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The Relationship of Supervision to Trainee Self Efficacy and Patient Involvement in Therapy

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THE RELATIONSHIP OF SUPERVISION TO TRAINEE SELF

EFFICACY AND PATIENT INVOLVEMENT IN THERAPY

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ABSTRACT

Research to date has explored trainee perceptions of effective supervision, but whether and how different styles of supervision affect the therapy relationship has been unclear. The present study investigated factors in the supervision process that contribute to patient involvement in therapy. Specifically, the author examined whether a trainee's perception of facilitative conditions offered by the supervisor would predict patient involvement in the therapy relationship via the mediating mechanism of increased trainee self efficacy. Other relationships examined were: facilitative conditions in the supervisory relationship and trainee satisfaction, trainee experience level and trainee self efficacy, and the effect of the following variables on the hypothesized model: duration of supervisory and therapy relationships, patient diagnosis, and trainee experience.

One hundred twenty-two graduate students in Clinical and Counseling Psychology programs in the midwest completed the Barrett-Lennard Inventory for Supervisory Relationships (Schacht, Howe, & Berman, 1988), the Counseling Self Estimate Inventory (Larson et al. 1992), the Patient Participation and Resistance subscales of the Psychotherapy Process Inventory (Baer, Dunbar, Hamilton, & Beutler, 1980), as well as demographic information. A Patient Involvement score was computed by subtracting scores on the Resistance subscale from scores on the Participation subscale. The results suggest that facilitative conditions were related to trainee satisfaction with supervision. More importantly, facilitative conditions in the supervisory relationship were predictive of trainee self efficacy, patient

participation in the therapy relationship, and patient involvement in the therapy relationship. The hypothesis that trainee self efficacy functioned as a mediating variable was supported when the patient participation variable was used as the outcome variable, but not when patient involvement was used. Although experience was predictive of trainee self efficacy, the supervisory relationship added a significantly unique dimension to ratings of self efficacy, regardless of experience level. Duration of supervisory and therapy relationships were not related to either self efficacy or patient involvement. There was some evidence that the supervisory relationship appeared to be particularly important for novice therapists. Possible explanations for the findings are discussed.

CHAPTER I

INTRODUCTION AND REVIEW OF RELATED LITERATURE

Supervision of psychotherapy began taking shape shortly after the birth of psychotherapy itself, in the early twentieth century (Ekstein & Wallerstein, 1958). The first formal training was carried out at the Institutes of Psychoanalysis in Berlin, Vienna, and Budapest, and was conducted by individuals who had had brief experiences with Freud. The focus of training at that time, moreso than coursework, was the developing analyst's personal psychoanalysis; this was considered above all else to be the cornerstone of training, in that it would allow the candidate (the analyst-in-training) to see evidence of the unconscious.

As time progressed, more academic requirements were instituted, as well as what was termed "control analyses," or supervised analytic cases. On this subject there was some debate; the Hungarians thought that the candidate's first analytic case should be supervised by his own analyst, with the rationale that a supervisor could only do effective supervision if he knew the candidate well. Thus in this model, the boundaries between the candidate's supervision and personal psychoanalysis were virtually non-existent. The Austrians, on the other hand, were opposed to this model, and maintained that it was more valuable for the candidate to be exposed to several different perspectives. For this reason, they recommended that the candidate's analyst and supervisor be two different individuals, with the latter taking on more of a teaching role.

Presently in the United States, the model of training generally employed most resembles the Austrian style, in which supervision is a form of training

separate and distinct from the trainee's personal therapy. While personal psychotherapy is often a suggested aid in becoming a more effective clinician (and is required to become an analyst), supervision is usually thought to be the main vehicle for training. Although most styles of supervision incorporate didactic elements, many clinicians argue for allowing personal issues into the supervisory dialogue, such as the trainee's countertransference or feelings toward her patient. The debate as to what should be the focus of supervision continues to this day.

While several models of therapy have emerged over the last 80 years, supervision has continued to be a primary teaching tool among all orientations of psychotherapy. However, supervisory models may differ approximately as much as do therapeutic approaches. The focus of investigation in supervision may vary in many ways. The supervisory dyad may focus on the *client*: on the manifest or latent content of what the client says, on case management issues, and/or on the dynamics posited to be underlying the client's behavior. The dyad might also focus on the *trainee*: on her affective experience in session, on her fantasies/thoughts that get provoked as she relays the session to her supervisor, and/or on her personal issues that become activated when interacting with the client. Finally, the focus may be more interactional or relational in nature; specifically, on the interaction between trainee and client, or between the trainee and the supervisor. Proponents of this latter focus (e.g., Doehrman, 1976; Muslin & Val, 1989) suggest that since issues in one relationship are often "acted out" in the other, it is important to examine and understand as best as possible the trainee's experience of <u>both</u> relationships, not just of the therapy relationship. Although the above may not be mutually exclusive (i.e., some supervisors may focus on more than one of these areas), different supervisors may view their roles very differently, and act accordingly.

While it is unclear which factors in supervision are most important in effecting a positive learning experience for the trainee, many believe that the relationship itself may be a powerful tool (Hess, 1986). Professionals across orientations point to the influence of the supervisory relationship, albeit in different terms: analytic therapists may speak of a "supervisory alliance," behaviorists may refer to the "reinforcing value" of that relationship, and client-centered therapists may focus on the "positive regard" of the supervisory relationship. However framed, it seems increasingly clear that "...the supervisory relationship may be as potent in effecting supervisory outcomes as the therapeutic relationship is in effecting client outcomes" (Friedlander & Ward, 1984, p. 544). How the supervisory relationship should function, however, is of some debate.

The supervisory relationship may parallel several kinds of relationships, including the teacher-student dyad or the therapist-patient dyad, or it may take on more of a collegial quality (Hess, 1986). Different professionals ascribe varying roles and degrees of importance to the supervisory relationship. Some professionals suggest that a quality relationship is important only inasmuch as it allows for a more productive didactic relationship. In other words, the role of the supervisory alliance is seen as merely setting the stage for the most important activity of supervision, teaching, thought of traditionally as the supervisor imparting knowledge unto the trainee.

Others see the supervisory relationship in and of itself as the vehicle for learning. For example, using the idea of "parallel process" (Doehrman, 1976), the supervisory relationship might be viewed as a barometer of the therapy relationship, and vice versa. For this reason, it is considered essential to discuss the supervisory relationship, both to understand the client better, and to strengthen the supervisory alliance which in turn would be likely to strengthen the therapy

alliance. Finally, there are those who take a more moderate or flexible position. These individuals suggest that while didactic components are important in the supervisory relationship, they are only effective when offered within a strong alliance, and when the experience of the supervisory relationship is also examined.

Regardless of the differing views on how supervision should be conducted, the various kinds of supervision play an integral role in the training of mental health professionals. While coursework and sometimes research are mandated in the training programs of psychologists, psychiatrists, and social workers, supervision is what allows therapists-in-training to integrate theory with practice, and to discuss situations they have encountered that they may have only previously read about. Over the last decade, as professionals have realized the importance of supervision, there has been an increased number of publications in this area, including both theoretical papers hypothesizing the important ingredients of supervision, as well as empirical studies attempting to ferret out trainees' assessments of the helpful ingredients of supervision.

The present review first examines in more depth theoretical or conceptual formulations of supervision. The empirical research will then be examined. Finally, conclusions will be drawn as to whether the research to date supports the theoretical premises put forward, and suggestions will be made as to what kind of research needs to be conducted in order to respond to questions that as of yet remain unanswered. Specifically, the question of what aspects of supervision promote optimal trainee development and therapeutic effectiveness will be explored.

Theoretical Literature

As previously mentioned, there has been an increase in the number of publications in the area of supervision over the last two decades. More attention

has been drawn to the supervisory relationship and its role in the process of learning to be a clinician. Perhaps the most in depth discussion of the supervisory relationship and the role of the supervisor in the learning process is provided in the Self Psychology literature. Because this model provides a framework for understanding the present project, it will be examined in greater detail, but alternative models for understanding the role of the supervisory relationship will also be considered.

A Self Psychological Approach to Learning

The process of learning and teaching has been related to Kohut's (1977) theory of child development (Cohler, 1989; Elson, 1989; Muslin & Val, 1989). According to this theory of Self Psychology, parents' capacity to empathize allows them to perform selfobject functions for the child (Muslin & Val, 1989). In the ideal development according to this theory, the parent mirrors and unconditionally accepts the child (Kohut, 1984). By "mirroring," Kohut (1971) explains that a child's phase-appropriate exhibitionism and grandiosity should be affirmed by the caregiver in order to support her self esteem and the development of a "grandiose self." Mirroring behavior is thus described as "...echoing, approving, and confirming" (Kohut, 1971, p. 117). Kohut suggests that the child also needs to idealize her caregiver, and in doing so, experiences a sense of security and joy in merging with that caregiver (Kohut, 1984). The combination of being mirrored and idealizing the caregiver allows the child to enjoy a sense of grandiosity. Although the child's needs should initially be mirrored as much as possible, the parent eventually is unable to respond perfectly to every one of the child's needs, and so the child is gently frustrated. This frustration, if not traumatic or continual, allows a transmuting internalization to take place, such that the child begins to perform the functions that were initially performed by the parent. For example, if

one were successfully soothed when young by a parent, s/he would be more able to cope with stress adaptively as an adult, perhaps using it as a source of change or growth, rather than coping in a more regressive, maladaptive way (Elson, 1989). This experience of having been soothed by a selfobject is said to have been transmuted into psychic structure (i.e., the self and its functions). Having this structure allows the individual to regulate stress and take steps to decrease anxiety when necessary (Elson, 1989). The child's gradual realization of the caregiver's limitations, as well as his own, results in more realistic views of himself (rather than grandiose) and of his caregiver (rather than idealized; Kohut, 1971). The child's grandiosity turns to healthy self esteem, and the idealizing libido directed toward the caregiver can be channeled toward the child's superego. Thus, Kohut (1971) would suggest that the ideal parent:

> ...creates a holding environment by providing empathic mirroring and validation of the self's experience, and admiration of the self's capabilities and "goodness" to bolster its vulnerable pride and self-esteem, and by serving as a figure for idealization and eventual identification-internalization. (Brightman, 1984, p. 307)

According to this model, when one becomes a new student, two things are hypothesized to occur: a reawakening of incompletely satisfied needs due to regression, and an influx of anxiety due to fears of failure (Elson, 1989). Elson (1989) explains that when one becomes a student, s/he finds herself in a regressive situation in that former needs to idealize and be mirrored are reawakened by participating in a relationship with an authority figure. Students finds themselves in a dependent position vis a vis the teacher, which stirs up feelings not unlike those they experienced with their parents (Elson, 1989). As the student's needs to be mirrored and to idealize become mobilized, the teacher becomes a new selfobject for the student.

