work. These features closely match how the literature describes supervision's role in self-of-the-therapist development. Frediani and Rober (2016) described post-session supervision as a space where reactions that went unnoticed during sessions can be brought into awareness, Rober (2017) developed a supervision method centered on the therapist's inner conversations, and the Person of the Therapist (POTT) model uses both live and reflective supervision to help therapists connect in-session reactions with their personal themes (Aponte & Kissil, 2016; Niño & Zeytinoglu-Saydam, 2020).

The SOTI assesses whether supervision included these elements, not whether integration took place. Supervision may therefore be best understood as a point where the *what* and *how* of self-of-the-therapist work meet: a component of self-of-the-therapist training that also provides conditions under which integration may occur. The inclusion of an item about supervisors modeling vulnerability and openness also points to the role of the supervisor's own self-of-the-therapist work, consistent with the literature's emphasis on self-of-the-supervisor work. Given that supervision often centers on technical skill development rather than the therapist's inner experience (Rober, 2017; Storm et al., 2001), these findings highlight the value of supervision that intentionally incorporates self-of-the-therapist work.

Distinguishing Self-of-the-Therapist Work, Integration, and Outcomes

Collectively, these findings suggest three distinct but related areas for continued self-of-the-therapist research: *what* constitutes self-of-the-therapist work, *how* therapists process and integrate that work (both internally and within therapeutic relationships), and what therapist and client *outcomes* may result from the process. The present study speaks directly to the *what* but does not establish how these three areas relate to one another or whether they occur in a particular sequence. Rather, this framework helps distinguish what the SOTI measures from related questions that remain unanswered. It may also explain some of the relationships between the SOTI and the other measures in this study: expertise, self-efficacy, self-awareness and management strategies, self-reflection and insight, and burnout may be related to self-of-the-therapist without necessarily being components of self-of-the-therapist itself (Banner et al., 2024; Glebova et al., 2022; Gori et al., 2022, 2023; Kissil & Niño, 2017; Williams et al., 2003).

One of the most important findings of the present study was that higher SOTI scores were significantly and positively associated with psychotherapy expertise, therapist self-efficacy,

management strategies, and aspects of self-reflection. These relationships are particularly meaningful because they provide preliminary empirical support for the potential value of self-of-the-therapist work in therapist development. Although self-of-the-therapist training has long been emphasized in the literature, quantitative evidence connecting therapists' experiences with this work to broader professional characteristics has been limited. The present findings begin to address this gap by demonstrating that therapists who reported greater experience with the components of self-of-the-therapist work also tended to report greater expertise, self-efficacy, and use of management strategies. These theoretically consistent associations also provide preliminary evidence of convergent validity for the SOTI.

The relationships with therapist expertise and self-efficacy are consistent with the expectation that self-of-the-therapist work would be related to therapists' broader professional development. These findings are particularly important because expertise and self-efficacy represent aspects of professional functioning that therapist training seeks to develop. The positive associations suggest that self-of-the-therapist experiences may have relevance beyond personal awareness and reflection, extending to how therapists perceive their professional competence and therapeutic abilities. Although the cross-sectional design cannot establish whether self-of-the-therapist training contributes to greater expertise or self-efficacy, these findings provide a basis for future research examining whether and how such training supports therapist development.

The positive associations with management strategies and self-reflection provide further support for the potential relevance of self-of-the-therapist work to therapists' professional functioning. The SOTI was positively related to the Self-Awareness and Management Strategies (SAMS) Management Strategies scale and its Self-Care/Self-Reflection and Cognitive/Relaxation subscales. These associations provide additional evidence of convergent

validity, as strategies for recognizing, reflecting on, and managing therapists' internal experiences are theoretically relevant to self-of-the-therapist work. Relationships with the Hindering Self-Awareness (HSA) portion of the SAMS were less consistent: the SOTI total score was not significantly related to the HSA total or the Distracting subscale but was positively related to the Anxious subscale. The direction of this last association is worth noting. Higher SOTI scores were associated with greater reported awareness of anxiety during sessions. Although the SAMS frames this awareness as hindering, self-of-the-therapist training explicitly encourages therapists to notice their in-session reactions, so this association may reflect heightened awareness rather than greater difficulty with anxiety during sessions, or both. Results for the Self Reflection and Insight Scale-Revised (SRIS-R) were similarly mixed: the SOTI was significantly related to the total score and the Self-Reflection subscale, but not to Insight. The positive relationship with Self-Reflection is consistent with the theoretical importance of reflective processes in self-of-the-therapist work, while the absence of a significant relationship with Insight suggests that these aspects of reflection may not be equally represented in the SOTI. This distinction may be particularly relevant to understanding what the SOTI measures. Self-reflection involves examining one's thoughts, feelings, and experiences, while insight involves developing a clearer understanding of those experiences and their meaning. Although self-of-the-therapist work encourages therapists to examine their personal experiences and reactions, engaging in that reflection does not necessarily mean that insight has developed. Insight may be more closely related to *how* therapists process and integrate self-of-the-therapist experiences than to the experiences themselves. This distinction is consistent with the conceptual separation between what constitutes self-of-the-therapist work, *how* therapists engage with that work, and *what* may develop as a result. Further research is needed to examine whether insight develops

through the processing and integration of self-of-the-therapist work rather than through participation in the experiences themselves. Together, these findings suggest that self-of-the-therapist experiences may be particularly relevant to therapists' reflective practices and strategies for managing internal experiences, although the relationships with different aspects of self-awareness and insight remain less clear.

