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Clinical Supervision and Trainees' Perceptions of Their Ability to Force Therapeutic Alliance

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Clinical Supervision and Trainees' Perceptions of their Ability to Forge Therapeutic Alliance

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Dedication

I would like to dedicate this dissertation to all the clinical supervisors I have worked with who helped create the experiences that inspired this project, shaped my clinical training, and most importantly encouraged me to explore and embrace my self as a psychotherapist.

I would also like to dedicate this dissertation to my family who supported me throughout this project and my graduate training: My parents, my siblings, and Elias.

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Abstract

Countertransference is a construct that originated in psychoanalysis that has been acknowledged in most forms of therapy. The management of countertransference is important for preventing it from adversely affecting treatment, especially for clinicians in training. While all therapists experience countertransference, training therapists may be more vulnerable to it impeding the development of a strong working alliance with clients. Outcome research has found a moderate relationship between the working alliance and treatment outcome. Only a small amount of writing has focused on the relationship between content and process of supervision and the trainee's ability to form strong working alliances with clients. This study explored the magnitude of the relationship between the topics most explored in supervision and the trainee's perception of her ability to form the working alliance. Participants were recruited through contacting directors of training of graduate schools around the country and were asked to complete a web-based survey. Quantitative methods were employed to test the following hypotheses: (a) Time spent processing thoughts and feelings, personal issues, and developing self-awareness in supervision is associated with a strong working alliance as reported by the trainee; (b) Trainees who identify with relational theoretical approaches to psychotherapy, such as psychodynamic or humanistic, will perceive themselves as more capable of forming working alliances and may spend more time in supervision processing their personal reactions and responses to their clients. Since the primary hypotheses were not confirmed in the present study, exploratory analyses were also performed. Also included is a discussion of the findings and the implications for clinical training and education.

Keywords: countertransference, working alliance, trainees, supervision

Clinical Supervision and Trainees' Perceptions of their Ability to Forge the Therapeutic Alliance

Literature Review

It is inevitable that all clinicians have thoughts, feelings, attitudes, and reactions towards the clients with whom they work. From a psychodynamic framework, this is referred to as countertransference. Countertransference is a dynamic unconscious phenomenon that was first introduced by Freud (1910) over a century ago. Although countertransference is of central clinical relevance to psychodynamic therapists, this construct has gained widespread acceptance in the field of psychology, in that how a therapist feels about a client and manages those feelings significantly impacts the therapeutic process (Fauth, 2006).

The definitions of countertransference multiplied as theories diverged within the psychoanalytic paradigm (Cutler, 1958, as cited in Rosenberger & Hayes, 2002) and there is little agreement on a central definition of countertransference. Exploring the diffuse definitions of countertransference is beyond the scope of this paper, though the various conceptualizations fall into three dominant definitions: (a) the classical definition, (b) the moderate definition, and (c) the totalistic definition. A brief overview of these definitions intends to help the reader understand the divergence in opinion on the definition due to the complexity of this construct. The classical definition of countertransference follows Freud's (1910) notion that it is the therapist's unresolved unconscious reactions to the client's transference. This definition carries a negative connotation, in which a therapist's countertransference is considered problematic in that it distorts the analyst's ability to interpret a client's transference, thereby hindering therapeutic progress. The moderate definition of countertransference considers the phenomenon to include the therapist's reactions to a client that stem from unresolved issues in the therapist (Rosenberger & Hayes, 2002). The totalistic definition considers all of the therapist's reactions and feelings

toward a client to constitute countertransference (Rosenberger & Hayes, 2002). Unlike the classical definition, these reactions are both unconscious and conscious. For the purpose of this study, the construct "countertransference" and "personal reactions" will be used interchangeably to refer to a clinician's thoughts and feelings toward a client. This description falls under the totalistic definition that considers all of the therapist's reactions and feelings toward a client to constitute countertransference (Rosenberger & Hayes, 2002).

Since the early countertransference literature illuminated the importance of processing countertransference reactions to avoid its adverse effects on treatment, more recent studies on this topic have concentrated on the construct labeled countertransference management (Hayes, Gelso, & Hummel, 2011). Hayes, a dominant researcher in this area, proposed a structural model of countertransference management that identifies five inter-related factors: self-insight, self -integration, conceptualizing ability, anxiety management, and empathy (Hayes, 1995, as cited in Rosenberger & Hayes, 2002). Studies using this model suggest that therapists who had greater empathy and were more open to their countertransference feelings were more apt to deal with them, which led to less negative countertransference behaviors. Furthermore, working from a solid theoretical standpoint in conjunction with high self-awareness and awareness to countertransference feelings resulted in the best management (Gelso & Hayes, 2001). While the authors may not have intended this, labeling the construct countertransference *management* carries a negative connotation that suggests that countertransference is something to be stifled or wrestled with, which may serve to perpetuate the stigma around countertransference that persists in the field, despite its growing recognition as a useful clinical tool.

Exploring how therapists understand countertransference is of special importance for clinicians in training who are at greater risk of countertransference reactions impeding their work

with clients (Lecours, Bouchard, & Normandin, 1995). The idea that countertransference is a constructive phenomenon was first introduced by Paula Heimann (1950, as cited in Lecours et al., 1995). Since her assertion several decades ago, countertransference has become widely accepted as an instrumental channel into the experience of the client (Gelso & Hayes, 2001).

In addition, exploring how understanding countertransference impacts therapy is related to the notion that the therapeutic relationship is one of the most important elements in successful psychotherapy. The cumulative research on the "common factors" of psychotherapy indicates that the working relationship, referred to as the working alliance, between the client and therapist is positively associated with treatment outcome (Horvath & Bedi, 2002; Horvath & Symads, 1991; Martin, Ganske, & Davis, 2000, as cited in Norcross, 2011). Since a solid therapeutic relationship, or bond, is an element of the working alliance (Norcross, 2011), one could surmise that time devoted to processing trainees' countertransference reactions in supervision may lead to trainees forming better working alliances with their clients. Due to the field's recent focus on revising and improving training and professional competency standards and guidelines, this topic is meaningful to stakeholders in clinical psychology, professional development, supervision, training, and education (Kaslow et al., 2007).

Why Process Reactions in Supervision?

Supervision is the primary context for clinicians in training to explore personal reactions towards their clients and may help them connect with and foster working alliances with clients. Having "personal awareness, internal processing, and strategic coping in personal affect is one of the major goals of supervision" (Holloway, 1997, as cited in Melton, Nofzinger-Collins, Wynne, & Susman, 2005, p. 93). While some supervisors endorse this idea, these issues may be neglected depending on the trainee and the supervisor's theoretical orientation, training model,

and comfort level. Some supervisors may shy away from these conversations in that they fear they create a "treating" rather than "teaching" supervisory relationship. According to Ladany, Friedlander, and Nelson (2005a), "…because beginning and even more advanced supervisees often misunderstand or are threatened by the personal/emotional aspect of supervision, an important aspect of supervision is clarification of expectations" (p. 20). This illustrates the importance in investigating how much time in supervision is devoted to these conversations, how trainees characterize the nature of their supervisory experience, and how this relates to trainees' working alliances with their clients.

While a trainee may disclose emotional experiences and personal reactions toward a client in the social context of a peer, among peers and a professor in a professional seminar course, or in personal therapy, processing countertransference *in supervision* serves beneficial functions that other social and training contexts may not provide. It may normalize trainees' personal reactions, decrease feelings of shame and guilt, increase the supervisory alliance (Walsh, Gillespie, Greer, & Eanes, 2002), allow trainees to better conceptualize their client's presentation, increase their sense of mastery over their countertransference, and increase professional growth (Gelso & Hayes, 2001). Additionally, it may prevent the trainee's countertransference from hindering effective treatment (Lecours et al., 1995). With these implications in mind, this study seeks to explore the strength of the relationship between reported time in supervision devoted to processing personal reactions and other relational concerns and the trainee's perception of her ability to form strong working alliances in therapy.

Although training clinicians learn basic counseling skills in coursework and experientially, they often struggle to manage anxiety and their personal reactions towards their clients during clinical encounters (Melton et al., 2005). These skills are often not directly

addressed in training and may not come up in the context of supervision. A qualitative study by Melton et al. (2005) found that trainees frequently have strong affective responses towards their clients during sessions that often shift the content and process of the therapy hour to the client's disadvantage. For example, some trainees emotionally withdrew, changed the subject, or became silent while having a strong affective response to their client (Melton et al., 2005). In addition, a quantitative study by Machado, Beutler, and Greenberg (1999) found that trainees' personal awareness and sensitivity to their own emotions increased their accuracy in identifying specific emotions in others. This human "skill" or ability is associated with self-awareness and is related to the important task of empathizing with clients, which is the foundation of developing a therapeutic alliance. If a trainee does not process her reactions towards her clients in supervision it may compromise her ability to connect with her clients.