It should be noted that anyone may be found in this regressive situation in which more primitive needs are mobilized, regardless of how "ideal" one's development may have been, since according to Kohut (1977), although the intensity of these needs may decrease with age, they never disappear completely:

> The psychologically healthy adult continues to need the mirroring of the self by self-objects..., and he continues to need targets for his idealization. No implication of immaturity or psychopathology must, therefore, be derived from the fact that another person is used as a self-object--- self-object relations occur on all developmental levels and in psychological health as well as in psychological illness. (Kohut, 1977, p.188)

Thus these stages of development are never fully mastered, but can be cycled through (with less intensity, that is) at later points in life when similar circumstances arise. In other words, any student in a new learning environment experiences some version of these needs. The selfobject functions provided by the teacher serve to enhance a self that is already formed, instead of establishing it, as would occur in a parent-infant relationship (Muslin & Val, 1989).

Just as it was important for the caregivers to acknowledge and accept the child's concerns, so is it important for the teacher to do the same with the student (Cohler, 1989). The feelings and needs from childhood that are reawakened in this parallel relationship, such as the need to be mirrored and the need to idealize the authority figure, must be accepted by the teacher in order for the student to have the courage to venture into uncharted areas and learn new material (Field, Cohler, & Wool, 1989). A self that is fragmented, on the other hand, needs to expend so much energy trying to gain a sense of cohesiveness that it is unavailable for other efforts such as learning (Field et al. 1989). The selfobject functions performed by the teacher result in increased self esteem and cohesiveness of the student (Muslin & Val, 1989). Bernstein (1989) agrees with this point of view that the teacher must first and foremost attend to the student's self esteem if optimal learning is to

occur. The teacher's "empathic resonance" (Kohut, 1984) is thought to be the essential ingredient in enhancing the student's self esteem.

The new learning environment brings with it anxiety regarding the potential for failure and accompanying shame (Elson, 1989). Field et al. (1989) agree that even the most secure child will encounter these feelings of anxiety and fear of failure when introduced into a new environment, until s/he is able to adapt to the new selfobject (in this case, the teacher).

This anxiety can be crippling for some students, yet growth-inducing for others, depending on how this stress has been handled in the past (e.g., whether students' parents soothed them such that they could eventually perform this function for themselves), and perhaps more importantly, how this stress is handled in the current teaching situation. The outcome of the learning situation depends in part on how the teacher handles these needs and feelings of anxiety (Elson, 1989).

Elson (1989) suggests that the optimal teaching situation consists of a teacher who is able to identify, mirror, understand, accept, and absorb the student's anxiety. It is suggested that the most helpful teacher will be able to provide a "holding environment" (as developed by Winnicott) for the student. This holding environment has been described with regard to the child's environment as follows: "empathically-based activities that: 1) permit the infant the normal expression of those physical needs that have psychological implications, and 2) prevent impingements that would threaten the infant's existence" (Jarmon, 1990, p.197). Thus the environment must be safe enough so that the infant can express her needs, yet without being intrusive so that the infant has space to be herself.

Another function of holding may be thought of as absorbing intense feelings that are overwhelming the student or trainee. Jarmon (1990) offers a case example of a successful holding environment in which the trainee's re-telling of a

powerful therapy session allowed the supervisor to absorb some of the painful feelings. The supervisor was thought to have "held" her, so that the trainee could re-establish her sense of self and return less anxiously to the client (p. 199).

In sum, the teacher's empathy is hypothesized to lead to the student's greater learning potential because of the following steps. The teacher's empathy is thought to create an environment in which the student feels safe revealing his/her anxiety and lack of understanding. The teacher's acceptance of the student's lack of understanding as well as of his/her shame related to not knowing something, is experienced as soothing by the student, which leads to the accretion of psychic structure (Basch, 1980). The accretion of self structure may be thought of as healthy narcissism (as opposed to grandiose) and a more stable self esteem. The student can then pursue his/her learning goals and acquire realistic expectations for him/herself (Elson, 1989), via the mechanism described in the proceeding section.

In the case of the therapist in training, trainees who enjoy a firmer "professional self" are thought to be more able to tolerate confrontation or constructive criticism (Sloane, 1986). Therefore it is important in a learning situation to create an environment in which the student acquires psychic structure by having her concerns mirrored and by being permitted to idealize the teacher. According to these authors, the student's sense of well-being depends on her perception of how this selfobject (the teacher) feels about the student. Field (1989) suggests that the supervisor accept the student's need to be valued.

Cohler (1989) writes from a similar perspective, suggesting that the source of a student's learning difficulty may actually be his/her sense of self. Cohler explains that one needs a cohesive sense of self in order to take risks, which is an important ingredient in being able to learn. This sense of cohesion arises out of the empathic attunement of one's caregivers (Cohler, 1989).

While some go so far as to say that learning only takes place if these selfobject functions are performed (Muslin & Val, 1989), this is not to suggest that a teacher's role should consist solely of providing selfobject functions to the student and attending to her sense of self. Of course the teacher also maintains her teaching role, helping the student acquire knowledge. These authors would only argue that that teaching should take place in a particular environment that does not ignore the vulnerability of the student.

The learning process of new therapists can be quite unique, in that the understanding of psychotherapy can involve one's entire personality and identity; that is, one's behavior in session with a client is often intimately tied to one's personality and background. Becoming intimately involved in any relationship tends to provoke intense feelings, and the therapy relationship is no exception. As previously noted, the supervisory relationship tends to awaken previously buried needs and regressive feelings. Unlike other professions, therefore, participants in the mental health field engage their selves intimately and completely in the practice of their career. "The setup tends to exert pressure on the boundary between the professional and personal identities of the participants" (Jarmon, 1990, p.197).

In addition to the stimulation of feelings, the new therapist undergoes a threat to the stability of her self esteem, or as self psychologists might say, to her narcissism. Brightman (1984) explains the Kohutian (1971) theory of narcissism as summarized in the following paragraph.

As has been previously mentioned, the developing child needs mirroring and acceptance of her exhibitionism and grandiosity, and s/he also needs to be able to idealize the caregiver. These two needs are characterized by the grandiose self ("I am perfect"), and the idealized parent imago ("You are perfect and I am a part

of you") respectively. The grandiose self is maintained only by *external* support. Ideally, the grandiose self develops into more mature narcissism, characterized by a more stable self esteem due to *internalized* mechanisms for preserving a positive self image. In other words, one's sense of self no longer fluctuates dramatically with external feedback or reactions, but remains somewhat stable regardless of environmental change. This mature narcissism is also characterized by the ability to empathize, and by realistic goals, values, and ideals.

Brightman (1984) suggests that individuals who choose to become therapists often have not developed this stable sense of self, but instead depend on their successfully fulfilling high expectations in order to maintain their self esteem. In addition to therapists' generally high expectations, new therapists are thought to experience a parallel to the child's development: the new therapist begins training with a grandiose professional self, characterized by unrealistically high expectations of omniscience, benevolence, and omnipotence. Being unable to attain these grandiose standards of perfection, the trainee experiences a sense of inadequacy and failure. In addition, the trainee cannot relate fully to her client, but may instead unconsciously maneuver him to support her self esteem.

Supervision is thought to be the vehicle via which these conflicts arise, and also the mechanism by which the trainee can attain a more stable sense of self. Brightman (1984) summarizes the design of supervision as provoking "...a recapitulation and reenactment of some of these earlier narcissistic dynamics which, like any developmental phase, are only partially "resolved" and therefore prone to reemerge under unmastered or stressful conditions" (p. 296). The author explains that supervision carries with it "... the potential for evoking the conflicts, fixations, and defenses of preceding life stages (as well as the potential for further growth)" (p. 297).

The supervisor is faced with two challenges: 1) how to help the trainee cope with narcissistic vulnerability, and 2) "how to promote a growth process that parallels that outlined by Kohut whereby the vulnerable grandiosity of the trainee's professional self is transformed into a more secure self-esteem as a therapist and an internalized system of attainable clinical ideals" (Brightman, 1984, p. 307).

Brightman (1984) suggests that the solution to both of the above issues lies in the supervisory relationship, "...specifically in the ways in which the supervisor may come to serve as a professional analog to the idealized parent." By accepting the trainee's resurfaced needs to be mirrored and to idealize, and by attending to her increased anxiety and relative vulnerability of self esteem, the supervisor creates the most effective learning environment. Brightman explains:

> It is only within a supervisory climate that actively addresses the.... sources of narcissistic vulnerability and provides some soothing and support of the trainee's fragile self-esteem that the novice can feel safe enough to share the broadest range of their training experience, without fear that the supervision will thereby become an arena of anticipated humiliation and defeat. (Brightman, 1984, p. 308)

Some clinicians see regression in a negative light. These individuals might object to the portrayal of a trainee in a regressive position, insisting that trainees are (or should be) much more autonomous, self-sufficient, and mature. In self psychological theory, however, some degree of regression is not seen as pathological, but merely as inevitable under these circumstances. It is also seen as an opportunity for growth, and as a possibility for enhanced communication (Jarmon, 1990).