Across the validity analyses, Perceived Value and Continued Engagement (PVCE) showed a distinct pattern. It had the strongest factor-level associations with expertise (r = .308), self-efficacy (r = .312), and the SRIS-R total score (r = .315). PVCE was also the only factor significantly associated with Insight (r = .225), the only factor negatively associated with HSA Distracting (r = –.188), and the only factor not significantly associated with HSA Anxious. Unlike the other factors, which primarily describe training experiences, PVCE reflects therapists' perceptions of the value of self-of-the-therapist work and their continued engagement with it. Its association with Insight is particularly noteworthy given that the SOTI total score was not significantly related to Insight. This finding raises the possibility that therapists who recognize the value of self-of-the-therapist work and continue engaging in it may also develop a greater understanding of their own internal experiences. The relationships with expertise and self-efficacy further suggest that PVCE may represent an important aspect of therapists' ongoing professional development, although the cross-sectional design cannot establish whether continued engagement contributes to these characteristics.

This interpretation must also be considered in light of differences across professional disciplines. MFTs reported the highest PVCE scores, while psychologists reported the lowest. These differences may reflect variations in exposure to self-of-the-therapist training as well as differences in how professional disciplines conceptualize the therapist's role in the therapeutic

process. The systemic and relational orientation of MFT training may place greater emphasis on therapists' personal experiences and participation in the therapeutic system, potentially contributing to the greater value MFTs reported placing on self-of-the-therapist work. Further research is needed to better understand whether these differences are related to professional training backgrounds, theoretical orientations, continued engagement in self-of-the-therapist work, or other factors.

Burnout presented a different pattern. The hypothesized negative relationship between the SOTI and burnout was not supported. Although the correlations between burnout and each of the five SOTI factors were negative, none reached statistical significance. The original expectation was based on literature suggesting that self-of-the-therapist work may contribute to resources such as greater awareness of personal reactions, self-compassion, boundary development, and management of the emotional demands of clinical work (Glebova et al., 2022; Kissil & Niño, 2017). The findings of this study, however, do not provide evidence that greater experience with the components of self-of-the-therapist work, as measured by the SOTI, is associated with lower burnout.

There are several possible ways to understand this finding, though the present study cannot determine which is accurate. First, burnout is influenced by more than therapists' internal development and may also reflect workload, professional demands, work environment, and other external conditions (Glebova et al., 2022; Rosenberg & Pace, 2006). Second, the SOTI primarily assesses therapists' exposure to and experience with self-of-the-therapist work rather than how fully that work has been integrated or how therapists have changed as a result. Burnout may therefore be more closely related to the integration and developmental outcomes of the self-of-

the-therapist work than to exposure to or experience alone. Third, burnout may simply have a more limited relationship with self-of-the-therapist than originally expected.

Taken together, the significant positive associations between the SOTI and measures of psychotherapy expertise, therapist self-efficacy, management strategies, and self-reflection represent an important finding of the present study. These relationships provide preliminary empirical support for the potential value of self-of-the-therapist work in therapist development, an area that has received relatively limited quantitative investigation. The findings suggest that therapists' experiences with self-of-the-therapist work are meaningfully associated with several characteristics relevant to professional functioning and provide a foundation for future research examining whether and how self-of-the-therapist training contributes to these aspects of therapist development.

Theoretical, Measurement, and Training Implications

The present study contributes to the conceptualization of self-of-the-therapist work by providing an empirically derived structure through which self-of-the-therapist can be more clearly defined and examined. Given the varied ways self-of-the-therapist has been described across the literature, the five-factor SOTI offers an initial framework for organizing these elements within a measurable construct. In this way, the contribution of the SOTI extends beyond the development of an instrument. It begins to provide greater specificity regarding the boundaries of self-of-the-therapist and provides a foundation for examining self-of-the-therapist as a multidimensional construct rather than as a broadly defined aspect of therapist development. By providing an initial empirical structure for a concept that has historically been discussed primarily through theoretical and clinical perspectives, this study represents a meaningful step toward establishing self-of-the-therapist work as a construct that can be systematically

investigated. This contribution creates opportunities for future research to examine the components of self-of-the-therapist work across training contexts and professional development.