Ligiéro and Gelso (2002) note that countertransference is harmful when emotional reactions are out of consciousness and that in-session awareness of feelings is an instrumental clinical tool. Thus, focusing on self-awareness, personal reactions to clients, and countertransference in supervision should aid trainee in preventing "acting out" in session and should support forming the alliance.

The Focus of Supervision: Technique vs. Common Factors

Since the 1970s, research on the "common factors" of psychotherapy has found that different models of psychotherapy typically produce similar results (Luborksy, Singer, & Luborksy, 1975; Smith & Glass, 1977; Stiles, Shapiro, & Elliot, 1986, as cited in Norcross, 2011). Meta-analyses of outcome research reveal a consistent finding of the "moderate but robust" relationship between the working alliance and treatment outcome across a variety of treatment models and client problems (Horvath & Bedi, 2002; Horvath & Symads, 1991; Martin,

Ganske, & Davis, 2000, as cited in Norcross, 2011, p. 26). Thus, helping trainees foster the ability to form strong working alliances with their clients should be a primary focus of supervision. Part of this work is undoubtedly fostering self-awareness, trusting and using one's internal reactions, and processing countertransference.

The concept of the therapeutic alliance is grounded in psychoanalytic theory and the notion that the alliance is distinct from the transferential aspects of the therapy relationship. Of the more contemporary definitions, Bordin's (1979) conceptualization is one of the most widely accepted. Although there is no universally agreed-upon definition of the construct, Bordin conceptualized the working alliance as a construct with three mutually exclusive elements: (a) Agreement on goals, (b) Alignment on tasks, and (c) Developing a bond. Hovarth and Greenberg (1989) developed the Working Alliance Inventory (WAI) based on Bordin's conceptualization. Research using the WAI has found the alliance positively associated with several outcomes, including but not limited to client satisfaction, symptom reduction, and agreement on termination (Norcross, 2011). According to Norcross:

> The alliance represents an emergent quality of partnership and mutual collaboration between therapist and client…it is not the outcome of a particular intervention; its development can take different forms and may be achieved almost instantly or nurtured over a longer period of time. (p. 28)

One may define the working alliance as the extent to which a client and therapist work purposefully and collaboratively and connect emotionally (Norcross, 2011). In order to connect emotionally with clients, the trainee must be aware of her own internal reactions towards the clients with whom she works. This should be collaboratively explored in supervision on a routine basis.

A quantitative study on trainee preferences found that trainees prefer supervisors who invite them to process their feelings towards their clients and allow them to experiment with developing their own style of therapy (Nelson, 1978). A series of quantitative studies on agreement on supervision topics among trainees and supervisor dyads indicated that "personal issues" and "skills and technique" were the two most frequently focused on topics of supervision (Ellis, 1991; Henry, Hart, & Nance, 2004; Heppner & Roehlke, 1984; Rabinowitz, Heppner, & Roehlke, 1986). The participants also ranked these two topics as the most important topics of supervision out of twelve commonly discussed supervision topics. This research suggests that while beginning trainees want to focus on skills and technique, they also want to discuss issues that may interfere with their ability to help their clients. These studies highlight the need to re-examine existing models of supervision and the commonly held belief that novice trainees primarily want structure and direction in supervision.

Supervision Effects on Trainee's Therapy

Direct clinical supervision is intended to have a positive effect on the trainee's counseling process and outcomes. However, little empirical research has focused on supervision effects on counseling process and outcomes. There is empirical research on supervision variables that impact the trainee's therapy. Variables studied in relationship to trainee variables include the supervisory relationship, supervisory styles, supervisor characteristics, parallel process, and supervisor theoretical approach (Holloway & Neufledt, 1995). Most of the literature to date has focused on the impact of supervision variables on trainee attitudes, preferences, self-perceptions, and skill acquisition (Holloway & Nuefeldt, 1995). Patton and Kivlighan (1997) studied the assertion that the supervisory process impacts the trainee's counseling process. They specifically looked at the relationship among the trainee's perception of the supervisory working alliance, the

trainee's adherence to the counseling approach being taught in supervision, and the client's perception of the working alliance. The results indicated a correlation of .66 between the trainees' perceptions of the supervisory working alliance and their client's perception of the therapeutic alliance (Patton & Kivlighan, 1997).

According to Holloway and Neufeldt (1995), supervision should influence the trainee's ability to form relationships with her clients and adhere to treatment models. However, research has not addressed what topics of supervision most influence the trainee's ability to form relationships with clients. Safran and Muran (2000) note:

> Because of the complexity of the skills therapists require to deal with negative therapeutic process, it is critical for their training to be more experiential in nature and to emphasize self-exploration as a primary vehicle for learning. (p. 5)

Supervision is undoubtedly where some of this self-exploration should occur and should be the context for learning more relationship-oriented skills. However this may depend on what topic (or topics) is the focus of supervision. Given the importance of the alliance to successful therapy outcomes, it is crucial to understand the relationship between how much time is devoted to certain topics in supervision and the trainee's perception of her ability to foster the alliance with her clients.

Implications for Professional Psychology Training

Presently, there is an emphasis on competency-based education, training, credentialing, and assessment to ensure the integrity of the field, and that practitioners are providing the most effective treatment possible (Kaslow et al., 2007). Professional competence in the field of psychology is a multifaceted construct that includes the interaction of skills, knowledge, abilities, behaviors, beliefs, self-perception, and personal characteristics (Kaslow et al., 2007).

Competence is defined as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 226, as cited in Daly et al., 2011). The ability to understand and use countertransference in the service of developing strong therapeutic alliances with clients surely falls in the realm of professional competence, specifically under the domains of relationship, reflective practice, and self –assessment (American Psychological Association [APA] & Council of Chairs of Training Councils [CCTC], 2007).

Founded in 1976, the National Council of Schools and Programs in Professional Psychology (NCSPP) is an organization of professional schools and programs in psychology formed to improve the standards of professional psychology education and training. Distinct from the model of competencies presented above, the NCSPP sees the relationship competency as the foundation upon which all the other competencies rest. Mangione and Nadkarni (2010) note:

> [The relationship competency] is also foundational in that it involves the whole person, including intellectual, emotional, cognitive, physical, cultural, and spiritual aspects as well as involving the context, as it is always relationship with someone. (p. 69)

The NCSPP's model of competency also asserts that the relational functioning of practitioners is immensely impacted by one's connection and awareness of one's own identity and self-concept, highlighting the importance of incorporating self-understanding and reflection into supervision and training (Mangione & Nadkarni, 2010).

Furthermore, since the working alliance is positively associated with treatment outcome, determining how processing countertransference, personal reactions, fostering self-awareness,

and other relational issues in supervision is related to the working alliance infers that this supervisory task may also relate to treatment outcome. These processes may be examined by obtaining trainee's perspectives on what they focused on in their supervision experiences and how they perceive their alliance-forming abilities. Understanding this relationship may lead to new strategies for improving competency-based training and provide insights regarding what topics in supervision relate to trainees forging strong working alliances.

Methodology

The purpose of this quantitative analysis was to understand the magnitude of the relationship between the trainee's ability to forge a strong working alliance and the frequency that countertransference, personal reactions, and other relational issues are addressed in supervision. The study also explored whether trainee variables, such as theoretical orientation, impact the trainee's ability to form working alliances. This chapter describes the study's research methodology and includes discussion around the following areas: (a) research questions and hypotheses, (b) study procedure, (c) inclusion criteria and recruitment, (d) data collection, (e) measurement strategy, and (f) data analysis.

Research Questions and Hypotheses

The study addressed the following: (a) What is the magnitude of the relationship between the time spent on processing trainees' reactions and responses to their clients and their perception of their ability to form working alliances in therapy? I hypothesized that there is a positive correlation between exploring trainees' personal reactions and other relational issues in supervision and the perception of the ability to form good working alliances. **(**b) Theoretical orientation was examined as a possible moderator of the relationship among what trainees and supervisors focus on in supervision and the trainee's perception of her capacity to form strong

working alliances. I hypothesized that trainees who identified with more relational theoretical approaches to psychotherapy, such as psychodynamic or humanistic orientations, perceived themselves as more capable of forming working alliances and reported spending more time in supervision processing their personal reactions and responses to their clients. (c) What is the strength and direction of association that exists between the frequency of what was discussed in supervision and which topics the trainee believed best characterized the nature of the supervision? I hypothesized that the frequency of what was discussed in supervision as well as how the trainee characterized her supervision experience both impacted her perception of her ability to form strong working alliances. However, it is important to note that a trainee may report she frequently discussed treatment planning in supervision but characterize her supervision as relationally focused. This research question intended to tease out the nuances of the trainee's supervision experience.

Study Procedure

This study aimed to determine the magnitude of the relationship between the time in supervision spent processing trainees' reactions towards clients, what topics of supervision they believed best characterized the nature of their supervisory experience, and trainees' perceptions of their working alliances thus far in their training. Evidence of a strong relationship would help supervisors and trainees prioritize what to focus on during supervisory meetings and could lead to innovations in competency-based training. If the time spent focusing on personal reactions and the relational components of psychotherapy in supervision was important to trainees who perceived themselves as capable of forming working alliances with her clients, more attention would be paid to understanding this relationship and how certain personal characteristics of trainees impact counseling and supervisory processes. This would have implications for training

and education in helping educators and supervisors determine how to tailor the structure and focus of the supervisory hour.