Some may suggest that regression is only promoted in particular types of supervisory stances, but Jarmon (1990) argues that "...no matter how much structure supervisors introduce to mitigate the effect, the supervisory context fosters regression in the sense that it is evocative of early emotionally-laden

relationships" (p. 197). The regression-promoting situation makes it all the more important to have a holding environment as previously discussed, since the emergence of more primitive needs leaves the trainee in a more vulnerable position. Brightman summarizes this view on supervision as a "...holding environment for the trainee during a period of extreme narcissistic vulnerability, and as an agent for the integration and consolidation of the trainee's professional self" (p. 297).

If the self psychologically informed theories of learning are applied to the training process of the psychotherapist, one sees the supervisor's role as not only didactic in nature, but also and perhaps more importantly, as fulfilling selfobject functions for the trainee. These selfobject functions would include "...empathy,...mirroring responsiveness, idealizable calmness, and strength despite his own 'not knowing,' as well as ...knowledgeability when needed" (Sloane, 1986, p. 208). The supervisor's empathy is what allows her to understand and accept the trainee's various needs, and thus is considered to be essential. The supervisor's challenge is to initially provide idealizable knowledge when the trainee needs to rely on an "expert" figure. However, the supervisor must not assume this expert role so often that the trainee's fantasy of the supervisor being omniscient is exaggerated; if this happens, the trainee both expects herself to be omniscient, but concurrently lacks self confidence, since there is such a felt disparity between her sense of the extent of her own knowledge and her supervisor's omniscience. Jarmon (1990) cautions: "To offer definitive interpretations or neatly-wrapped formulations about the patient for the supervisee to take in whole is no more an effective way of encouraging a supervisee's learning than it is for therapists to support their patient's growth" (p. 200). In addition, it has been suggested that trainees are more affected by the supervisor's style of relating than by her specific

instructions about what to do with a patient. "What we do as supervisors will have more impact on our supervisees than what we say about what should be done" (Jarmon, 1990, p. 200).

If these conditions of mirroring and empathic understanding are met, the experience of safety in the relationship is thought by some to result in freer communication. Sloane (1986) suggests that optimal growth of the trainee will take place in "...an empathically receptive and responsive selfobject environment in which it is possible to acknowledge the inevitably occurring empathic failures" (p. 195). Open communication in supervision of potentially uncomfortable topics is suggested to be essential if the same is to occur within the therapy relationship (Cohen, 1980; Rubin, 1989):

> We know that aspects of modeling and identification with the supervisor have an impact on how the supervisee conducts therapy. This is true for almost all therapists, although more so for less experienced therapists. Supervisors model avoidance of topics by a too rigid avoidance of the interpersonal issues of supervision. When difficulties in the process between therapist and supervisor are generally neglected or studiously avoided, a model for how not to communicate in the two person relationship is being taught. (Rubin, 1989, p. 39)

In sum, the trainee's feelings toward the supervisor, especially those of dissatisfaction and anger (resulting from empathic failures) should be encouraged and elicited (Cohen, 1980). The notion that blocked communication in supervision may result in the same blockage in therapy is one form of parallel process. Parallel process has been described as follows: "...one ascertains in supervision certain vestiges of the relationship between a supervisee and his or her client..." and one finds "...vestiges of the supervisory relationship [manifesting] themselves in a reciprocal manner in the therapeutic setting..." (McNeil & Worthen, 1989). This phenomenon has been explained in various ways, but most explanations incorporate the idea of the therapist's identification with the client or supervisor.

With this parallel in mind, one can see how "In supervision, the clinician should experience first hand the interest, empathy, acceptance, freedom, and openness from the supervisor that he or she is expected to deliver to clients" (Fox, 1989).

As a result of the supervisor fulfilling the selfobject functions described, several things are thought to occur. The acceptance of the trainees' feelings is thought to result in decreased anxiety as well as a sense that her feelings are valuable. This valuing of one's own feelings can prove to be very helpful if one is to employ "use of self" as a diagnostic tool in therapy.

In addition to increased self esteem and valuing of one's phenomenological experience, higher levels of empathy and respect communicated from the supervisor is thought to result in deeper self exploration by the trainee (Lennon, 1972). Self exploration allows the trainee to better understand her own reactions to the client, and to try to separate out what part of her reactions are due to her own history and unresolved issues, and what part have more to do with the client's dynamics.

As has been described, the supervisory relationship is thought to affect and/or parallel the therapy relationship. For this reason, it is thought that when a trainee experiences an accepting, empathic supervisory relationship, it will be more likely that a client will experience the therapy relationship in a similar way.

It has been suggested that the supervisor's "primary empathic concern" should be the trainee (Sloane, 1986). As a result of this "good-enough empathic attunement" (Sloane, 1986, p. 208), the trainee establishes a regressive mirroring or idealizing, (or a combination of the two) selfobject transference to the supervisor (Sloane, 1986). Idealization by the trainee results in two important changes: the trainee's self esteem increases as s/he is accepted by the idealized other, and the trainee internalizes the supervisor's functions (including clinical

skills and a sense of professional identity) as s/he experiences non-traumatic empathic failures by the supervisor (Brightman, 1984; Kohut, 1971). This allows her to modify the image of her supervisor to include actual weaknesses (Brightman, 1984).

Part of the process of supervision is thought to include the trainee's identification with her supervisor, just as a child identifies with her parent, and as some would say, occurs in every relationship: "...and is (as) profound and lasting...as the relationship is..." (Padel, 1985 in Jarmon, 1990, p. 162). Identification with others is thought to be one mechanism via which the self develops (Jarmon, 1990). Not only does it allow for the introjection of self esteem (Kohut, 1984), but it can provide a sense of faith in the process of therapy. In the early stages of training when the trainee may not yet be convinced of the value of therapy or of her work, her ability to identify with the supervisor, who ideally possesses a sense of confidence and hope regarding the therapy process, can be essential (Brightman, 1984).

Thus the end result of the optimal supervisory relationship is thought to be similar to the end result of good-enough parenting or of a successful therapeutic alliance: there is a transmuting internalization of selfobject functions, as well as of the capacity to empathize (Muslin & Val, 1989; Sloane, 1986). The trainee's ability to empathize with her clients is considered by many to be an essential condition of psychotherapy (e.g., Kohut, 1984; Rogers, 1957).

Alternate Theoretical Explanations of Learning

While the self psychology approach provides perhaps the most elaborate discussion of the importance of empathy and its role in the learning process, it is important to note that authors from other perspectives have also emphasized the importance of the teacher-student relationship. For example, Rogers (1957), a

client-centered theorist, argues that a quality relationship is most facilitative of the learning process, and that the most significant learning occurs via an experiential rather than a purely didactic process. He states, "It seems to me that anything that can be taught to another is relatively inconsequential and has little or no significant influence on behavior" (Rogers, 1957). Rogers suggests that this kind of experiential learning is only possible if the relationship between student and teacher is of a certain quality: "...the facilitation of significant learning rests upon certain attitudinal qualities that exist in the personal *relationship* [emphasis his] between the facilitator and the learner" (Rogers, 1957).

Rogers (1957) enumerates several qualities in the teacher that he identifies as being important in order to form a relationship with the student that is facilitative of learning. The first and most important is genuineness. A second important quality is acceptance, which involves a prizing of the learner's "feelings, her opinions, her person" (p. 308). A teacher who is able to do this "...can accept personal feelings that both disturb and promote learning--rivalry with a sibling, hatred of authority, concern about personal adequacy" (p.309). The third element that facilitates learning according to Rogers is empathic understanding, which is characterized by a non-judgmental attempt to see things from the student's perspective. Rogers also emphasizes the importance of trusting the student's own potential for growth. Without this trust, the teacher supposes, "...I *must* [emphasis his] cram her with information of my own choosing lest she go her own mistaken way" (p. 313). This hesitation to be too directive is reminiscent of self psychology's careful balance between being the idealizable expert yet refraining from portraying oneself as omniscient such that the student doubts her ability to make her own decisions. Both approaches, then, emphasize the importance of an

empathic, accepting, trusting relationship with a teacher who has something to offer yet allows the student freedom to think for herself.

Social learning theorists such as Bandura (1977) also acknowledge the contribution of the relationship in learning new behavior, but in a different way. According to social learning theory, certain qualities of the relationship increase the chances that the teacher's behavior will be "modeled." Bandura explains modeling as a learning of behavior by watching/hearing about the consequences of another's (the model's) actions. Individuals are thought to attend to certain models, the choice of which is affected by the potential model's status, attractiveness, similarity, affective valence, and credibility. Thus a child might be most likely to attend to a parent who is idealized, seems like an authority, seems knowledgeable, and being in the same family, might be similar. In describing Bandura's theory, Dowling and Frantz (1975) add: "...the affective quality of a model as mediated through a nurturant relationship enhances imitative learning by augmenting and maintaining strong attending behaviors" (p.260). Thus a nurturant relationship is thought to facilitate modeling by sustaining the observer's attention more effectively. The anticipation of positive reinforcement also influences what will be observed, so that if one knows that a certain model is particularly effective, he/she will pay more attention to him/her (Bandura, 1977). These anticipated benefits also strengthen the retention of what is being learned, since there is higher motivation to code and rehearse the behavior (Bandura, 1977). Thus, social learning theory might suggest that trainees model supervisors' behavior if they admire or idealize the supervisor, if they are similar to the supervisor (or can identify with her), and if they anticipate positive consequences of this behavior. Bandura might support the notion that experiencing a behavior directly is more effective than being given a directive devoid of accompanying consequence.

Developmental Considerations

The self psychological perspective on supervision is developmental in nature. Just as a client may unconsciously pull the therapist to perform different functions depending on her point of developmental arrest, a therapist-in-training may need the supervisor to fulfill various functions depending on her level of personal and professional development. Trainees are thought to develop most effectively if the supervisor recognizes and accepts the varying needs of each individual trainee.