From a measurement perspective, the SOTI may be understood as an initial operationalization of the *what* of self-of-the-therapist work. Situating it within the broader *what* to *how* to clinical *outcomes* framework also helps clarify what the SOTI does and does not measure. Although the SOTI includes therapists' perceptions of the value and potential benefits of self-of-the-therapist work, it does not directly measure how therapists integrate that work or the clinical outcomes that may result. Keeping these areas distinct is important so that the components of self-of-the-therapist work, how therapists integrate that work, and what results from it are not treated as the same thing. The SOTI therefore provides a starting point rather than a comprehensive measure of the full self-of-the-therapist process. Identifying the components that make up the *what* of self-of-the-therapist provides a framework for considering how those components might be intentionally addressed in therapist training and supervision, particularly in supervision, where self-of-the-therapist content and its clinical application appear most connected. It also provides a starting point for future research examining how therapists integrate self-of-the-therapist work and what therapist and clinical outcomes may result.

One potential application of the SOTI is its use in evaluating how self-of-the-therapist work is experienced within therapist training programs. Rather than relying solely on whether self-of-the-therapist content is included in a curriculum, programs could use the SOTI to examine students' reported experiences across the five factors. For example, differences in responses related to Supervision and Use of Self could help programs identify areas where students perceive fewer opportunities to explore their personal reactions or connect those experiences to clinical practice. Responses to the Supervision factor could also help programs

examine differences in students' experiences across supervisors, particularly the extent to which self-of-the-therapist work is intentionally incorporated into supervision. This potential application is also reflected in optional participant comments describing differences in the extent to which individual supervisors incorporated self-of-the-therapist work into supervision. These findings could inform discussions about curriculum development, supervision practices, and the integration of self-of-the-therapist work throughout training. With further validation, the SOTI may also provide a means of examining differences in reported training experiences across programs or successive student cohorts. Although the instrument cannot establish training effectiveness or clinical competence, it offers a potential framework for identifying areas of training that warrant further attention.

Limitations

Several limitations should be considered when interpreting the findings of the present study. Although the sample was sufficient for exploratory factor analysis, the five-factor structure was not tested with confirmatory factor analysis in an independent sample. The structure should therefore be treated as an initial model requiring replication rather than an established representation of self-of-the-therapist.

The elimination of items associated with the original SAR and PHRTD domains does not necessarily indicate that these areas are unimportant to self-of-the-therapist work. Rather, the original item pool may not have adequately operationalized Self-Awareness and Reflection (SAR) or Personal History, Relationships, and Therapist Development (PHRTD) as distinct constructs. Therefore, their failure to emerge as factors cannot establish that they aren't distinct components of self-of-the-therapist work. Future research should examine whether additional

items or alternative factor structures could capture aspects of self-of-the-therapist work that were not retained in the present instrument.

The use of self-report and cross-sectional data also limits the conclusions that can be made. The SOTI reflects therapists' perceptions of their experiences with self-of-the-therapist work at a single point in time and cannot establish how self-of-the-therapist develops or changes throughout training and professional development. Although the five components that emerged in developing the SOTI may represent a developmental process, this could not be established given the study design. Self-report may also be influenced by participants' ability to accurately assess their own experiences as well as their interpretation of individual items. The present findings therefore reflect participants' reported experiences rather than direct observation of self-of-the-therapist processes or behavior. Optional open-ended comments from several participants further suggested that self-of-the-therapist experiences may occur across different stages and settings of professional development. Participants described differences between master's and doctoral training, graduate and post-graduate supervision, formal academic training and later professional development. Because these comments were not formally analyzed as qualitative data, conclusions cannot be drawn from them. However, they highlight a limitation of assessing self-of-the-therapist experiences without clearly distinguishing when and where those experiences occurred. Future research could examine self-of-the-therapist development across specific stages and contexts of professional training and practice.

The sample also limits generalizability. Participants were predominantly White women, and recruitment combined convenience sampling, a prescreened research panel, and a managed panel that relied on self-reported eligibility, with substantial exclusions for bot responses and ineligibility. The proportion of MFTs also varied across recruitment samples, and PVCE scores

differed by professional discipline. Because most SOTI items ask about training experiences, therapists from disciplines where self-of-the-therapist training is less common may have had limited exposure to the content items described.

A final limitation involves the measures available for evaluating construct validity. Because no established measure of self-of-the-therapist was available for direct comparison, validation relied on measures of theoretically related constructs, including therapist expertise, self-efficacy, self-awareness and management strategies, self-reflection and insight, and burnout. These constructs provide useful points of comparison but were not expected to represent self-of-the-therapist itself. As a result, the generally small to moderate relationships observed with these measures provide information about how the SOTI relates to neighboring constructs but does not independently establish the validity of the SOTI.

Future Research

The present findings suggest several directions for future research. An immediate priority is continued psychometric evaluation of the 30-item SOTI, beginning with confirmatory factor analysis in an independent sample and followed by further reliability and validity testing. Replication across therapist populations, professional disciplines, training programs, and levels of clinical experience would also help determine the stability and generalizability of the five-factor structure. Future studies should also consider whether Self-Awareness and Reflection and Personal History, Relationships, and Therapist Development emerge differently with items designed to more clearly assess these areas as distinct aspects of self-of-the-therapist work.