Inclusion Criteria and Recruitment

Participants were recruited by emailing directors of clinical training from graduate programs in the United States, and asking them to forward a recruiting email to their students. Participants were eligible if they had previously worked with individuals 18 years of age or older and conducted individual psychotherapy within the past year and met with a supervisor weekly for at least one hour. Participants were asked how many years of psychotherapy experience they had. Doctoral-level and masters-level clinicians in training in the areas of clinical psychology, counseling psychology, and social work who have conducted individual weekly or bi-weekly psychotherapy in the past year were considered for inclusion in this study. While social work trainees receive education and training in psychotherapy, it is important to note that their training tends to emphasize advocacy and connecting individuals to community and support services. Their inclusion in this study is such that a sample of trainees from an array of training backgrounds who deliver psychotherapy was obtained. Eligible participants were clinicians who had a primary supervisor whom they met with for at least one-hour weekly. Including individuals with varying amounts of psychotherapy experience allowed the researcher to obtain a range of data on how the focus of supervision impacts trainees' ability to forge alliances at different stages of professional development.

Data Collection

Participants completed a survey that was housed on Survey Monkey, a web-based survey cloud-based company. They accessed the survey by clicking a hyperlink contained in the recruiting email. The recruiting email contained a brief description of the study, details including

eligibility criteria, informed consent, confidentiality, and anonymity (Appendix A). The study was described as one on supervision topics.

Measurement Strategy

Demographic information. All participants filled out a demographic form, asking them to indicate their gender, age, race/ethnicity, state they reside in, state they resided in prior to graduate school, theoretical orientation, years in training program, approximate hours of clinical supervision received, approximate hours of one-to-one psychotherapy experience, and type of training program (Appendix B). This allowed me to obtain a detailed description of the sample and examine the moderating effects of these variables.

Working Alliance Inventory-Short Form. Tracey and Kokotovic (1989 as cited in Hanson, Curry, & Bandalos, 2002) developed a shortened version of Hovarth and Greenberg's (1989) Working Alliance Inventory (WAI). The Working Alliance- Short Form (WAI-S) is a self-report measure that clients and therapists complete as a way of monitoring treatment. The WAI-S measures constructs identical to the WAI subscales. Items that loaded highest on each of the subscales on the WAI were retained from the WAI to form the WAI-S. As the WAI does, the WAI-S assesses three key aspects of the therapeutic alliance: agreement on goals of therapy, agreement on tasks of therapy, and development of an affective bond. Like the WAI, the WAI-S has three subscales: (a) Goals, (b) Tasks, and (c) Bond. The WAI-S has a therapist form that asks the individual to answer 12 items on a 7-point Likert scale ranging from "Never" to "Always." For example, "My client and I both feel confident about the usefulness of our current activity in counseling" (Hovarth & Greenberg, 1989). The measure was adapted for this study in that participants were asked to think about the clients they worked with within the past year, rather than an individual client. Participants answered adapted items on the WAI-S with these clients in

mind. The WAI-S is intended to address the working alliance with one client. For example, an original item on the WAI-S states, "I believe my client likes me." The corresponding adapted item in this study states, "I believe my clients like me." Thus, the only change that was made was pluralizing the word client.

Subscale scores range from 4 to 28 and can be added to obtain a total score. Higher scores reflect more positive ratings of the working alliance. Based on an initial validation sample of 124 pairs of actual clients and their therapists, internal consistency estimates of the three subscale scores ranged from .83 to .91 for the therapist version. Internal consistency estimates of the total scores were .95 (Tracey & Kokotovic, 1989 as cited in Hanson et al., 2002). Since the measure was adapted for this study, the researcher assessed the internal consistency reliability of the WAI-S using Cronbach's alpha.

Topics of supervision. The Topics of Supervision measure was used to examine what trainees report as the topics they spent the most time discussing in their supervision sessions. The measure contains 12 topics and is a theoretically derived measure adapted from previous studies on supervision, namely studies by Heppner and Roehlke (1984), Rabinowitz et al. (1986), and Henry et al. (2004). The twelve topics are deemed important and most typically discussed topics for supervision by Loganbill, Hardy, and Delworth (1982, as cited in Henry et al., 2004). The twelve topics are inclusive of those used by Henry, Hart, and Nance (2004) who revised the topics used by Rabinowitz et al. The authors replaced two topics from the previous authors' list. They added Monitoring in that it is thought to be a frequently used supervisory strategy and Evaluation in that it is mandated for trainees in practicum. They omitted the Rabinowitz topics, "being non-judgmental and respectful of the differences between one's clients and me" (Rabinowitz et al., 1986, p. 293) and "becoming aware of my personal motivation for being a

counselor or psychotherapist" (p. 293) because they received the lowest percentage of frequency in the Rabinowitz et al. study. The "being non-judgmental . . ." item and the "becoming aware . . ." item were conceptualized and condensed in Henry et al.'s study as a part of the Awareness topic.

Additionally, the authors changed the Rabinowitz et al. (1986) item "believing that I have sufficient skills as a counselor or psychotherapist to be competent in working with my clients" to read "developing and refining competency with a range of intervention skills" (p. 296) and was labeled Skills and Techniques. The focus was shifted from beliefs of the supervisee to more behavioral and less abstract development of skills. Lastly, they changed the Rabinowitz et al. item "dealing with transference and countertransference" to "dealing with client-counselor therapy issues" to make the item less theoretically narrow.

The 12 topics are labeled with descriptions in parentheses when warranted:

1. Treatment Planning (developing and carrying out a treatment plan)
2. Trusting and using feelings in responding to clients
3. Making appropriate independent decisions and actions)
4. Theoretical Conceptualization (understanding clients in a theoretical framework)
5. Dealing with personal issues or problems that interfere with working with clients
6. Skills and Techniques (developing and refining competency with a range of intervention skills)
7. Supervisory Relationship (defining, clarifying the supervisory relationship)
8. Support (the supervisor providing support for work with clients)
9. Awareness (confronting personal blind spots, increasing personal and/or professional awareness)

10. Therapy Relationship (dealing with client-counselor relationship)

11. Monitoring (reviewing the status of client load, client by client)

12. Evaluation (evaluating supervisee's performance, level of functioning and progress).

Participants were asked to rank on an ordinal scale from 1 to 12, which topics they believe best characterize the nature of their supervisory experience (1 being the most and 12 being the least). In addition, for all twelve topics, participants were asked to rate the degree to which their time in supervision was devoted to that topic, using a continuous scale from 1-7 (1 being "Never" and 7 being "Always").

Lastly, at the end of the questionnaire, participants were asked explicitly: "Rate the degree to which you agree with the following statement: Talking about myself in supervision helps be form working relationships with my clients." Participants used a continuous scale ranging from 1-7 (1 being "Extremely Disagree" and 7 being "Strongly Agree").

Data Analysis

A regression analysis was used to test the hypothesis that time spent processing thoughts and feelings, personal issues, developing self-awareness, and other relational issues in supervision was associated with a perceived strong working alliance. The assumptions for a regression are that the scores on the WAI-S are independent of the each other. The scores on the WAI-S and the Topics of Supervision form should be normally distributed and linearly related. And lastly, the scores on the Topics of Supervision form should have homogenous variance across levels of the WAI-S, and vice versa (Warner, 2012). Once these assumptions were confirmed, the researcher generated a regression analysis using SPSS to see the magnitude of the relationship between the topics of supervision and the WAI-S Therapist Form.

Sample size and statistical power were considered for understanding an effect size (Cohen, 1992). I needed a sample size of at least 85 in order to perform the statistical analyses. For the first hypothesis, I expected to observe a medium effect size to able to reject the null hypothesis that there is no relationship between the trainee's perception of her ability to form the therapeutic alliance and the focus of supervision. I set the minimum number of participants at 85 in order to detect a medium effect size at $\alpha = .05$ ($r \geq .30$; Cohen, 1992). If the p-value falls below .05, a statistically significant relationship exists.

The question of whether theoretical orientation impacts the trainee's ability to form the working alliance was assessed using an analysis of variance (ANOVA). The main effect of theoretical orientation was examined. The presence of a statistically significant main effect would demonstrate that the difference between the group means is larger than would be obtained by chance if there really were no difference between the groups. It is important to note here that the factorial ANOVA does not speak to causality. Therefore, if a statistically significant main effect is obtained, this result will invite further investigation into the specific reasons why theoretical orientation influences the trainee's perception of her ability to forge the working alliance. In order to increase the number of participants in each group to increase statistical power for the analysis, the researcher collapsed the Humanistic and Feminist theories into one group, called Egalitarian/Post-modern theories to form a total of five groups.