Others who have written about supervision take a developmental stance with regard to trainee professional development, suggesting that trainees need different things from their supervisors at different times in their training, and that the credo "Start where the patient is" should also be applied to the trainee (Kaslow, 1986). Friedman and Kaslow (1986) suggest that the development of a psychotherapist in training parallels that of a child, such that the supervisor, not unlike a parent of a growing child or a therapist of a changing client, must be sensitive to the trainee's changing needs. They recognize six stages in the development of a trainee's professional identity (lasting at least four years).

During the first stage, the trainee is thought to experience anxiety and excitement regarding this novel task. At this time, the supervisor's primary task is to provide a "holding environment" for the trainee; this environment is created when the supervisor is able to accurately empathize with the trainee's feelings and sense of vulnerability. This sense of safety provided by the supervisor allows the trainee to explore the various levels of his experience and to investigate the unknown.

During Friedman and Kaslow's second stage of development, trainees are thought to experience "affirmation hunger" (Friedman & Kaslow, 1986, p. 34),

during which time the support of the supervisor is crucial. This is consistent with Cohen's (1980) suggestion that early in training, the trainee equates her evaluation as a therapist with her evaluation as a person, and thus criticism can be experienced as a threat to one's vulnerable self esteem. The supervisor continues to maintain the holding environment by helping the trainee to organize her information and thoughts, thus reducing the trainee's sense of chaos. In the third stage of trainee development, Friedman and Kaslow suggest that a primary role of the supervisor is to acknowledge the degree of responsibility experienced by the new trainees, which often feels awesome to a new psychotherapist. New therapists tend to feel entirely responsible for the outcome of their clients' therapies (Eckler-Hart, 1987). Along with their acceptance of the trainee's sense of responsibility, the supervisor's acceptance and mirroring of the trainee's experience in general is thought to increase her self esteem and sense of self as a therapist. The authors suggest that trainees in stage four, in addition to needing a supervisor who is empathic and warm, feel at this point that they also need that supervisor to be knowledgeable. During the final two stages of development, trainees are sometimes thought to devalue their supervisors, and then to reach a point where the supervisor is neither idealized nor devalued.

Muslin and Val (1989) also see supervision as a developmental process, in that the supervisor must assess the trainee's "self-requirements" (p. 163) at each stage, and respond appropriately. According to these authors, during the first phase of supervision, it is important for the trainee to feel that her perceptions and reactions are of value, and that her need to be understood is accepted. In addition, an atmosphere of safety is thought to be of primary importance, so that the trainee feels comfortable expressing her thoughts and feelings to her supervisor. This atmosphere is thought to be promoted by the supervisor's empathic understanding

of the trainee's experience. In this sense, it is not unlike the therapy relationship, in which the therapist's empathy and mirroring often results in decreased defensiveness on the part of the client, and the trust in their relationship allows the client to show her inner world to the therapist.

Skovholt (1992) notes that theorists have described the development of the therapist in various ways. For example, Fleming (1953) names three kinds of learning that the trainee is thought to experience in sequence: imitative, corrective, and creative learning. Loganbill, Hardy, and Delworth (1982) name stagnation, confusion, and integration as the trainee's three stages in development. Grater (1985) identified four stages: 1) developing basic skills and adapting the therapist role, 2) expanding the range of therapy skills and roles, 3) using the working alliance to understand the client's habitual patterns, and 4) using the self in assessment and intervention.

Others have also suggested developmental models of supervision, each highlighting different issues. Borders (1989) reports that Goodyear (1988) has counted 25 different developmental theories of supervision, and for practical reasons they will not all be described here. In general, there seems to be some consensus that the initial stages of training are more stressful, anxiety-ridden, dependent times, when the trainee needs the most support and guidance. As the trainee internalizes clinical skills, s/he relies less on external support and direction, and is more available to examine not only what s/he brings to the process, but also to free up his/her creative side in dealing with people, rather than rigidly adhering to one theory or set of techniques. The tie that binds these different stages of development seems to be the importance of supervisory empathy and acceptance in recognizing and understanding the varying needs of the developing trainee.

<u>Summary</u>

Although different contributors to the theoretical literature of supervision emphasize different ingredients of effective supervision, there are certain hypotheses that are found across several orientations, albeit presented in different languages.

A strong supervisory alliance or the degree of empathic connection and support experienced in supervision has been suggested as an important ingredient of successful supervision by many theoreticians (e.g., Brightman, 1984; Cohen, 1980; Duci, 1992; Fox, 1989; Friedman & Kaslow, 1986; Haesler, 1993; Jarmon, 1990; Muslin & Val, 1989; Sloane, 1986). In fact, degree of support is thought by many to be the "...essential ingredient of successful supervision..." (Heppner & Roehlke, 1984; Nelson, 1978; Worthington, 1984).

Many writers speak of the need to address the changing needs of trainees depending on their level of development. It is thought that a safe supervisory environment allows these needs to surface, at which point development proceeds most effectively if the supervisor is able to empathically understand and accept these needs. While there continues to be some debate as to the relative importance of didactic teaching versus an experiential component of supervision, many authors agree that the trainee tends to adopt the supervisor's style of relating, regardless if this style is consistent with the supervisor's directives. In other words, whether it is explained by modeling or parallel process or identification/internalization, trainees may be more affected by what supervisors do than by what they <u>say</u> to do.

<div align="center">Empirical Studies of Supervision</div>

The increase in theoretical papers on supervision over the last two decades has fortunately been accompanied by an increase in the number of empirical

studies on this topic. The research that has been conducted thus far has generally been descriptive in nature, in that many investigators asked trainees what they found to be most helpful in supervision. Much of the research has been atheoretical, in that particular theories or models of supervision have not been tested. Rather, initial explorations have been conducted to find out such things as what kind of supervision leads to greatest trainee satisfaction, and whether trainees want different things at different stages.

This chapter will outline the research that has been conducted to date. Trainee preferences and phenomenological experiences will be examined, as well as differences in preferences as a function of experience. Since the theoretical literature suggests that an empathic supervisory relationship results in greater trainee self esteem as well as improved performance as a therapist, particular attention will be paid to findings related to the following: empathy in the supervisory relationship, trainee self efficacy, and whether these factors affect the course of therapy. Since developmental theories of the therapist-in-training have been put forth, such that the trainee is thought to require different things in supervision at different times, developmental differences across levels of training will be also explored.

Trainee Preferences

The importance of the quality of the supervisory relationship has been suggested as one of the most salient predictors of efficacy of supervision. In testing for empirical support of this theory, researchers have asked trainees, both through questionnaires and interviews, what they value in supervision. Three general methods have been used to assess this question: asking which supervisory behaviors correlate with greater trainee satisfaction, comparing trainees' descriptions of positive and negative supervisory experiences, and examining

trainees' descriptions of positive supervisory experiences. Examples of studies in each of these areas will be outlined.

Preferences with regard to supervisory behavior. A number of investigations have explored trainees' preferences by asking trainees to rate the frequency of various supervisory behaviors, along with their degree of satisfaction with supervision.

Worthington and Roehlke (1979) asked 31 beginning trainees to complete the Supervision Questionnaire, assessing the importance of 42 supervisory behaviors that had been compiled from interviews with experienced supervisors. Trainees also completed Likert-type items on satisfaction with supervision, supervisor competence, and extent to which supervision improved their counseling. Beginning trainees characterized good supervision as consisting of "a personal and pleasant supervisor-supervisee relationship" (p.64) in which counseling skills were taught.

When Worthington (1984) replicated this study with 237 trainees at five levels of experience, he found that highly rated supervisors frequently used the supervisory relationship to demonstrate therapeutic behavior. Highly rated supervisors also were described as showing respect for the trainee, as offering support, helping the trainee increase self confidence, and teaching skills.

Worthington and Stern (1985) investigated whether a relationship existed between supervisors' and trainees' perception of behavior in supervision and their ratings of satisfaction with supervision, as well as of the supervisor's contribution to trainee improvement. The authors asked 86 trainees (two thirds pre-master's level and one-third post-master's but pre-internship level) and 92 supervisors to complete the same measure, the Supervision Questionnaire (SQ), plus six Likert-scale items tapping into the supervisory relationship. Results suggest that

supervisors' ratings of the quality of the supervisory relationship (examples of items are: "How well do you get along?", "How close a personal relationship exists between you?", and "How well do you know your supervisee?") were correlated with ratings of satisfaction and of contribution to trainee improvement. The SQ was assessed to understand which supervisory behaviors were predictive of ratings of evaluation of the supervisor and the quality of the supervisory relationship. In this regard, a positive evaluation of the supervisor was predicted by supervisor openness and by encouragement of independence without cessation of all assistance. Quality of the supervisory relationship was predicted by supervisor reliance on in-session behavior, goal-oriented supervision, and supportiveness of the supervisor. Limitations of the Worthington studies include the positive wording of all of the items on the SQ, resulting in the risk of a positive response set influencing the ratings.

Cross and Brown (1983) asked 51 trainees to rate the same Supervision Questionnaire, along with two additional items suggested in the authors' conversations with various supervisors. The authors also asked trainees to complete a Likert scale assessing their perceptions of the degree of effectiveness of supervision. They found that supervisory relationships described by trainees as less structured and more supportive (as opposed to focusing on mechanics or tasks) were seen to be more effective. It is important to note, however, that the less structured interactions also involved more advanced trainees. Thus it is unclear whether the increased trainee satisfaction was due to the different kind of supervisory interaction, or whether it was due to increased trainee experience.

Further studies corroborated the finding that trainees find supportive supervision to be helpful. Carsen and Roskin (1984) asked 24 psychiatry residents to rate what aspects of supervision contribute most to their effectiveness as

therapists. The residents were asked to rate on a Likert scale which factors in their training they perceived to result in an increased level of empathy for their clients. The authors chose this variable of empathy toward client because 78% of residents surveyed felt that empathy was one of the three most important attributes a therapist could have in order to be effective. Sixty-five percent of residents indicated that having a supportive supervisor increased their level of empathy for their clients. Of course the limitations of this study (other than small sample size) include the fact that these factors endorsed by trainees were thought to increase empathy purely by trainees' account; in other words, there was no evidence to suggest that trainee empathy actually did increase as a result of these experiences.