Future research should also examine how the five components identified in this study may work together over time. The relatively strong relationships among Self-of-the-Therapist Training Experiences, Supervision, and Use of Self raise questions about whether training

experiences and supervision contribute to how therapists come to use themselves more intentionally in clinical work. Cultural Self-Awareness may operate across these areas rather than as a separate point in a developmental process, while Perceived Value and Continued Engagement may reflect therapists' continued engagement with self-of-the-therapist work over time. These possibilities cannot be tested with the present cross-sectional data but provide questions that could be examined longitudinally.

Research should also extend beyond identifying *what* constitutes self-of-the-therapist work to explore *how* therapists process and integrate self-of-the-therapist work into clinical practice. Supervision may be a particularly useful starting point for this work. Studies could follow supervision over time, include supervisors' perspectives alongside supervisees', or examine how self-of-the-therapist material is addressed in supervision sessions. This work may ultimately support the development of a separate measure of self-of-the-therapist integration rather than an expansion of the SOTI beyond the construct it currently measures.

Longitudinal research will be particularly important for examining potential *outcomes* of self-of-the-therapist work. Following therapists across training and professional development could help clarify whether and how self-of-the-therapist training and integration relate to changes in therapist characteristics or clinical practice over time and potential impact on client outcomes. Such research could also examine whether the constructs examined in the present study, including expertise, self-efficacy, self-awareness, reflection, and burnout develop alongside self-of-the-therapist work or represent potential outcomes of that process. More broadly, longitudinal research could begin to examine the relationships among *what* therapists engage in, *how* that work is integrated, and what *outcomes* may follow, without assuming that these areas operate as a simple sequential process.

Conclusion

The present study represents an initial effort to operationalize self-of-the-therapist work through the development of the Self-of-the-Therapist Inventory (SOTI). The resulting 30-item, five-factor instrument (Appendix B) provides an empirically derived framework for examining Self-of-the-Therapist Training Experiences, Perceived Value and Continued Engagement, Use of Self, Cultural Self-Awareness, and Supervision as components of self-of-the-therapist work. The significant positive associations between the SOTI and measures of psychotherapy expertise, therapist self-efficacy, management strategies, and self-reflection provide preliminary evidence of convergent validity and suggest that the SOTI captures aspects of self-of-the-therapist work that are related to, but distinct from, these broader professional characteristics. Beyond providing an initial measure, the findings also point to the importance of distinguishing the components of self-of-the-therapist work from *how* therapists integrate that work and the potential *outcomes* that may follow. Continued validation of the SOTI, along with research examining how therapists integrate self-of-the-therapist work into clinical practice and the outcomes associated with that work, may help clarify not only *what* therapists engage in, but *how* that work becomes part of who they are as clinicians.

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Table 1

Demographic and Professional Characteristics of the EFA Sample and Validity Subsample

Variable	EFA Sample *N* = 285	Validity Subsample *n* = 199
Age (years)	38.27 (11.32)	37.14 (11.45)
Gender identity		
Woman	80.4%	79.4%
Man	16.8%	16.6%
Transgender	0.7%	1.0%
Nonbinary	3.2%	4.5%
Agender	0.4%	0.5%
Genderqueer	1.1%	1.5%
Race/ethnicity		
American Indian or Alaska Native	0.7%	1.0%
Asian/Asian American	5.6%	7.5%
Black or African American	12.3%	10.6%
Hispanic or Latino/a/x	9.1%	9.0%
Native Hawaiian or Pacific Islander	0.4%	0.5%
Middle Eastern or North African	1.1%	1.0%
White	78.9%	79.9%
Another race or ethnicity	1.1%	1.0%
Prefer not to answer	0.4%	0.5%
Sexual orientation		
Heterosexual	75.4%	74.4%
Lesbian	5.6%	5.5%
Gay	1.1%	1.0%
Bisexual	14.0%	15.6%
Queer	6.0%	8.0%
Asexual	1.1%	1.0%
Pansexual	2.8%	3.0%
Questioning	1.1%	1.5%
Prefer to self-describe	0.4%	0.5%
Relationship status		
Single	13.0%	13.6%
Casually dating	4.2%	2.0%
Seriously dating	4.6%	5.0%