The Spearman rank-order correlation coefficient was used to assess the strength and direction of association that exists between the frequency of what was discussed in supervision and which topics the trainee believed best characterized the nature of the supervision. The assumptions of a Spearman correlation are that variables should be measured on an ordinal, interval, or ratio scale. Another assumption is that there is a monotonic relationship between

variables (Mertens, 2009). Once these assumptions were confirmed, the researcher generated a regression analysis.

Results

The following section includes a description of the sample and a presentation of the results of the performed data analyses in narrated and table form. Based on the results of the hypothesis under question, additional exploratory analyses were performed, and the results of those analyses are also included.

Sample Characteristics

Among the trainees in the analysis, 78 participants identified as female and 15 identified as male (N=93). There was a 7% attrition rate, with those participants exiting the survey during or immediately after filling out their demographic information. Some participants omitted items and were, thus, removed from the analyses on a case-by-case basis. Age ranged from 21 to 51, with a median at 28; years in training program ranged from 1 to 10 years, with a median of 5.5 years; hours of one-on-one supervision received ranged from 0 to 3000, with a median at 1500 hours; hours of providing one-on-one therapy ranged from 0 to 4500, with a median at 2500 hours (see Table 1). The sample was comprised of participants who indicated they were in Ph.D. or Ed.D training programs, Psy.D. programs, Master's-level mental health counseling or marriage and family programs, and masters-level social work programs (Figure 1). The majority of the sample identified as White (84.9%), though participants identified as African American, Asian, Hispanic, and Native American. (Figure 2). A number of states were highly represented including Massachusetts, California, New York, Texas, and New Hampshire. The other states represented by the sample include Florida, Iowa, Montana, New Jersey, Ohio, Vermont, and Virginia (Figure 3).

Table 1

Demographic Variables of Sample (N=93)

	Mean	Standard Deviation	Minimum	Maximum
Age	29.29	6.532	21	51
Years in Training Program	2.88	1.730	1	10
Hours of Supervision	264.19	479.601	0	3000
Hours of Therapy	521.86	780.384	0	4500

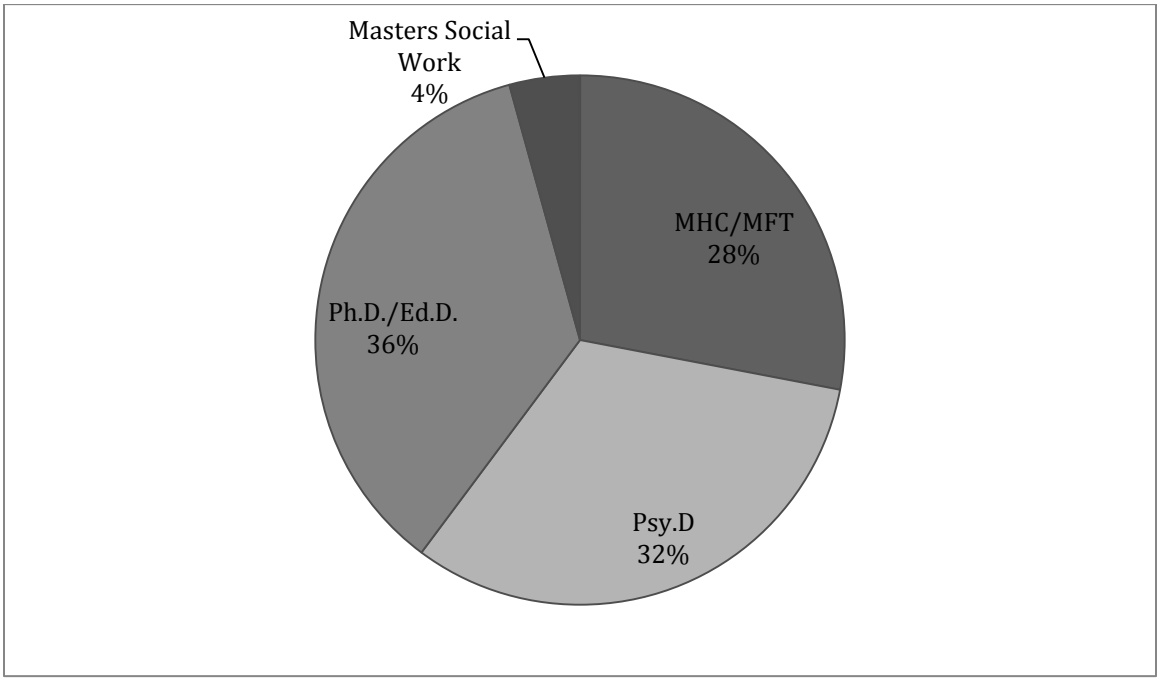

Figure 1. Participants by type of training program
Note. MHC= mental health counseling; MFT= masters in marriage and family therapy