Similar to relating supervisory behavior to trainee satisfaction, some investigators have related trainee satisfaction to style or focus of supervision. "Supervisory style" has been defined as the "supervisor's distinctive manner of approaching and responding to trainees and of implementing supervision" (Friedlander & Ward, 1984). Friedlander and Ward (1984) devised the Supervisory Styles Inventory (SSI) in order to try to tap into how trainees rated their supervisors on various dimensions, and to assess whether differential ratings on these dimensions correlated with ratings of supervisory effectiveness, trainee professional development, and client progress. They identified three constructs describing supervisory style: The first is "task-oriented," which is defined by descriptive items such as "structured, goal-oriented, didactic." The second style is called "interpersonally sensitive," reflecting a process-oriented and therapeutic approach to supervision. Items from this scale include adjectives such as "perceptive," "reflective," and "intuitive." The third supervisory style is "attractive," which reflects a more collegial approach to supervision. Examples of items from this scale are: "warm, friendly, supportive."

Upon analysis of 147 completed SSI's from doctoral trainees and 36 SSI's from master's level trainees, the authors found that trainees rated interpersonally sensitive supervisors as contributing significantly more to their own professional development and to client progress (as measured on two Likert items ranging from 1 (no effect) to 6 (very great effect)) than did task oriented supervisors ($p<.0001$). The authors add that supervisors with a psychodynamic orientation more often were rated as "interpersonally sensitive," whereas behavioral supervisors were more often rated as "task-oriented." The authors suggest that a psychodynamic supervisor may be more focused on relational aspects of supervision, whereas a behavioral supervisor may be more focused on particular tasks. This finding is similar to Ladany's (1993) conclusion that trainee satisfaction is related to the emotional bond subscale of the supervisory version of the Working Alliance Inventory, but is unrelated to the subscales measuring agreement on tasks and goals. Thus the emotional bond or interpersonal sensitivity of the supervisor may be more important to trainee satisfaction than focus or agreement on tasks.

Efstation, Patton, and Kardash (1990) used the Supervisory Working Alliance Inventory (measuring degree of client focus and supervisory rapport) and the Supervisory Styles Inventory to explore the relationship between the dimensions of supervisory style and supervisory rapport. They found that 178 advanced trainees' (advanced practicum students and interns) ratings of rapport within the supervisory relationship were not correlated with their ratings of their supervisor's task-orientedness. However, supervisory rapport was significantly correlated with the attractive and interpersonally sensitive subscales of the SSI. This may suggest that the latter two subscales are more intimately involved in rapport than is task-oriented behavior.

A variation of this methodology has been to ask trainees to rate which supervisory behaviors and interactions are deemed most important to them. Rabinowitz, Heppner, and Roehlke (1986) asked three levels of trainees (N=45) to rate the most important issues (e.g., designing treatment plan vs. conceptualizing clients vs. clarifying relationship with supervisor) and supervisor interventions (e.g., supportive vs. confronting vs. teaching) that occurred in supervision following each session during the course of a semester. Of the twelve possible issues, two were most often rated as most important by trainees at all levels: "developing a treatment plan," and "getting support from supervisor" (p.294).

In summary, research relating supervisory behaviors to trainee ratings of satisfaction and contribution to improvement suggest that supportiveness of the supervisor is consistently rated by trainees at all levels as one of the most helpful ingredients of supervision. The desired relationship is described as a pleasant, relationship-focused alliance in which skills are taught and trainee confidence is bolstered. The results regarding how much emphasis should be placed on skills training are less clear; while some studies suggest that trainees prefer a less structured supervision in which the supervisory relationship is the primary teaching tool, others suggest that trainees like supervision that is goal-oriented and which helps them develop a treatment plan.

Descriptions of positively versus negatively rated supervisors. Another method utilized to explore what trainees value in supervision has been to compare descriptions of positively and negatively rated supervisors. Schacht, Howe, and Berman (1988) asked 152 recent doctoral graduates in clinical or counseling psychology to rate their supervisors who contributed most and least to their therapeutic effectiveness. Supervisors who contributed most to trainees' effectiveness had significantly higher ratings on facilitative conditions (regard,

empathy, congruence, unconditionality, willingness to be known) than did other supervisors.

Allen, Szollos, and Williams (1986) used a similar design when they asked 142 advanced trainees from 37 APA-accredited programs in clinical and counseling psychology to rate their best and worst supervisors on variables designed to tap into issues of structure of supervision, supervisors' personal attributes, and interactional aspects of supervision (e.g., didactic components, evaluation, and power). They found that the best predictors of quality were (presented in no particular order): a) perceived expertise (which may indicate "idealizableness" in Kohutian terms), b) trustworthiness of the supervisor (indicating a safe holding environment in "Winnicotian" terms), c) amount of weekly contact, and d) emphasis on personal growth issues over teaching of technical skills. Good supervisors also tended to be e) psychodynamic, f) clear in communicating expectations and feedback, and g) supportive. Allen et al. (1986) concluded that "didactic and structural aspects of supervision were not nearly as influential determinants of quality as clear communication and respect" (p.95).

Other studies used a similar design of comparing positively and negatively rated supervisors. Kennard, Stewart, and Gluck (1987) asked 26 advanced trainees (subjects had completed all graduate coursework as well as internship within the last two years) to rank order all of their supervisors throughout their graduate training. The supervisors receiving extreme positive and negative rankings were divided into two groups: a positive supervision experience group and a negative supervision experience group. The two groups consisted of 68 trainee-supervisor pairs total, and supervision experiences were evenly distributed among first, second, and third years of therapy experience. The authors found that supervisors assessed as contributing to a positive experience received significantly higher

ratings from supervisees on the following dimensions: "supportive, instructional, and interpretive."

In a slight variation of this method, Gandolfo and Brown (1987) asked 102 advanced trainees (interns) to rate their actual and ideal supervisors on a) focus of supervision, b) supervisor and trainee roles, c) format of supervision, d) evaluation, e) atmosphere, and f) supervisor characteristics. They found that these advanced trainees wanted the focus of supervision to be primarily on self understanding and client understanding. Interns preferred that the supervisor take the role of a facilitator, and that the intern take that of problem solver. Trainees preferred using the session to discuss the case, and wanted supervisors to be open to feedback, and to deliver an evaluation that is clear. They also hoped for a supportive and relaxed atmosphere, a warm supervisor, and an emphasis on personal insight and the dynamics of the interconnected relationships of supervisor-therapist-client.

Hutt, Scott, and King (1983) also compared positively and negatively viewed supervision, but did so using the results of interviews instead of questionnaires. The investigators chose six post-Master's level trainees in counselor education, social work, and clinical psychology from the same university to participate in interviews regarding positive and negative supervisory experiences. Supervisees were chosen based on their ability to articulate their experience, their willingness to participate, and their ability to recall positive and negative experiences in supervision. Trainees were asked: "Try to recall a positive (or negative) experience you have had in supervision and describe it in as much detail as you can" (p. 119). Statements were analyzed according to meaning and theme, and supervisees were then interviewed a second time to validate or correct these meanings. The authors concluded that positive supervisory experiences were

those in which the supervisee's anxiety was perceptively met with support by the supervisor, and a positive supervisory relationship was characterized by "...warmth, acceptance, respect, understanding, and trust" (p. 120). The supportive supervisory relationship in turn resulted in greater willingness on the part of the trainee to explore feelings or concerns. The authors suggest that the result of positive supervision experiences is that the trainee gains skill, knowledge, and self-awareness. Trainees' self confidence is also thought to increase, as does willingness to trust their own professional judgment. Negative supervisory experiences, on the other hand, were those in which the supervisory relationship lacked a supportive quality, and the trainee felt the need to focus his/her attention on minimizing damage to his/her self: "..the work of supervision becomes less meaningful to the supervisee than avoiding the threat of exposure that supervision poses" (p.121). The result of this protective stance taken by the trainee was that much was hidden from the supervisor, and learning was limited in breadth. In addition, the authors suggest that frequent criticism by the supervisor may transfer to the therapy relationship. The authors conclude that although the quality of the relationship may not be sufficient for good supervision (e.g., some focus on tasks is also suggested), it seems to be necessary.

In sum, the results of studies comparing trainee perceptions of positive and negative supervisory experiences suggest that whereas negative experiences are characterized by a critical supervisory stance and a lack of support, positive experiences involve supervisors who offer higher levels of facilitative conditions, and who are seen as warm, understanding, and trustworthy. Good supervisors were able to offer support at times when they perceived a rise in trainee anxiety. Highly rated supervisors were also described as clearly communicating

expectations and feedback, focusing on the interconnected relationships of therapy and supervision, as well as on the personal growth of the trainee.

Limitations of these studies include occasionally small sample sizes, as well as some studies' retrospective nature. It is impossible to know whether subjects looking back on their experience may be viewing it with regard to their current needs and preferences, rather than according to what they may have actually needed at the time.