Variable	EFA Sample *N* = 285	Validity Subsample *n* = 199
Committed relationship	21.4%	21.1%
Formally engaged	3.5%	3.5%
Married	46.7%	50.8%
Separated: working to get back together	0.4%	0%
Separated: in the divorce process	0.7%	0.5%
Divorced	3.2%	2.5%
Widowed	2.5%	1.0%
Highest degree completed		
Bachelor's degree	22.8%	20.1%
Master's degree	61.1%	61.3%
Doctoral degree	14.0%	17.1%
Other	1.8%	1.0%
Prefer not to answer	0.4%	0.5%
Professional discipline		
Marriage and Family Therapy	35.8%	48.2%
Counseling	25.3%	21.6%
Social Work	25.6%	19.1%
Clinical Psychology	14.7%	14.6%
Psychiatry/Medicine	0.7%	0.5%
Other	6.7%	5.5%
Not currently pursuing licensure	1.1%	0%
None of the above	0.4%	0%
Professional role		
Student therapist	23.2%	26.6%
Provisionally licensed	19.3%	16.6%
Licensed therapist	70.9%	53.3%
Supervisor	25.1%	21.6%
Faculty	9.9%	9.5%
Other	4.5%	3.5%
Licensure status		
Unlicensed student	—	26.1%
Provisionally licensed	—	18.6%
Fully licensed	—	53.8%
Other	—	1.5%
Hours of clinical supervision		
0–10	6.0%	7.5%
11–50	7.7%	9.5%
51–100	11.9%	10.6%

Variable	EFA Sample *N* = 285	Validity Subsample *n* = 199
101–150	15.1%	13.6%
151–200	9.1%	9.5%
More than 200	50.2%	49.2%
Religion/spiritual affiliation		
No affiliation	—	50.3%
Christianity	—	36.7%
Judaism	—	2.5%
Islam	—	1.5%
Hinduism	—	0.5%
Buddhism	—	1.0%
Indigenous/Earth-based spirituality	—	2.5%
Other	—	5.0%
Relationship structure		
Monogamous	—	91.9%
Polyamorous	—	1.5%
Open relationship	—	2.4%
Swinging	—	0.5%
Another relationship structure	—	4.6%
Clinical experience (years)	—	8.92 (9.60)

Note. Values for continuous variables are reported as *M* (*SD*). Percentages for gender identity, race/ethnicity, sexual orientation, professional discipline, professional role, and relationship structure are based on multiple-response items and may exceed 100%. Age was reported by 267 participants in the EFA sample and 184 participants in the reliability and validity subsample; age ranged from 21–83 years in both samples. Licensure status was reported by 199 participants in the EFA sample. Relationship structure was reported by 197 participants in the validity subsample. Clinical experience was reported by 193 participants and ranged from 0 to 56 years in the reliability and validity subsample. An em dash indicates the variable was not available for the full EFA sample.

Table 2

Factor Loadings for the Final 30-Item Self-of-the-Therapist Inventory (SOTI)

SOTI item	Factor loading				
	1	2	3	4	5
Factor 1: Self-of-the-Therapist Training Experiences					
During my academic program, self-of-the-therapist training was integrated into both coursework and supervision.	**.764**	.076	-.026	-.012	-.015
The intensity of my self-of-the-therapist training matched my developmental stage as a therapist.	**.734**	-.110	.085	-.047	.033
Experiential learning activities (e.g., supervision, reflective assignments) increased my self-awareness as a therapist	**.558**	.149	-.084	.057	.062
I felt emotionally safe in training settings, which allowed me to engage meaningfully in self-of-the-therapist work.	**.519**	-.125	.143	-.084	.199
My training provided structured opportunities to examine my personal experiences and biases in relation to my clinical work.	**.720**	-.062	-.098	.075	.088
My self-of-the-therapist experiences (e.g., classes, supervision, workshops) were presented in a cohesive way that supported my growth as a therapist.	**.765**	.024	.181	-.043	-.100
Factor 2: Perceived Value and Continued Engagement					
My engagement in self-of-the-therapist work has continued throughout my career.	.066	**.701**	.111	.001	-.034
My ongoing self-of-the-therapist training evolves and deepens as I continue to grow as a therapist.	-.106	**.785**	.007	-.034	.159
With experience, the depth of my self-of-the-therapist work has appropriately increased.	-.074	**.641**	.299	-.065	-.020
I view self-of-the-therapist work as a lifelong process of self-discovery.	.010	**.847**	-.109	.008	.000
I believe self-of-the-therapist work contributes to more effective client outcomes.	-.054	**.713**	-.027	.034	.041
I see self-of-the-therapist work as central to ethical and responsible clinical practice.	.103	**.766**	-.120	.117	-.053
Factor 3: Use of Self					
My self-of-the-therapist training helped me understand how to use myself as a therapeutic tool.	.165	.226	**.633**	-.088	-.093
Developing emotional presence, intuition, and self-awareness was central to my training.	-.010	.158	**.714**	-.077	-.016
My training helped me recognize when my personal needs or unresolved issues were shaping my clinical interventions.	-.041	-.015	**.712**	.020	.048