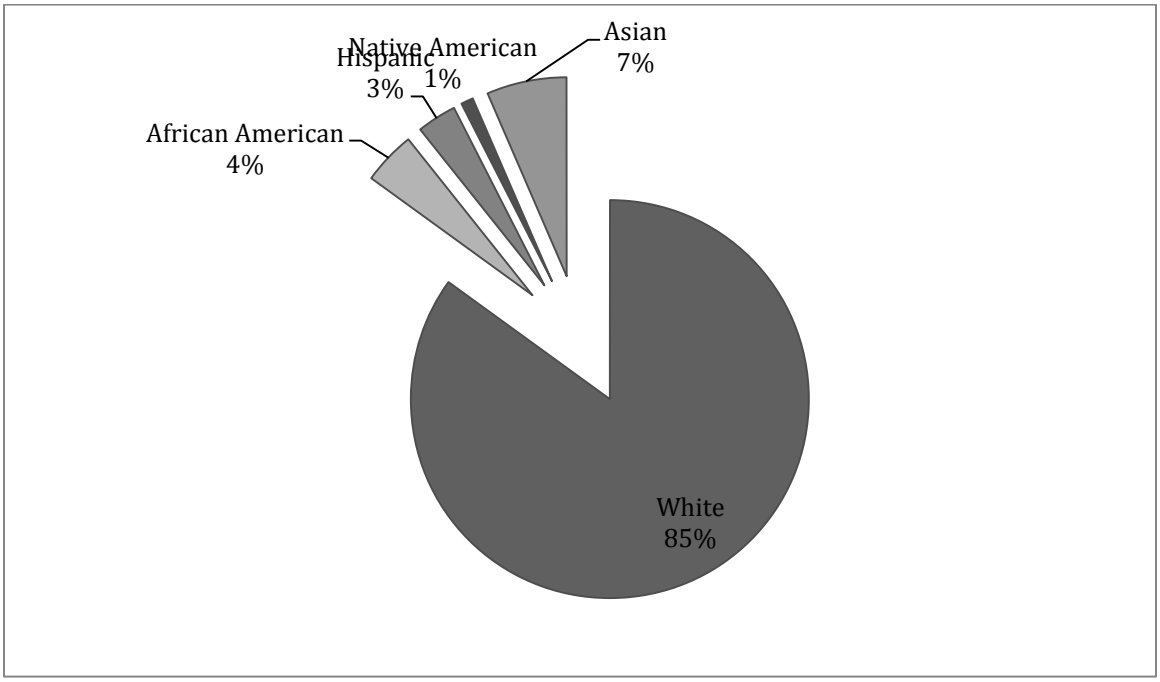

Figure 2. Participants by self-identified ethnicity

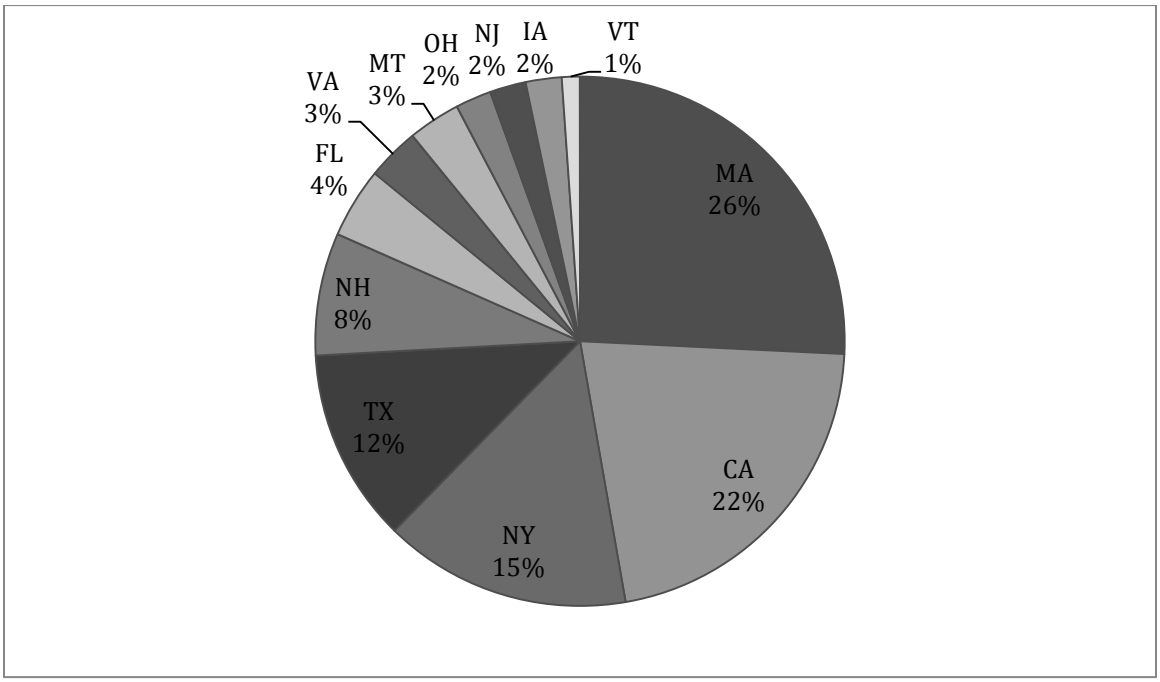

Figure 3. Participants by current abbreviated state

Hypothesis 1

A Pearson correlation was performed to test the hypothesis that there is a positive correlation between the frequency of exploring trainees' personal reactions and other relational issues in supervision and trainees' perception of their ability to form good working alliances. The following items of the Topics of Supervision form were positively correlated and combined to form what will be referred to as the *relational total*: (a) Trusting and using feelings in responding to clients, (b) dealing with personal issues or problems that interfere with working with clients, (c) defining and clarifying the supervisory relationship, (d) confronting personal blind spots, (e) increasing personal/professional awareness, and (f) dealing with client-counselor relationship. The results of the correlation showed that there was not a statistically significant correlation between participants' relational total score and the WAI-S (*rho*=.054, *p*=.63). Since the results were not statistically significant, no regression analysis was developed.

Hypothesis 2

A one-way analysis of variance (ANOVA) was performed to test the hypothesis that trainees who identify with more relational theoretical approaches to psychotherapy, such as psychodynamic or humanistic orientations, will perceive themselves as more capable of forming working alliances with their clients. Initially there were six groups (CBT, Psychodynamic, Humanistic/Existential, Family Systems, Integrative, and Feminist) but I collapsed the Humanistic and Feminist theories into one group, called Egalitarian/Post-modern theories. Thus, five groups were compared using a one-way ANOVA. The results showed that theoretical orientation was not a statistically significant moderator of how trainees rated their alliance forming abilities, as measured by the

WAI-S (F 4, 80)= .558, p= .69).

Hypothesis 3

A one-way analysis of variance (ANOVA) was performed to test the hypothesis that trainees who identify with more relational theoretical approaches to psychotherapy, such as psychodynamic or humanistic orientations may report spending more time in supervision processing their personal reactions and responses to their clients, as measured by the relational total. A post-hoc test was performed using a Bonferroni adjustment. The results of the ANOVA showed that there was a statistically significant difference for the frequency that trainees reported processing their personal reactions and responses to their clients between trainees who identified their theoretical orientation as CBT and those who identified as Family Systems. There was no statistically significant difference between the relational totals of the other groups (F 4,76) =2.454, p=.05)**.** The descriptive statistics for these analyses are presented in Table 2.

Table 2.

ANOVA of Theoretical Orientation and Relational Total

	Sum of Squares	*df*	Mean square	*F*	Significance
Between Groups	194.48	4	48.619	2.454	.05
Within Groups	1505.75	76	19.812		
Total	1700.22	80			

Spearman rank-order correlation

The Spearman rank-order correlation coefficient was used to assess the strength and direction of association that exists between the frequency that relational aspects (of therapy) were discussed in supervision and how trainees' characterized the nature of their supervisory experiences using the Topics of Supervision Form. Treatment Planning was negatively correlated with Trusting and using feelings in responding to clients (*rho*= -.438, *p*=.00), Defining and clarifying the Supervisory Relationship (*rho*= -.234, *p*=.041), and Support (*rho*= -.234, *p*=.044). Theoretical Conceptualization was negatively correlated with Support (*rho*= -.260, *p*=.024) and Increasing personal/professional awareness (*rho*= -.268, *p*=.019). Dealing with personal issues or problems that interfere with working with clients was negatively correlated with Evaluation (*rho*= -.295, *p*=.009). Support was negatively correlated with Evaluation (*rho*= -.261, p=.023). Lastly, Monitoring was positively correlated with Evaluation (*rho*=.229, *p*=.045). The results are displayed in a correlation matrix in Table 3.

Table 3
Correlation Matrix for Frequency and Characterization of Topics of Supervision

	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12
T1												
T2	-.438											
T3	-.208	-.014										
T4	.207	-.112	-.043									
T5	-.181	.199	-.069	-.222								
T6	.016	-.282*	-.048	.040	-.130							
T7	-.235*	.078	-.033	.030	-.032	-.118						
T8	-.234*	.059	.136	-.260*	.026	-.049	-.151					
T9	-.132	.192	-.119	-.268*	.178	-.229*	.027	.207				
T10	-.191	.220	-.154	-.143	-.097	-.001	.085	-.108	-.078			
T11	.048	-.308	-.149	-.241*	-.155	-.112	-.209	-.237*	-.126	-.192		
T12	.071	-.327	.116	.027	-.295	.005	-.050	-.261*	-.243*	-.165	.229*	

**Note.* Correlates at the .05 level

T1: Treatment Planning
T2: Trusting and using feelings in responding to clients
T3 Making appropriate independent decisions and actions
T4: Theoretical Conceptualization
T5: Dealing with personal issues or problems that interfere with working with clients
T6: Skills and Techniques
T7: Supervisory Relationship
T8: Support
T9: Awareness
T10: Therapy Relationship
T11: Monitoring
T12: Evaluation

Exploratory Analyses

Because the major hypotheses of the investigation were not confirmed, I examined the results further to see if any patterns emerged that had not been observed in the obtained findings. This exploratory study focused on evaluating if there was significant variance in how participants from different training programs and of different years of experience rated their perception of their alliance-forming abilities.

A one-way analysis of variance (ANOVA) was performed to see if there were differences in how participants rated their ability to form the working alliance from the four types of training programs. A post hoc test was performed using a Bonferroni adjustment. The results of the ANOVA showed that the difference in WAI scores among PhD/EdD and PsyD trainees was not statistically significant. However, participants from PhD/EdD programs scored 5 points higher on the WAI than those from MHC/MFT programs (F (3,81) =3.475, p=.020). The results are presented in Table 4.

Table 4.

ANOVA of Type of Training Program and Working Alliance Inventory

	Sum of Squares	*df*	Mean square	*F*	Significance
Between Groups	392.928	3	130.976	3.475	.020
Within Groups	3052.719	81	37.688		
Total	3445.647	84			

A Pearson correlation was performed to examine whether there is a positive correlation between years in training program and trainees' perception of their ability to form the working alliance. The results of the correlation showed that there was a statistically significant correlation between participants' score on the Working Alliance Inventory-Short Therapist Form (WAI-S) and how many years of training they have had (*rho*=.229, *p*=.036).

Discussion

In this chapter major findings are summarized and discussed. These findings are considered in the context of the previously reviewed literature. Limitations of the research, directions for future research, and implications for training and education are presented, along with concluding thoughts.

Summary of Results

The current study sought to test three hypotheses:

1. There is a positive correlation between the frequency of exploring trainees' personal reactions and other relational issues in supervision and trainees' perception of their ability to form good working alliances
2. Trainees who identify with more relational theoretical approaches to psychotherapy, such as psychodynamic or humanistic orientations, will perceive themselves as more capable of forming working alliances with their clients

3. Trainees who identify with more relational theoretical approaches to psychotherapy, such as psychodynamic or humanistic orientations, would report spending more time in supervision processing their personal reactions and responses to their clients.

The results of the present study did not confirm the three primary hypotheses of the study. Instead, the results indicate that trainees from different theoretical orientations rate their alliance-forming abilities similarly, and also report spending a similar amount of time discussing relational concerns in their supervision sessions, which was not associated with higher perceptions of alliance-forming abilities. One explanation for these results relates to the methodology in that the Topics of Supervision form is not a psychometrically validated measure for assessing frequency that supervision topics are discussed. Due to the lack of sensitivity of this instrument, there was not enough statistical power.

Hypothesis 1

For the first hypothesis, there are several explanations for the finding that there was not a statistically significant relationship between the frequency of exploring trainees' personal reactions and other relational issues in supervision and trainees' perception of their ability to form good working alliances. One explanation for this finding is that most trainees will not claim that they are not capable of forming a strong alliance. The results indicate that most participants rated their alliance-forming abilities as high (*N=85, M=64.7, SD=6.40*), thus there was not enough variation in participants' responses. Additionally, whether relational concerns are a focus of supervision or not may have no bearing on trainees' *perceptions* of their alliance-forming abilities. One's perception of her abilities and actual abilities may be quite different, especially early in training when trainees are beginning to develop their self-assessment competencies.