Descriptions of positive supervisory experiences. Another method used to explore the components of good supervision is to ask trainees to describe a positive supervisory experience. In their review of the literature, Worthen and McNeil (1996) note that past studies have found that supervisory relationships that are positively rated tend to be characterized by "...warmth, acceptance, respect, understanding, and trust" (p. 26). To test this, Worthen and McNeil (1996) interviewed four intermediate and four advanced trainees (interns), and simply asked them: "Please describe for me as completely, clearly, and concretely as you can, an experience during this semester when you felt you received good psychotherapy supervision" (p.26). The transcribed interviews were then analyzed by breaking down the sentences into "meaning units" in order to attempt to extract the essential characteristics of good supervision. The authors concluded that "...the quality of the supervisory relationship was cited as a crucial and pivotal component by all supervisees" (p.25). Good supervision experiences generally began with the trainee feeling somehow "disrupted" by a new kind of challenge faced in the therapy relationship, which was accompanied by anxiety, a sense of inadequacy, and intensified "need" of the supervisor. The trainee's discomfort was optimally addressed by a "...nonjudgmental, empathizing, supporting, and validating supervisory stance that acts to normalize the struggle" (p. 28). A result

of this stance, according to the authors' conclusions, was a reduced defensiveness and a greater openness to supervision on the part of the trainee. According to trainees, this stance allows the trainee to gain an alternate perspective on the situation, improve his/her ability to conceptualize the client's issues, as well as to strengthen the trainee's level of confidence. The trainees interviewed were reportedly then able to return to their clients with enthusiasm rather than dread, anxiety, or confusion. These conclusions are consistent with the self psychological theory of optimal conditions for effective learning. While this study is valuable in that it articulates more specifically "good supervision" from the trainee's perspective in an open-ended way that is not confined to the measures available, it also was limited to eight trainees (and thus may have limited generalizability).

In his conversations with his own trainees, Brightman (1984) found that training seemed to be valued when: 1) the supervisor seemed to understand, respect, and care about the trainee and his/her training, and 2) the supervisor was seen as an excellent clinician whom the trainee admired and would wish to be like professionally. The author saw this finding as support for the hypothesis that trainees have needs to be mirrored and to idealize the supervisor. This study was qualitative in nature, with a limited sample, leaving the question remaining of whether these results may be generalized to other trainees.

Summary. The most robust finding in the supervision literature seems to be that regardless of trainee experience, trainees desire a supportive supervisory relationship characterized by empathic understanding. In their review of the literature, Gandolfo and Brown (1987) note: "The need for a supportive relationship appears to be a high priority for supervisees from beginning to advanced training levels" (p.27). The literature to date suggests that across a variety of methodologies, ratings of supervision are consistently correlated with

support from the supervisor and the quality of the supervisory relationship (i.e., warmth, acceptance, respect, trust). Other qualities of supervision have been endorsed by trainees as being desirable, but support and empathic attunement are most commonly found across studies. While these studies clarify what trainees find helpful in supervision, only one study examined whether trainees' experiences of "good" supervision actually translated into more effective therapy (Friedlander & Ward, 1984), and even this study was limited in the conclusions that could be drawn given the methodology; the only assessment that was used of the relationship of supervision to therapeutic effectiveness was gained by asking trainees to rate how much of an effect supervision had on client outcome.

Developmental Differences in Trainee Preferences

There is some debate in the literature as to whether trainee preferences or needs regarding supervision change over the course of training. Although Rabinowitz et al. (1986) (as previously described) found that support was even more important to beginning and intermediate trainees than to interns, they concluded that support was critically important to all levels of trainees.

This finding was corroborated by Heppner and Roehlke (1984), who administered the Supervisory Behaviors Questionnaire (SBQ) to 49 trainees across three levels of training. In addition to the SBQ, trainees were asked to complete three items designed to tap into the effectiveness of supervision, and to rate their degree of satisfaction, their perception of the supervisor's degree of competence, and their assessment of the extent to which the supervisor contributed to improvements in their counseling skills. The authors found that although beginners found rapport to be an even more important ingredient of supervision than did interns, at all levels satisfaction with supervision was related to the degree to which supervisors helped trainees assess their strengths and gain confidence. In

addition, when asked to rate critical incidents of supervision, beginners and intermediate level trainees highlighted incidents that involved support and self-awareness, whereas interns related incidents in which personal issues were discussed, such as feelings of defensiveness and how those feelings may affect the therapy. Other studies found similar results; for example, when Rabinowitz et al. (1986) asked trainees to rate the most important issues in supervision, they found that advanced trainees were more interested in looking at personal issues, transference and countertransference. Brightman (1984) might explain this preference by suggesting that whereas beginning trainees entering a new learning environment need to use supervision to "preserve narcissistic equilibrium" and to bolster a more vulnerable self esteem, more advanced trainees can use the time to explore other issues. The author maintains that the ability to discuss countertransference signals a shift to a more mature developmental level of the professional self.

While the studies mentioned so far suggest that beginners may need or desire even more support than advanced trainees, a few studies found conflicting results. While Worthington's (1984) study supports the notion that support and encouragement were important to novice trainees, these ingredients were also found to be important to interns, moreso than for intermediate trainees. The author speculates that trainees may feel most sensitive to evaluation at these times.

Whereas the theoretical literature suggests that beginners need a holding environment to help them with their anxiety about trying on a new role, two studies suggest that, along with that environment, beginners also desire more focus on skill training than do interns. Heppner and Roehlke (1984) (from the study just mentioned) found that beginning trainees' ratings of supervisory effectiveness correlated with their perception of supervisors as being supportive, instructive, and

able to focus on skill training. Upon asking 31 beginning trainees to rate the importance of 42 supervisory behaviors to good supervision, Worthington and Roehlke (1979) also found that beginning trainees prefer supervisors who *teach* counseling skills within a supportive environment.

Thus there is some evidence (albeit inconsistent) that suggests that trainee needs as viewed by the trainee may change over the course of training (e.g., beginners may desire more support and skill training, whereas interns may desire a focus on personal issues and countertransference). Developmental differences have also been examined from the perspective of the supervisor; that is, attempts have been made to assess whether supervisors change their style or behavior according to trainee level.

In order to assess whether supervisors vary their approach according to trainee level, investigators have asked for the perspectives of both supervisors and trainees. Miars et al. (1983) surveyed 37 Ph.D. level supervisors about their behavior in supervision across experience level of trainee. The authors used the Level of Supervision Survey (LSS), a questionnaire based on Stoltenberg's Counselor Complexity Model, a developmental model of supervision, which postulates that beginning trainees need more structure and instruction in supervision, whereas intermediate trainees prefer a supportive relationship in response to their conflict of dependency vs. autonomy, and advanced trainees prefer a collegial supervisory relationship (Stoltenberg, 1981). This model is consistent with Gardner's (1995) notion of beginners needing idealizable selfobjects to provide structure, intermediate trainees needing mirroring selfobjects to mirror the student's developing professional self, and the advanced trainee needing a sense of twinship or likeness with the supervisor. The LSS assesses three dimensions: the *importance* of various aspects of supervision, the *frequency*

of various behaviors, and the amount of *time* spent on various supervisory functions. Supervisors were asked to complete the LSS four times, once for each of four levels of trainee experience. With beginning trainees, Miars et al. (1983) found that supervisors described their behavior as consisting of significantly more direction, instruction, support, and of listening to more tapes, whereas with advanced trainees, supervisors focused more on personal and relationship issues. The primary limitation of this study concerns the method of asking supervisors to complete the instrument repeatedly for each of four training levels. It would seem that this method would force a differentiation that may or may not exist in practice.

Using a method that controlled for this potential confound, Yogev and Pion (1984) administered a questionnaire to supervisors of beginning trainees, supervisors of intermediate trainees, and supervisors of interns. Results indicated no significant differences in supervisors' goals, procedures, or expectations according to trainee level, suggesting that supervisors did not vary their approach according to trainee experience.

Instead of assessing supervisors' perspectives on changes across training level, Cross and Brown (1983) assessed trainee views of supervisors' behavior. The authors asked 51 trainees at different levels of experience to rate the frequency of supervisory behaviors. Beginning trainees reported that their supervisors were more often focusing on mechanics and concrete tasks, whereas trainees with at least one year of experience reported a less structured, more supportive interaction with their supervisors. Friedlander and Ward (1984) similarly found that supervisors at the internship level tended to be rated by trainees and by themselves as more interpersonally sensitive, whereas those at the practicum level were described as more task-oriented.

In sum, while investigators seem to agree that a supervisory relationship characterized by empathy and support is important to trainees at all levels, some investigators suggest that it is especially important to beginners (Heppner & Roehlke, 1984; Rabinowitz et al. 1986), yet this finding was not corroborated by one study (Worthington, 1984). The inconsistent findings may be related to other variables not measured (e.g., duration of supervisory relationship at time of completing questionnaires), but it is unclear at this time how to explain the conflicting results.

Studies also suggest that while overall, trainees may prefer an "interpersonally sensitive" supervisor, beginners may, in addition, desire a concrete focus on skill-training, whereas more advanced trainees may be less needy of this focus, and more interested in pursuing personal issues that affect the therapy. Although some studies found that supervisors of beginning trainees actually do tend to be more didactic, whereas supervision of advanced trainees is described as less structured with more focus on relationship issues (as may be preferred), another study found no significant differences in supervisory behavior across trainee level.

Supervision and Self Efficacy

The theoretical literature reviewed previously hypothesizes that an empathic, supportive supervisory relationship results in increased self esteem and optimal learning by the trainee. The research on trainee preferences suggests that this kind of supervision is, indeed, preferred by trainees, and particularly by beginning trainees.

However, the fact that trainees *prefer* supervision that attends to their self esteem does not necessarily mean that supportive, nurturing supervision is actually more effective. Bandura might suggest that one's sense of self efficacy actually

influences one's performance. In fact, there is preliminary evidence to suggest that trainee expectations of performance as a therapist are positively related to their actual performance (Larson, 1992). It may be, then, that trainees' expectations of their own performance may affect that performance. Thus it would be important to understand what factors affect trainee self efficacy.

In order to better understand exactly what happens in supervision and its effect on trainee self-ratings, Holloway and Wampold (1983) analyzed verbal interactions within the supervisory relationship and related these interchanges to participants' ratings of satisfaction with supervision including three dimensions: evaluation of self, evaluation of other, and level of comfort. Thirty novice trainees were supervised by nine advanced doctoral students. The authors found that trainees rated themselves more highly when supervisors followed trainees' expressions of ideas with a request for more ideas (this interaction happened to occur the least often). This may indicate that trainee self efficacy increases when supervisors seem interested in their thought process, when supervisors value trainees' ideas, and when supervisors encourage self reliance and trust in one's own abilities rather than turning to the "expert" supervisor for the answers. This finding highlights the delicate balance between offering direction and allowing the trainee to try to learn on her own. It also shows the salience of trainees' vulnerable self esteem, and the need for the supervisor to participate in bolstering it. Again, the findings are limited to a small and specific population: novice trainees and novice supervisors.