SOTI item	Factor loading				
	1	2	3	4	5
My training explicitly addressed how personal experiences influence clinical decisions.	.041	-.089	**.611**	.121	.101
My training enhanced my awareness of my bodily, emotional, and mental responses during therapy sessions.	-.002	-.067	**.650**	.060	.183
My training addressed how my experiences of trauma or loss might affect my presence as a therapist.	.008	-.149	**.616**	.135	.096
Factor 4: Cultural Self-Awareness					
In class, I examined my psychological, spiritual, cultural, and social identities.	.144	.116	.019	**.564**	-.011
I was encouraged to examine how my positions of privilege and marginalization influence my clinical lens.	-.131	.029	.068	**.893**	-.098
My training addressed how sociopolitical and historical contexts affect both myself and my clients in therapy.	-.043	-.042	.172	**.644**	.016
I was encouraged to examine how power and privilege affect how I use myself in the therapy room during my training.	.046	-.026	**.320**	**.627**	-.122
I explored how my social identities (e.g., race, gender, sexuality, socioeconomic status) influence my clinical work.	.166	-.021	-.192	**.737**	.119
I reflected on how systemic factors (e.g., privilege, oppression) shape my perceptions of clients and their problems.	-.082	.035	-.087	**.846**	.051
Factor 5: Supervision					
In supervision, I felt able to be trusting, vulnerable, and authentic when exploring self-of-the-therapist topics.	.038	-.002	.140	-.111	**.749**
My supervisor helped me gain insight into who I am and what I bring to the therapeutic process.	-.036	.024	-.054	.040	**.911**
Supervision provided support to apply self-of-the-therapist learning to clinical practice.	-.004	-.019	.210	-.053	**.710**
My supervisor modeled vulnerability and openness in ways that encouraged my own self-exploration.	-.019	.039	-.025	-.003	**.841**
Supervision addressed moments when my reactions to clients reflected parallel processes with my personal life.	.057	.055	.044	-.003	**.697**
In supervision, I explored how my beliefs, feelings, behaviors, biases, and blind spots could affect my clinical work.	.128	.054	-.038	.152	**.550**

Note. $N = 285$. The extraction method was principal axis factoring with an oblique (Promax with Kaiser normalization) rotation. Factor loadings above .30 are in bold.

Table 3

Correlations Between the Self-of-the-Therapist Inventory and External Validation Measures

Measure	SOTI	SOTTE	PVCE	UST	CSA	SUP
Psychotherapy Expertise (PEQ)	.302***	.236***	.308***	.256***	.203**	.184*
Hindering Self-Awareness (HSA)	.133	.123	-.084	.123	.150*	.143*
HSA – Anxious	.180*	.160*	.000	.148*	.192**	.152*
HSA – Distracting	.033	.040	-.188**	.058	.053	.097
Management Strategies (MS)	.327***	.227**	.318***	.297***	.225**	.211**
MS – Self-Care/Self-Reflection	.338***	.223**	.355***	.307***	.248***	.200**
MS – Cognitive/Relaxation	.233**	.174*	.203**	.213**	.146*	.167*
Therapist Self-Efficacy (T-SES)	.299***	.208**	.312***	.271***	.216**	.172*
Self-Reflection and Insight (SRIS-R)	.175*	.089	.315***	.099	.195**	.037
SRIS-R – Self-Reflection	.250***	.114	.287***	.202**	.266***	.129
SRIS-R – Insight	.050	.037	.225**	-.020	.067	-.052
Burnout (BMS)	-.078	-.097	-.069	-.083	-.023	-.033

Note. SOTI = Self-of-the-Therapist Inventory total score; SOTTE = Self-of-the-Therapist Training Experiences; PVCE = Perceived Value and Continued Engagement; UST = Use of Self; CSA = Cultural Self-Awareness; SUP = Supervision. Pearson correlations were calculated using pairwise deletion for missing data. $n = 199$ (valid sample sizes vary by correlation). *$p < .05$. **$p < .01$. ***$p < .001$.

Appendix A

Self-of-the-Therapist Inventory (SOTI)

Likert Scale Format: Strongly Disagree / Disagree / Somewhat Disagree / Neither Agree nor Disagree / Somewhat Agree / Agree / Strongly Agree

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Section #1: Experience-Based Constructs

1. During my academic program, self-of-the-therapist training was integrated into both coursework and supervision.
2. The intensity of my self-of-the-therapist training matched my developmental stage as a therapist.
3. Reflecting on my own and clients' emotions in group supervision deepened my clinical understanding.
4. Experiential learning activities (e.g., supervision, reflective assignments) increased my self-awareness as a therapist.
5. I felt emotionally safe in training settings, which allowed me to engage meaningfully in self-of-the-therapist work.
6. My training provided structured opportunities to examine my personal experiences and biases in relation to my clinical work.
7. My self-of-the-therapist experiences (e.g., classes, supervision, workshops) were presented in a cohesive way that supported my growth as a therapist.
8. Continuing education after graduate school included relevant self-of-the-therapist training.
9. My training included space to explore uncomfortable or painful aspects of myself that affected my work as a therapist.
10. Self-of-the-therapist work in my training addressed how to manage feelings of shame, inadequacy, or defensiveness in supervision.