Another explanation is that trainees are not self-disclosing in supervision around issues of countertransference, personal issues, and other relational concerns. Previous research indicates that trainees are reluctant to discuss sensitive issues, including personal issues and countertransference reactions in supervision (Ladany, Hill, Corbett, & Nutt, 1996; Pisani, 2005; Yourman, 2003), and often disclose to peers, personal therapists, or significant others outside of supervision due to its evaluative context (Giddings, Vodde, & Cleveland, 2003; Power & Bogo, 2002). In particular, trainees with poor alliances with their supervisors are most likely not to disclose these kinds of issues (Falender & Shafranske 2013).

Another possibility is that trainees, and their supervisors, who are not deliberately and explicitly attending to relational concerns in supervision may be having these discussions but not labeling them as such, thus under-reporting the frequency of this work on the Topics of Supervision Form. A trainee may frequently disclose life stressors that are occurring in her life but not think of them as "personal issues." Participants may have had different interpretations of the topics of supervision. Thus, misinterpreting the meaning of the different topics of supervision may have also contributed to under-reporting or inaccuracy in reporting. Furthermore, some theorists would argue that much of this relational processing occurs out of conscious awareness, which would contribute to under-reporting. Wilner (1990) notes that much of what happens and is worked through in supervision is not part of a conscious goal, making it hard to measure what kind of relational work is occurring in supervision when a lot of it is left unnamed, not commented upon, and outside of conscious experience.

Hypothesis 2

For the second hypothesis, there are several explanations for the finding that theoretical orientation was not a statistically significant moderator of how trainees rated their alliance

forming abilities. One explanation is that theoretical orientation does not impact how trainees perceive their alliance-forming abilities. As mentioned above, there was little variation in how participants rated their alliance forming abilities, as most participants rated them high, making it difficult to detect differences between theoretical orientations.

According to Cohen (1992), in order to detect a medium effect at the .05 significance level when conducting a one-way analysis of variance (ANOVA) among five groups, each group must contain at least 39 participants. In the present study there were 25 participants who identified as CBT, 10 as Family Systems, 10 as Egalitarian/Postmodern, 24 as Integrative, and 16 as Psychodynamic. Thus, due to the small number of participants in each group the analysis was not able to detect a statistically significant difference between the groups. However, the data did follow a trend in that psychodynamic participants tended to talk about relational concerns more than other orientations. It is also not surprising that Family Systems participants discussed relational concerns more than CBT participants, given the relational and contextual underpinnings of Family Systems theories of psychotherapy.

Another explanation is that there was too much within-group difference among the different groups of theoretical orientations. We have no way of knowing which specific theories the participants from the Integrative group subscribe to, or whether the term “eclectic” was mistaken for integrative. Trainees who have not landed on a specific orientation may have also identified as integrative, which could have further skewed the results.

Moreover, the term “psychodynamic” is rather diffuse and reflects a paradigm of thought that contains theories and approaches to psychodynamic therapy with vast differences in opinion about how to handle issues of transference/countertransference, the therapeutic alliance, and other relational concerns that impact therapy and supervision. Of notable difference would be the

distinction between one-person and two-person psychodynamic theories. One-person theories posit that the client's psyche and what transpires in therapy exists independently of the therapist and that the therapist is an objective observer of the client's psyche. On the other hand, two-person theories argue that a therapist is unable to observe the client's psychological structures objectively and is a participant and an observer in the therapeutic context (Watchel, 2008). If participants were able to be more specific regarding what psychodynamic theory they subscribed to there may have been more between group differences.

Hypothesis 3

The hypothesis that trainees who identify with more relational theoretical approaches to psychotherapy, such as psychodynamic or humanistic orientations, would report spending more time in supervision processing their personal reactions and responses to their clients was not confirmed in the present study. One explanation is that the hypothesis was incorrect and regardless of theoretical orientation, most clinical supervision focuses on these concerns. Given the recent focus on the "common factors" literature and the recent emphasis on competency-based supervision, this would make sense. Given that participants are current graduate students training in the climate of the published literature on the importance of the working alliance, one can assume that most have been exposed to the common factors literature and have been encouraged to focus on the therapeutic alliance, regardless of the graduate institution's training model or theoretical orientation. The only significant between group differences were between participants who identified as Family Systems and those who identified as CBT. Similar to the discussion of findings in Hypothesis 2, issues around between and within-group differences and the small number of participants in each group may have contributed to the results.

Additionally, some consideration around factors impacting supervision topics is relevant. Often a supervisor's theoretical orientation will frame the course of supervision, tasks, objectives, and how the trainee's personal reactions and relational concerns are addressed. Thus, maybe the trainee's theoretical orientation is less indicative of what is discussed in supervision and instead the supervisor's orientation has some impact on the frequency certain concerns are raised.

Since there is no unified model of supervision, many supervisors may apply their clinical knowledge to the practice of teaching and learning. For example, an Object Relations-oriented supervisor may routinely work to create a holding environment where the trainee can bring intense emotions, which helps the trainee learn the capacity to bear the intense emotions of being a therapist. On the other hand, a CBT-oriented supervisor may regularly invite self-monitoring and create objective goals for the trainee and emphasize evaluation. Perhaps the orientation of the supervisors is more influential than the orientation of the trainee in relationship in what is most frequently discussed in supervision. This also relates to the idea that supervisors from different theoretical backgrounds may think similarly about the importance of developing the alliance and focusing on relationship competencies, but go about discussing it with trainees differently in supervision practice and may also describe these topics using the language of their theoretical orientation.

A related consideration is there are often differences among how supervisors think they practice and how their practices are experienced by their supervisees. This difference in perspective between how a supervisor thinks they are practicing supervision and how the trainee experiences that practice may also play a role in the supervision process. For example, a self-identified relational supervisor may be experienced as abrasive or intrusive by one trainee

and as curious and invested by another. These differences in how we experience one another surely impact what is worked through in supervision.

Spearman rank-order correlation

The Spearman rank-order correlation coefficient was used to assess the strength and direction of association that exists between the frequency that relational aspects of therapy were discussed in supervision and how trainees' characterized the nature of their supervisory experiences using the Topics of Supervision Form. The results were consistent with what one might expect in terms of which topics trainees ranked as characterizing their supervision experience and the topics they reported most frequently discussed.

Trainees who reported that their supervision experience was characterized most by "Monitoring" (reviewing the status of client load, client by client) reported that "Evaluation" (evaluating supervisee's performance, level of functioning and progress) was a frequently occurring supervisory task. Whereas trainees who characterized their supervision most by "Evaluation" reported they less frequently discussed "Personal issues and problems that interfere with their work with clients." This makes sense in light of the literature on trainee self-disclosure that was mentioned above, and how the evaluative nature of supervision can inhibit disclosure of personal issues, even when they are relevant to the trainee's clinical work and personal/professional development (Giddings et al., 2003; Power & Bogo, 2002).

Trainees who characterized their supervision most by "Support" (the supervisor providing support for work with clients) reported discussing "Evaluation" less frequently. This result may be interpreted a few ways. One perspective is that supervisors who focus less on the evaluative aspects of supervision may focus more on supporting their supervisees. This type of supervision approach is consistent with the literature on the supervisory alliance that indicates

that trainees who feel more supported and less judged (or evaluated) by their supervisors have a stronger alliance with their supervisor (Shafranske & Falender, 2013). This finding could also be thought of using Bion's (1961) understanding of group process and his notion of dependency in that the supervisee may not express her needs overtly, but at an unconscious level is disappointed that the supervisor is not all-knowing and capable of fulfilling her every need. Bion posited that often groups shift between processes of being productive, task-oriented, and collaborative and taking on a regressive, unconscious, and phantasy-dominated quality. Perhaps the need for the supervisee and supervisor to be close and connected is one way of avoiding the actual tasks of supervision and explicitly addressing the tensions and one another's anxieties about working together.

Similarly, trainees who characterized their supervisory experience most by "Treatment Planning" (developing and carrying out a treatment plan) reported spending less time discussing "Trusting and using feelings in responding to clients," "Attending to issues in the supervisory relationship," and "Receiving support for their work with clients from their supervisor." Although discussing developing and carrying out a treatment plan in supervision could look vastly different depending on the clinical setting, complexity of the trainee's caseload, the trainee and supervisor's clinical opinions and theoretical orientations, among other factors, one could hypothesize that these types of conversations tend to be more instructional and didactic in nature. They may also include less discussion around relational concerns if there were not specific relational concerns in the therapeutic or supervisory relationships that needed attention.

One finding that was somewhat unexpected is that trainees who characterized the nature of their supervision most by "Theoretical Conceptualization" (understanding clients in a theoretical framework) reported they less frequently dealt with issues around "Support," and

"Awareness" (confronting personal blind spots, increasing personal and/or professional awareness. One might conclude that discussions around theoretical conceptualization were also rather didactic in nature, and involved discussion around how theory translates into practice, and less around the supervisee's own contributions to the therapeutic encounter.