Other investigators found that trainee self efficacy was related to the quality of the supervisory relationship. Efstation, Patton, and Kardash (1990) developed the Supervisory Working Alliance Inventory to assess the dimensions of supervisor-trainee rapport, focus of supervision, and trainee identification with the

supervisor. Advanced trainees' ratings of supervisory rapport (which accounted for 30% of the variance) and client focus (accounting for 8% of the variance) predicted trainee scores of self efficacy as measured on the Self Efficacy Inventory. It is important to interpret these results cautiously; due to the correlational nature of the study, we are unable to definitively conclude that a supervisory relationship characterized by higher rapport resulted in a greater sense of self efficacy on the part of the trainee. In fact, a similar study was unable to corroborate this finding. Ladany (1993) found that trainee self efficacy was unrelated to the supervisory alliance as assessed using trainee scores on the supervisory version of the Working Alliance Inventory, which measures agreement on tasks and goals, as well as degree of emotional bond between supervisor and trainee. Thus there is inconsistent evidence with regard to whether the supervisory relationship affects trainee self efficacy.

Few studies have actually examined the question of whether trainee self efficacy is related to therapeutic effectiveness. Larson et al. (1992) defined self efficacy as "...people's perceptions of their expected performance levels and their expectancies for success..." (p. 105). The notion was derived from Bandura's theory that one's perception of self efficacy in part determines how s/he will behave (Larson et al. 1992). Larson et al. devised the Counseling Self-Estimate Inventory (COSE) in order to assess counselors' sense of efficacy with basic therapy-related behaviors. The items were written in such a way as to be meaningful to all levels of trainees, and without theoretical underpinnings, so that the behaviors tapped on the COSE would be those employed by therapists across theoretical orientations. The items on the COSE were factor analyzed to yield five factors that were minimally correlated with each other (<.30): microskills (e.g., conciseness and clarity of counselor responses as well as tracking of client),

process (therapist behavior over a series of responses, such as clarification of the problem and development of goals), difficult client behaviors (e.g., ability to respond to suicidal, unmotivated, or silent clients), cultural competence (working with clients of different cultures), and awareness of values (counselor's insight into his/her own biases). The authors found that self efficacy was positively related to counselor performance of microskills (assessed by rating taped therapy sessions). Trainees with higher scores on the COSE also had moderately higher self concepts (as measured on the Tennessee Self Concept Scale), but the authors hypothesize that although self efficacy and self concept may be related, self concept is a more enduring trait, whereas self efficacy as measured on the COSE is sensitive to experiences that would be expected to alter self efficacy (e.g., trainees who have had more therapy experience and more supervision show higher scores on the COSE). In fact, although test-retest reliability after three weeks was high (.87), trainees' ratings after one semester of counseling experience increased significantly. Self efficacy was found to be negatively related to state and trait anxiety. Self efficacy was minimally related to aptitude, achievement, personality type, and defensiveness. These results suggest that a trainee's rating of self efficacy is predictive of his/her performance as a therapist. It is unclear, however, whether this is a causal relationship, or whether trainees are simply accurate in their self assessment. A relationship between self efficacy and therapist performance would not be surprising to self psychological theorists, however, who would suggest that attention to the student's sense of self and vulnerable esteem makes for a greater ability to learn.

In sum, although theory suggests that an empathic, accepting supervisory relationship results in greater sense of efficacy in the trainee, the limited research in this area offers inconsistent evidence regarding the relationship between a

positive supervisory rapport and trainee self efficacy. Trainee ratings of self efficacy are significantly correlated with improved ability to perform basic microskills as rated by an external observer. It may be that an empathically attuned supervisory relationship results in increased trainee self efficacy and improved therapist abilities, but due to the limited research, this conclusion cannot clearly be drawn. Furthermore, the conflicting results regarding how supervision affects trainee self efficacy makes it even more difficult to draw clear conclusions.

Relationship Between Supervision and Therapeutic Effectiveness

Carsen and Roskin (1984) hypothesized along similar lines as Cohler (1989) when they suggested that "...just as empathic understanding fosters positive change in psychotherapy, so in supervision and teaching should sensitive attention to the felt experience of the student be conducive to better learning" (p. 270). Clinicians have often suggested that trainees can become more effective therapists if supervised within a safe, empathic, supportive relationship. Indeed, research has indicated that trainees feel more positively about supervision when it occurs within a supportive, empathically attuned relationship. The important question, however, is whether this kind of supervisory environment actually translates into more effective therapy. Lambert and Arnold (1987) suggest:

> Interpersonal skills and positive therapist attitudes are the most important and well-researched common factors in therapy. It is therefore essential that supervision have an impact on therapist attitudes and skills and that researchers of supervision assess the nature and degree of this impact. (p. 217)

In order to begin to examine the effect of supervision on therapeutic effectiveness, three kinds of studies have been conducted: 1) an exploration of how facilitative conditions offered by the teacher or supervisor affects learning, as well as how they affect the ability of the trainee to provide those same conditions to

their clients, 2) investigations into the theory of parallel process, and 3) studies focused on how supervision affects trainee expectations and performance.

Facilitative conditions and learning. Facilitative conditions offered by the teacher such as empathic understanding and regard have been hypothesized to increase the student's learning (Rogers, 1957). The mechanism of this increased learning has been identified differently by different theorists, as will be discussed shortly. Aspy (1965) conducted a study examining whether Rogers' hypothesis would be empirically supported. The investigator studied six classes of third graders, and found that students who had teachers showing the highest degree of facilitative conditions mentioned above improved the most in their reading scores. Although this study does not provide definitive or incontrovertible support, it may suggest the value of further research in this area.

Dowling and Frantz (1975) explored whether level of facilitative conditions (empathy and respect) affected the degree to which observers adopted models' attitudes. The authors randomly assigned 72 college students to one of eight groups which varied by level of facilitative conditions displayed by the group leader, and by attitude exhibited by the leader on an issue (ethnocentrism vs. nonethnocentrism). Subjects then completed the Ethnocentrism Scale. Results suggest that participants imitated the attitudes of the group leader significantly more when the leader offered high levels of facilitative conditions. The results support Bandura's theory that imitative learning occurs more effectively within a nurturant relationship. If these results are translated to the supervisory relationship, one might hypothesize that trainees would learn therapist behaviors more effectively within a facilitative supervisory relationship.

Researchers have also examined the learning situation of the supervisory dyad specifically. Pierce and Schauble (1970) investigated whether supervisors'

ability to provide facilitative conditions identified by Rogers of genuineness, acceptance, and empathic understanding affected trainees' ability to provide these to clients. In this study, supervisors and trainees were each rated on the levels of facilitative conditions they were able to provide. These conditions were defined as empathy, respect, genuineness, and concreteness. Concreteness was defined as the dimension of specificity ranging from "... the vague and abstract discussions to the direct discussion of specific feelings and experiences" (Pierce et al. 1967, p. 213). These facilitative conditions were assessed by trained raters who rated random excerpts of taped therapy sessions. Results suggest that trainees who had supervisors that offered high levels of these facilitative conditions increased on these dimensions, whereas those who worked with supervisors low on these dimensions decreased slightly (Pierce & Schauble, 1970). The authors conclude that a trainee can only increase her levels of facilitative conditions as high as those of one's supervisor, but one cannot surpass the supervisor's level. Thus, for example, the trainee's ability to communicate empathically to his/her client is limited by how well the supervisor is able to do the same thing. In addition, Pierce and Schauble (1971) conducted a follow-up study nine months later, and found that trainees of supervisors manifesting high levels of facilitative conditions continued to manifest high levels themselves. These findings support the idea that a trainee may learn more from what the supervisor does than from what s/he says to do. It is also supportive of Rogers' (1957) notion of a facilitative learning environment consisting of genuineness, acceptance, and empathy. While some authors may explain this transfer of facilitative conditions from supervision to therapy as modeling, Gardner (1995) suggests that "...the more the supervisor can strengthen the professional self of the therapist by understanding what the therapist is experiencing....the sooner the therapist will be able to offer the patient what he

or she needs" (p. 281). She suggests that the trainee will not offer an optimally empathic environment to a client until s/he personally experiences that empathic supervisory environment as valuable.

Limitations of these studies, however, include small sample size, and choice of subjects. Specifically, the therapist-client dyad used in these studies is not representative of what would be found with trainees in graduate school, since "therapists" were not graduate students in psychology, but were laypeople gaining training in counseling. In addition, "clients" were not actual clients but were individuals trained to role play a client. It is unclear what effect this may have on the results. Another limitation of the study is that facilitative conditions were assessed only by external raters, when the theory suggests that it is the *experience* of facilitative conditions *by the participating individual* that is crucial. In other words, it is unclear whether an external observer could adequately assess the client's *experience* of facilitative conditions.

Although these researchers have supported the idea that facilitative conditions experienced by the trainee in supervision result in the same being experienced by the client of that trainee, there remains a debate as to whether a facilitative climate is necessary for the learning of those kinds of skills. Lambert and Arnold (1987) object: "There exists little empirical evidence supporting the necessity of a therapeutic climate for the acquisition of interpersonal skills..., and it appears that learning these skills can occur without high levels of empathy, genuineness, and unconditional positive regard" (p. 219). These authors suggest that these skills can just as easily be *taught*, and need not be *experienced.*

Silverman and Quinn (1974) investigated the question of how experiencing facilitative conditions may differ from receiving instruction on them. The authors rated taped therapy sessions on levels of facilitative conditions provided by the

therapist-trainee prior to and following involvement in one of the training groups (modeling vs. feedback). The authors found that novice trainees (N=24) who worked with their supervisors as co-therapists (i.e., modeling) increased on their levels of facilitative skills, whereas trainees who worked alone but received immediate feedback on their performance did not increase on this dimension. This study may suggest the importance of a modeling component to learning, over and above the role of feedback, supporting the hypothesis of the importance of experiential learning over instruction alone. The limitations of this study include the lack of variability in trainee level (no trainees had had any prior counseling experience), and the question of the generalizability of the results, since the "clients" were actually drama students trained to act as clients. It is unclear whether this situation may have differed from an actual therapy session.