Section #2: Perceived Value and Progression of Self-of-the-Therapist Work

11. I believe all therapists in academic training should engage in self-exploration and self-of-the-therapist work.
12. My engagement in self-of-the-therapist work has continued throughout my career.
13. Consulting with trusted professionals (colleagues, personal therapy, etc.) supports my self-of-the-therapist development.
14. My ongoing self-of-the-therapist training evolves and deepens as I continue to grow as a therapist.
15. With experience, the depth of my self-of-the-therapist work has appropriately increased.
16. I view self-of-the-therapist work as a lifelong process of self-discovery.
17. I believe self-of-the-therapist work contributes to more effective client outcomes.

18. I see self-of-the-therapist work as central to ethical and responsible clinical practice.

Section #3: Use of Self in Therapy

19. My self-of-the-therapist training helped me understand how to use myself as a therapeutic tool.
20. I learned to use my own physical reactions as information in therapy, alongside what clients say and do.
21. Developing emotional presence, intuition, and self-awareness was central to my training.
22. My training included guidance on effective self-disclosure.
23. I learned about the risks and benefits of therapist self-disclosure during my training.
24. My self-of-the-therapist training addressed how to balance sharing myself with clients while maintaining professional boundaries.
25. My training helped me recognize when my personal needs or unresolved issues were shaping my clinical interventions.
26. I was encouraged to examine how power and privilege affect how I use myself in the therapy room during my training.

Section #4: Self-Awareness and Reflection

27. My training explicitly addressed how personal experiences influence clinical decisions.
28. In supervision, I explored how my beliefs, feelings, behaviors, biases, and blind spots could affect my clinical work.
29. In class, I reflected on how my personal beliefs, biases, and experiences shape my work as a therapist.
30. I actively engaged in self-reflection through self-of-the-therapist work during my training.
31. My training helped me recognize and manage my personal patterns of reactivity to keep them from interfering with client work.
32. I became more mindful of how I showed up in the therapy room as a result of my self-of-the-therapist work during my training.
33. My training enhanced my awareness of my bodily, emotional, and mental responses during therapy sessions.
34. Self-reflection and self-of-the-therapist work were integrated throughout my training.
35. As my training progressed, I deepened my understanding of my strengths, growth areas, and emotional wounds.
36. I developed insight into how aspects of myself were reflected or surfaced during therapy sessions.
37. I developed insight into how aspects of myself were reflected or surfaced during supervision.
38. I learned to recognize when client traits or experiences reminded me of myself.

39. I received guidance on recognizing when client dynamics contributed to me feeling stuck in session.
40. Supervision provided meaningful opportunities for self-exploration.
41. Classroom experiences provided meaningful opportunities for self-exploration.
42. I explored how my social identities (e.g., race, gender, sexuality, socioeconomic status) influence my clinical work.
43. I reflected on how systemic factors (e.g., privilege, oppression) shape my perceptions of clients and their problems.
44. My training addressed how to work with feelings of vulnerability, inadequacy, or burnout as part of self-awareness.

Section #5: Personal History, Relationships, and Therapist Development

45. My self-of-the-therapist training helped me understand how my family, relationships, and major life events shape me as a therapist.
46. Through self-of-the-therapist work, I explored how my ways of interacting with others, family of origin issues, and current life circumstances affect my ability to remain emotionally regulated with clients.
47. In class, I discussed personal issues as they related to my clinical development.
48. In supervision, I discussed personal issues as they related to clinical development.
49. My self-of-the-therapist training addressed how personal issues might impact the development of my clinical skills.
50. I learned that I bring my whole self – experiences, relationships, ability to self-regulate, emotional intelligence, biases, and psychological development – into the therapy room.
51. My self-of-the-therapist work helped me recognize how the systems I've been a part of (or am still a part of) – e.g., family, culture, community, religious, political – shape me as a therapist.
52. I reflected on how unresolved issues from my personal history might interfere with therapy.
53. My self-of-the-therapist work helped me differentiate between shared emotional understanding and over-identifying with client's experiences.
54. My training addressed how my experiences of trauma or loss might affect my presence as a therapist.

Section #6: Culture, Spirituality, and Contextual Awareness

55. My self-of-the-therapist training helped me explore how my religious or spiritual beliefs could impact my work with clients.
56. My self-of-the-therapist training helped me explore how my cultural background may affect the therapeutic relationship.

57. My self-of-the-therapist training addressed how cultural self-awareness interacts with my emotional responses, assumptions, and potential shifts of objectivity within the therapeutic process.
58. In supervision, I examined my psychological, spiritual, cultural, and social identities.
59. In class, I examined my psychological, spiritual, cultural, and social identities.
60. My self-of-the-therapist training increased my comfort with identifying and addressing the personal and cultural influences on my professional work.
61. I was encouraged to examine how my positions of privilege and marginalization influence my clinical lens.
62. My training addressed how sociopolitical and historical contexts affect both myself and my clients in therapy.
63. I explored how to hold space for spiritual or cultural differences when they conflict with my own values.