Exploratory Analyses

Exploratory analyses revealed that trainees from Ph.D./Ed.D programs perceived stronger alliance forming abilities than those from MHC/MFT programs and that trainees with more years of experience rated their ability to form the working alliance higher than those with less experience. Most MHC/MFT programs are two years in duration, whereas Ph.D./Ed.D programs tend to be 5+ years. Thus, one possibility is that masters-level trainees are less likely to rate their alliance-forming abilities high since they likely have much less clinical experience than the doctoral-level participants. This trend is consistent with the developmental model of supervision and what we might assume about trainee development; that the more experience a trainee has, the more confident she feels in connecting with clients and establishing a strong working relationship. This confirms what is known about beginning trainees' often feeling anxious about their performance and the therapeutic encounter in general (Machado, Beutler, and Greenberg, 1999; Melton et al., 2005).

Limitations

This study is not without limitations. The sample acquired in this study was predominantly female (84%), young (*M*= 29 years), and White (85%). Thus, there may be limited generalizability to men, older trainees, and trainees from racial and ethnic minority groups. Of note, there may be gender differences in how women and men rate their alliance forming abilities. A study done by, Favorite, Hardy, Goode, Deshetler, and Thomas (2005) found

that female therapists scored higher on measures of empathy than male therapists. Nelson (2005) notes that female therapists may be more responsive and nurturing than male therapists. Thus, future research should include more male participants.

Due to the web-based survey data collection methodology, response rates could not be calculated. Although e-mail solicitations were sent to directors of APA-accredited graduate programs in the country, it is unknown how many and which directors actually forwarded the recruiting email. Thus, it is unknown how many students were provided with the opportunity to choose to participate in the study. For these reasons, caution should be taken in terms of representativeness of the sample and the degree to which the findings can be generalized to the overall population of graduate trainees.

Additionally, this study was conducted on a voluntary basis and trainees who volunteered to participate may have been a biased sample and compromised the external validity of the study. The external validity may have also been compromised by the data collection, which was conducted through the Internet, and may further distinguish the characteristics of the participants who participated in the study from non-volunteers. One should consider whether the findings would have been different if more students had chosen to respond to the survey. It is possible that technologically savvy supervisees may have been oversampled and may differ from trainees who were not willing to participate online.

Another limitation regarding the generalizability of the findings in the study is the self-report nature of the research. Rosenthal and Rosnow (1975) indicate that self-reports are subject to distortion and social desirability effects. In addition, self-report data may not correlate well with participants' actual behavior. Participants were also asked to consider the last year of

their training, making their self-report data subject to retroactive effects. Thus, the potential for bias and inaccuracies must be considered.

Furthermore, it is possible that students who felt particularly strongly about their experiences in clinical supervision were more-or-less likely to take the survey. Another limitation is the numerous ways in which respondents might have interpreted the Topics of Supervision Form. For each topic, a brief description was provided. There could have been wide variation in what respondents thought a particular topic of supervision meant. In addition, the present survey was limited in scope and extraneous variables may exist that were not assessed. It is also important to highlight the fact that the findings in the current study are associations between the variables of interest and do not imply causal relationships. Therefore, current results can only suggest potential relationships and cannot imply causality. Finally, the results should also be interpreted in light of the fact that due to the large number of correlations that were conducted in the data analysis, there was a higher chance of committing a Type I error.

Future Directions

This study primarily focused on the experiences of the supervisee; information about the experience of the supervisor and the supervisee's clients would be interesting and clinically relevant in that an examination of how these perspectives converge or diverge could inform supervision and training. Supervisors' perspectives of the topics of supervision that were discussed and characterized the supervision as well as clients' perspectives of the working alliance were not obtained and could result in a different viewpoint of these relationships. Future researchers should consider the supervisee and supervisor's perspective of the supervisory working alliance and the client's perspective of the working alliance. It is possible that different viewpoints could lead to results that are different from results obtained in this study.

Given the result that there was little variability among trainees from different theoretical orientations regarding what topics were discussed in supervision, researchers may want to explore through qualitative and quantitative methods how the theoretical orientation of the supervisor impacts what is discussed in supervision and trainees' perception of their ability to form the working alliance. This would also account for the potential biases in self-assessment in that supervisors' rating of supervisees' alliance forming abilities may be a more accurate measure of the trainee's actual competence in this area. Since much of the literature on this topic emphasizes the importance of the supervisory relationship on trainee disclosure of relational concerns, future research may include measures of the supervisory alliance as a possible moderator for the relationship between what is discussed in supervision and the working alliance.

Implications for Education, Training, and Supervision

In light of the present study, there are several implications for training, education, and clinical supervision that should be considered. Based on the finding that trainees who characterized their supervision most by "Treatment Planning" and "Theoretical Conceptualization," tended to report they spent less time attending to relational concerns, points to the importance of balancing didactic instruction with the trainee's self-as-therapist and personal development in supervision. Supervisors may need some guidance in how to encourage their students to openly discuss their personal development, experience of the supervisory relationship, as well as other sensitive issues, like self-disclosure and their personal reactions in supervision. Several authors have observed that the supervisor must explicitly encourage this discussion (Davis, 2002; Fontes, 1995; Ward, 2008 as cited in Knight, 2014) and that supervisors often collude with trainees in the avoidance of these issues (Milne, Leck, & Choudhri, 2009).

There is a need to address what supervisors can do to encourage trainees' openness and increase their willingness to discuss sensitive topics regardless of the evaluative context of supervision. Research suggests that one way to promote this is supervisors' own willingness to be open and transparent, which models the use of this skill and creates mutual disclosure in the supervision dyad (Knight, 2014). This notion is supported by research that indicates that increased supervisor self-disclosure was correlated with a more effective supervisory style (Kreider, 2014). This can be accomplished at the outset of training during the contracting phase between trainee and supervisor. Explicit contracting may facilitate the clarification of expectations regarding supervisee self-disclosures and acknowledge the power differential and evaluative context of supervision as potential barriers to this kind of work. Borders (2014) notes that supervisors should:

> …View supervisee anxiety as well as supervisee resistance as normal responses to challenge and change, and thus manage these dynamics in ways that allow ongoing growth and development. They anticipate some level of conflict in the supervisory relationship and deal with it productively. They also address parallel process issues, transference, and countertransference in developmentally appropriate ways. (p. 155)

Regardless of theoretical orientation, supervisors must be mindful in exploring personal factors and countertransference and its effect on the trainee's conceptualization and engagement with her clients and the supervisory relationship (Falender & Shafrankse, 2015). If a supervisor explicitly invited the trainee to express and explore a range of emotions and thoughts towards her clients it may remove the social constraints of the evaluative aspect of supervision, allowing the trainee and supervisor to process and resolve the reactions together.

Given the result that most participants tended to rate their alliance-forming abilities as high, there may be a need for educators and clinical supervisors to help trainees be more critical in their self-assessment of their relationship competencies. Often individuals who seek careers in helping fields believe they have a natural gift when it comes to relating to people and helping others, which is usually based on their own personal experiences. Thus, it may be difficult for trainees who have these beliefs about themselves to evaluate their competencies in this domain.

Given the finding that trainees with more years of experience were more confident about their ability to form the working alliance highlights a need to address beginning trainee anxiety and accurate self-assessment of relational competence early in training. Attention should also be given to this topic in the classroom. Students are given instruction, information, and experiential activities to prepare them for the nuts and bolts of the clinical work they will engage in with clients during practicum and internship, but much less attention is given to helping students prepare for engaging in the working alliance with clients and in the supervisory relationship. This places the responsibility on not only clinical supervisors but also training institutions to adequately orient students to how to deal with relational concerns with clients and the expectations of supervision. This may increase novice trainee's confidence *and* ability to accurately and critically assess their relationship competencies early in their development, reduce anxiety, and would ensure that trainees were aware of the boundaries and limits of confidentiality regarding supervision, and may mitigate fear and anxiety regarding evaluation in the light of disclosing sensitive information in supervision.

Concluding Thoughts

The results of this study indicated that trainees from different theoretical orientations rate their alliance-forming abilities similarly high, and also report spending a similar amount of time

discussing relational concerns in their supervision sessions, which was not associated with higher perceptions of alliance-forming abilities. Trainees rating their alliance-forming abilities high calls into question how educators and clinical supervisors could facilitate trainees' self-assessment and self-reflective competencies throughout graduate training. Contrary to the primary hypothesis, what is discussed in supervision appears to have no bearing on how trainees rate their capacity to form the working alliance. Changes to the methodology, such as using supervisee-supervisor pairs, increasing sample size, and employing qualitative methods may offer insights regarding this finding. In closing, that the content and process of supervision has no impact on how trainees think about their own capacities, leads to the importance of understanding what factors contribute to this and should be examined in future research on professional development and clinical training.

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APPENDIX A: Participant Recruiting Email

Hello Students!

My name is Julia Taddonio and I am currently a graduate student in the clinical psychology program at Antioch University New England. I am conducting a research project under the mentorship of Dr. Theodore Ellenhorn that explores the experiences of clinical supervision for masters and doctoral-level clinicians in training.

You are eligible to participate if you are (1) 18 years of age or older, and (2) are a masters or doctoral-level clinical psychology student and are willing to fill out a 24-item questionnaire that asks you to think about the clients of 18 years of age or older that you have worked with within the past year. You will also be asked to answer questions related to the supervision you received while working with those clients.

The study will take about 15 minutes to complete. Your participation is completely voluntary and your responses are anonymous and confidential. This study has been approved by the Antioch University New England Institutional Review Board.

If you choose to participate, you have the option of entering to win one of 5 $20 Amazon giftcards!

Additional information about the study and direct access to the survey are provided at the following link:

https://www.surveymonkey.com/s/P2N99V3

I am fully aware that you may have had a number of opportunities to participate in online research projects during your time in graduate school. Therefore, I want to thank you in advance for considering and, hopefully, for participating in my study.

Sincerely,
Julia Taddonio, M.A., M.S.
Department of Clinical Psychology
Antioch University New England

APPENDIX B: Survey

Page 1 of 7: Informed Consent

Antioch University New England – Clinical Psychology Department
40 Avon Street, Keene, NH, 03431

Principal Researcher: Julia Taddonio
Research Title: Clinical Trainees' Experiences in Clinical Supervision

You are invited to participate in a research study that explores the experiences of clinical supervision for masters and doctoral-level clinicians in training. Specifically, you can participate in this study if you are a masters or doctoral-level clinical psychology student and are willing to fill out a 24-item questionnaire that asks you to think about the clients of 18 years of age or older that you have worked with within the past year. You will also be asked to answer questions related to the supervision you received while working with those clients.

The researcher, Julia Taddonio, a doctoral student at Antioch University New England, will conduct this study.

Risks and Benefits
This research will hopefully contribute to understanding your experiences in supervision, so will potentially benefit clinical training practices. Participation in this study carries no risk. There is no financial compensation for your participation in this study.

Data Storage to Protect Confidentiality
Under no circumstances will you be identified by name at any point in this research study, or in any publication thereof. Every effort will be made to ensure that all information provided by you will be treated as strictly confidential. All data will be coded and stored securely electronically and will be password-protected. It will only be used for this dissertation, and then destroyed. Only the researcher and her faculty advisor will be able to access the data.

How the Results Will Be Used
This research study is to be submitted in partial fulfillment of requirements for the degree of Doctor of Clinical Psychology at Antioch University New England, Keene, New Hampshire. The results of this study will be published as a dissertation. Additionally, information may be used for educational purposes in professional presentations and/or educational publications.

Participant's Rights
1. I have read the research description and my participation is voluntary. I may withdraw participation at any point without it jeopardizing me in any way.

2. If at any point I have any questions regarding the research or my participation, I can contact the researcher, Julia Taddonio, who will answer my questions (phone number: xxx-xxx-xxxx; email: xxxxxxxx@antioch.edu). I may also contact the researcher's faculty advisor, Theodore Ellenhorn, Ph.D. at 603-357-3122 or his email, tellenhorn@antioch.edu.

3. If at any time I have comments or concerns regarding the conduct of this research or my rights, I should contact Donald Woodhouse, the chair of the Antioch University New England Institutional Review Board (email: dwoodhouse@antioch.edu).

4. I should receive a copy of the Research Description and this document.

By selecting "Yes" in the dropdown menu, I am agreeing to participate in this study.

Page 2 of 7: Demographic Data

Thank you for agreeing to participate in this study. Please complete the survey below. Please note that the information obtained in this questionnaire is confidential and will only be used for the purposes of this research study.

1. What is your gender?
   a. _____ Female
   b. _____ Male
   c. _____ Transgender
   d._____ Other (please specify)

2. What is your age? ____

3. What is your race/ethnicity?
   a. _____ White
   b. _____ African American
   c. _____ Asian
   d. _____ Hispanic
   e. _____ Native American
   f. _____ Other (please specify)

4. What state do you currently train in? _____

5. What state did you reside in before graduate school? _____

6. How many years have you been in your graduate program? _____

7. What is your primary theoretical orientation?
   a. _____ Cognitive Behavioral
   c. _____ Eclectic/Integrative
   f. _____ Family Systems
   g. _____ Feminist
   h. _____ Humanistic/Existential
   i. _____ Psychodynamic
   j. _____ Systemic

8. What theoretical orientation do you use second most?
   a. _____ Cognitive Behavioral
   c. _____ Eclectic/Integrative
   f. _____ Family Systems
   g. _____ Feminist
   h. _____ Humanistic/Existential
   i. _____ Psychodynamic
   j. _____ Systemic

9. What theoretical orientation do you use third most?
   a. _____ Cognitive Behavioral
   c. _____ Eclectic/Integrative
   f. _____ Family Systems
   g. _____ Feminist
   h. _____ Humanistic/Existential
   i. _____ Psychodynamic
   j. _____ Systemic

10. Approximately how many hours of providing one-to-one psychotherapy experience do you have? _____

11. Approximately how many hours of clinical supervision have you received? _____

12. What type of training program are you in?
   a. _____ Doctoral-level (Ph.D. or Psy.D.)
   b. _____ Masters-level (mental health counseling, school counseling, marriage and family therapy, clinical psychology)
   c. _____ Social Work

Page 3 of 7

Instructions: On the following page are sentences that describe some of the different ways you might think or feel about your clients. As you read the sentences think about all the adult clients (ages 18 and above) you have worked with within the past year. Answer the questions below with these clients in mind as best as you can.

Below each statement there is a seven-point scale: If the statement describes the way you always feel (or think) mark the number 7; if it never applies to you mark the number 1. Use the numbers in between to describe the variations between these extremes. Work quickly, your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM

1. My clients and I agree about the steps to be taken to improve his/her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. My clients and I feel confident on the usefulness of our current activity in counseling.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe my clients like me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I have doubts about what my clients and I are trying to accomplish in counseling.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in my ability to help my clients.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. My clients and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciate my clients as people.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. My clients and I agree on what is important for them to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. My clients and I have built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. My clients and I have different ideas on what his/her real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. My clients and I have established a good understanding between us of the kind of changes that would be good for them.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. My clients believe the way we are working on their problems is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Page 4 of 7

Instructions: On the following page are some topics you may have discussed in supervision while working with your clients. Now think about the supervision you received. Using the spaces on the left, ***rank on a scale of 1 to 12, the topics that best characterize*** your supervision experience, with 1 being the topic that best describes the nature of your supervision and 12 being the topic that least describes your supervision.
***Please note that the options will sort automatically based on the ranking that you give your responses.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM

Rank order the topics that best characterize your supervision experience (1=the topic that best characterizes; 12 being the topic that least characterizes)

_____ 1. Treatment Planning (developing and carrying out a treatment plan)

_____ 2. Trusting and using feelings in responding to clients

_____ 3. Making appropriate independent decisions and actions

_____ 4. Theoretical Conceptualization (understanding clients in a theoretical framework)

_____ 5. Dealing with personal issues or problems that interfere with working with clients

_____6. Skills and Techniques (developing and refining competency with a range of intervention skills)

_____ 7. Supervisory Relationship (defining, clarifying the supervisory relationship)

_____ 8. Support (the supervisor providing support for work with clients)

_____ 9. Awareness (confronting personal blind spots, increasing personal and/or professional awareness

_____ 10. Therapy Relationship (dealing with client-counselor relationship)

_____ 11. Monitoring (reviewing the status of client load, client by client)

_____ 12. Evaluation (evaluating supervisee's performance, level of functioning and progress)

Page 5 of 7

Instructions: On the following page are some topics you may have discussed in supervision while working with your clients. Now think about the supervision you received. Using the scale below, rate the following supervision topics in terms of the ***frequency*** in which the topics were the focus of your supervision sessions. Below each statement there is a seven-point scale: If the statement describes the way you **always** feel (or think) mark the number 7; if it **never** applies to you mark the number 1. Use the numbers in between to describe the variations between these extremes.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM

1. Treatment Planning (developing and carrying out a treatment plan)

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. Trusting and using feelings in responding to clients

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. Making appropriate independent decisions and actions

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. Theoretical Conceptualization (understanding clients in a theoretical framework)

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. Dealing with personal issues or problems that interfere with working with clients

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. Skills and Techniques (developing and refining competency with a range of intervention skills)

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. Supervisory Relationship (defining, clarifying the supervisory relationship)

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. Support (the supervisor providing support for work with clients)

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. Awareness (confronting personal blind spots, increasing personal and/or professional awareness

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. Therapy Relationship (dealing with client-counselor relationship)

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. Monitoring (reviewing the status of client load, client by client)

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. Evaluation (evaluating supervisee's performance, level of functioning and progress)

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Page 6 of 7

Instructions: Please rate the degree to which you agree with the following statement:

1. Talking about myself in supervision helps me form better working relationships with my clients.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	Unsure	Somewhat Agree	Agree	Strongly Agree

Thank you so much for your participation in this study!

Page 7 of 7

To enter to win a $20 Amazon gift card, please leave your email address in the space provided. Thank you for your participation!