Section #7: Supervision, Structure, and Training Conditions

64. In supervision, I felt able to be trusting, vulnerable, and authentic when exploring self-of-the-therapist topics.
65. I was informed of the potential risks and benefits of self-of-the-therapist work in supervision.
66. I was informed of the potential risks and benefits of self-of-the-therapist work in class.
67. My self-of-the-therapist training emphasized process-oriented learning (e.g., reflection, exploration, emotional engagement).
68. My self-of-the-therapist training emphasized content-oriented learning (e.g., concepts, models, structured material).
69. My self-of-the-therapist training emphasized the personal qualities I bring as a therapist.
70. My supervisor helped me gain insight into who I am and what I bring to the therapeutic process.
71. My self-of-the-therapist training included mentorship or supervision focused on becoming a helping professional.
72. I learned how to use the therapeutic relationship as a tool for intervention.
73. My training included reflection on how being a therapist affects me personally.
74. Supervision provided support to apply self-of-the-therapist learning to clinical practice.
75. My self-of-the-therapist training helped me develop self-efficacy as a therapist.
76. Learning about others' self-of-the-therapist journeys deepened my own development.
77. My supervisor modeled vulnerability and openness in ways that encouraged my own self-exploration.
78. Supervision addressed moments when my reactions to clients reflected parallel processes with my personal life.
79. I received feedback on how my self-of-the-therapist work translated into observable changes in therapy.
80. Supervision helped me link self-of-the-therapist insights to specific clinical interventions.
81. My training emphasized the importance of boundaries in self-of-the-therapist exploration to avoid harm to clients or therapists.

Appendix B

Final 30-Item Self-of-the-Therapist Inventory (SOTI)

Likert Scale Format: Strongly Disagree / Disagree / Somewhat Disagree / Neither Agree nor Disagree / Somewhat Agree / Agree / Strongly Agree

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Section #1: Self-of-the-Therapist Training Experiences

1. During my academic program, self-of-the-therapist training was integrated into both coursework and supervision.
2. The intensity of my self-of-the-therapist training matched my developmental stage as a therapist.
3. Experiential learning activities (e.g., supervision, reflective assignments) increased my self-awareness as a therapist.
4. I felt emotionally safe in training settings, which allowed me to engage meaningfully in self-of-the-therapist work.
5. My training provided structured opportunities to examine my personal experiences and biases in relation to my clinical work.
6. My self-of-the-therapist experiences (e.g., classes, supervision, workshops) were presented in a cohesive way that supported my growth as a therapist.

Section #2: Perceived Value and Continued Engagement

7. My engagement in self-of-the-therapist work has continued throughout my career.
8. My ongoing self-of-the-therapist training evolves and deepens as I continue to grow as a therapist.
9. With experience, the depth of my self-of-the-therapist work has appropriately increased.
10. I view self-of-the-therapist work as a lifelong process of self-discovery.
11. I believe self-of-the-therapist work contributes to more effective client outcomes.
12. I see self-of-the-therapist work as central to ethical and responsible clinical practice.

Section #3: Use of Self

13. My self-of-the-therapist training helped me understand how to use myself as a therapeutic tool.
14. Developing emotional presence, intuition, and self-awareness was central to my training.
15. My training helped me recognize when my personal needs or unresolved issues were shaping my clinical interventions.
16. My training explicitly addressed how personal experiences influence clinical decisions.
17. My training enhanced my awareness of my bodily, emotional, and mental responses during therapy sessions.

18. My training addressed how my experiences of trauma or loss might affect my presence as a therapist.

Section #4: Cultural Self-Awareness

19. In class, I examined my psychological, spiritual, cultural, and social identities.
20. I was encouraged to examine how my positions of privilege and marginalization influence my clinical lens.
21. My training addressed how sociopolitical and historical contexts affect both myself and my clients in therapy.
22. I was encouraged to examine how power and privilege affect how I use myself in the therapy room during my training.
23. I explored how my social identities (e.g., race, gender, sexuality, socioeconomic status) influence my clinical work.
24. I reflected on how systemic factors (e.g., privilege, oppression) shape my perceptions of clients and their problems.

Section #5: Supervision

25. In supervision, I felt able to be trusting, vulnerable, and authentic when exploring self-of-the-therapist topics.
26. My supervisor helped me gain insight into who I am and what I bring to the therapeutic process.
27. Supervision provided support to apply self-of-the-therapist learning to clinical practice.
28. My supervisor modeled vulnerability and openness in ways that encouraged my own self-exploration.
29. Supervision addressed moments when my reactions to clients reflected parallel processes with my personal life.
30. In supervision, I explored how my beliefs, feelings, behaviors, biases, and blind spots could affect my clinical work.