The research findings may be understood theoretically as follows. Facilitative conditions may be effective in two ways: 1) by creating an environment that is more conducive to learning (perhaps by increasing the likelihood of attending, as Bandura would hypothesize), and 2) by allowing the trainee to experience first hand what s/he hopes to provide to the client. While facilitative conditions alone may not be sufficient to supervision, it appears that they may be necessary, in that optimal learning only seems to occur within a facilitative relationship.

Parallel process. A second area of investigation into how supervision affects the therapy relationship has been a limited inquiry into the theory of parallel process: the notion that the supervisory and therapy relationships are intimately connected, and that issues in one relationship may be acted out in the other. Friedlander, Siegel, and Brenock (1989) conducted an in-depth investigation into one supervisor-trainee-client triad regarding participants'

experiences of their therapy and supervision sessions. Profiles from the Session Evaluation Questionnaire showed a correlation between the trainee's assessment of value and ease in supervision and in therapy over eight weeks. For example, an increase in perceived ease in supervision was followed by an increase in perceived ease in therapy. Finally, communication styles in supervision and therapy sessions were compared using two coding schemes of transcribed sessions (the Relational Communication Control Coding System, assessing which person leads and who follows, and the Interpersonal Communication Rating Scale, assessing style of self presentation including dimensions such as critical, cooperative, self-effacing, and nurturant). Results suggest a relationship between communication styles in therapy and supervisory relationships. Specifically, it was found that the supervisor used mostly leading self-presentations, and the trainee was categorized as primarily cooperative. Trainee and client took on these same communication styles in therapy, with the trainee primarily leading and the client primarily cooperative. The authors' data support theories of parallel process, in which the supervisory and therapy relationships are hypothesized to be intimately connected, such that behavior or communication styles arising in one relationship may manifest themselves in the other. The obvious limitation of this study, however, is that only one supervisor-trainee-client triad was assessed.

Doehrman (1976) conducted an intensive study using primarily qualitative but also quantitative measures in which she found support for parallel process in four supervisor-trainee-client triads. In addition to having therapists, supervisors, and researchers fill out questionnaires designed to assess trainees' and supervisors' feelings about each other and about supervision, she also conducted weekly in-depth interviews of trainees, patients, and supervisors. Interview questions were open-ended and focused on participants' experiences of the relationships in which

they were involved. Doehrman found that "... each therapist played supervisor with his patients" (p. 72). She found that patients were only able to work through problem areas in the therapy relationship once trainees were able to work through problem areas in the supervisory relationship. Again, the most obvious shortcoming of the study was the small number of subjects: two supervisors, four trainees, and four patients.

Trainees' perceptions and expectations. There is some evidence that the experience in supervision affects the trainee's expectation about how s/he will be perceived by his/her client. Lanning (1971) asked 29 beginning trainees to complete the Barrett-Lennard Relationship Inventory to assess level of regard, congruence, empathy, and unconditionality offered by the supervisor. He found that knowing how a trainee perceives her supervisor allows one to predict how that trainee expects her clients to perceive her. The correlation between trainees' perceptions of their supervisory relationships and their expectations of their therapy relationships was significant beyond the .001 level. In other words, trainees expected their therapy relationships to be similar in quality to their supervisory relationships. The author concludes that "supervisors might focus more on the working relationship they establish with their trainees and in that way foster better working relationships between trainee and client" (Lanning, 1971, p. 405). These findings support the notion of parallel process, in which the quality of one relationship may directly affect the quality of the other.

Summary. There is some evidence to suggest that style of interaction in supervision is directly related to style of interaction in the therapy relationship. These findings support the theoretical literature regarding the transfer of approach from the supervisory relationship to the therapy relationship, either via parallel process, modeling, or through the strengthening of the trainee's professional self

through the provision of selfobject functions, which theoretically results in the trainee's increased ability to do the same with the client.

The finding that experiences in supervision affect trainees' expectations of how things will go in therapy is important given Bandura's notion of expectations of successful performance (self efficacy) being predictive of performance (Bandura, 1977). In other words, the data suggest that supervision may affect trainees' expectations of therapy, and Bandura would suggest that these expectations actually influence trainees' performance.

The Present Study

The research to date provides support for some of the theoretical tenets put forth regarding the ingredients of optimal supervision. The studies done on trainee preferences suggest that trainees at all levels prefer a supportive supervisor who is empathic and accepting. Trainees also report needing supervisors to help them with their doubts and to bolster confidence. There is some evidence to suggest that experiences in supervision affect trainees' expectations of the therapy, and that expectations correlate with actual performance. There is also limited evidence to suggest that experiences in supervision and in therapy may parallel each other, such that a trainee's experience of supervision may be similar to the client's experience of therapy. However, there has been no attempt to study each step of the theoretically derived process of optimal supervision: empathic supervision, greater therapist self efficacy, and therapeutic effectiveness.

The present study seeks to examine the relationship among the degree of facilitative conditions such as empathy and regard in the supervisory relationship, self efficacy of the trainee, and therapeutic effectiveness. Patient involvement in the therapy relationship has been selected as a measure of therapy effectiveness because it has been consistently found to be related to patient outcome.

The results of many studies investigating psychotherapy process and outcome suggest a consistently positive relationship between patient involvement in the therapeutic alliance (as assessed by the therapist) and outcome (e.g., Bourgeois, Sabourin, & Wright 1990; Gerstley, McLellan, Alterman, & Woody, 1989; Kolb, Beutler, Davis, Crago, & Shanfield, 1985; Marziali, 1984; Salvio, Beutler, Wood, & Engle, 1992). Specifically, therapists' assessment of patient involvement is thought to be of greatest interest, since "the reliability of process ratings is improved when therapists rather than outside observers rate" (Gurman, 1977 cited in Baer, Dunbar, Hamilton, & Beutler, 1980, p.564).

This study focused on the effect of trainees' perceptions of the supervisory relationship on trainee self efficacy and on patient involvement in the therapeutic relationship. Specific aspects of the supervisory relationship that were investigated were trainee perceptions of facilitative conditions such as supervisory empathy and perceived regard.

Hypotheses:

1) Facilitative conditions within the supervisory relationship as rated by the trainee will be predictive of increased patient involvement in the therapy relationship, via the mediating mechanism of increased trainee self efficacy.

2) Trainee perceptions of greater facilitative conditions in supervision will correlate with greater trainee satisfaction with supervision.

3) Level of trainee experience (in addition to facilitative conditions within the supervisory relationship) will also predict trainee self efficacy.

In addition to testing the hypotheses mentioned, exploratory analyses were also conducted to examine how the following variables may relate to trainee self

efficacy and patient involvement: patient diagnosis, trainee experience level, duration of therapy relationship, duration of supervisory relationship.

CHAPTER II

METHOD

Participants

In order to participate in the study, trainees needed to be currently involved in a psychotherapy practicum and in the process of seeing a client who meets criteria for inclusion in the study (as outlined in Procedure). Of the 317 questionnaires that were distributed, 50% were returned. Of these 158 questionnaires, 28 were returned blank with notes indicating that the individual did not meet criteria for inclusion in the study; seven were completed and returned months later than the rest of the participants and therefore were not included in the data analyses; and one subject was eliminated from the analyses because of his outlying data points on several variables (greater than three standard deviations from the mean).

Table 1 presents a summary of the demographic information collected from the final 122 participants that were included in the analyses. Sixty-six percent of respondents were female, and 33% were male. Participants ranged in age from 22 to 49, with a mean age of 29. All participants were currently enrolled in APA-accredited graduate programs in psychology in the Midwest; 58% of respondents reported working towards a Psy.D. degree, 29% were earning a Ph.D., and 11% reported working towards a terminal Master's degree. Participants were students in either Clinical (84%) or Counseling (10%) Psychology. While most participants reported being Caucasian (86%), 17 participants endorsed other ethnicities, as indicated in Table 1. Trainees endorsed a variety of theoretical orientations, including Psychodynamic (37%), Eclectic (27%), Cognitive-

Table 1

Demographics of Respondents

Variable	M	SD
Age	29.46	5.82
Year in School	3.88	1.35
#Practica Completed	2.42	0.93
#Practicum Hours	1590.20	1082.01
#Supervisors	5.03	3.27
Years Work Experience		
prior to grad school	2.71	3.31
#Supervisors		
prior to grad school	1.82	2.46

Variable	n	%
Gender		
Female	81	66.4%
Male	40	32.8%
unknown	1	0.8%

Table 1 continued

Variable	n	%
Degree sought:		
M.A.	14	11.5%
Ph.D.	35	28.7%
Psy.D.	71	58.2%
unknown	2	1.6%
Psychology Program:		
Clinical	103	84.4%
Counseling	12	9.8%
unknown	7	5.7%
Ethnicity		
African-American	4	3.3%
Asian-American	4	3.3%
Caucasian	105	86.1%
Latino/Latina	5	4.1%
Native American	2	1.6%
Trainee theoretical orientation		
Cognitive	3	2.5%
Cognitive-Behavioral	23	18.9%
Eclectic	33	27.0%
Family Systems	4	3.3%
Humanistic/Existential	12	9.8%
Psychodynamic	45	36.9%
Other	2	1.6%

Behavioral (19%), Humanistic/Existential (10%), Family Systems (3%), Cognitive (2%), and Other (2%).

Participants varied both in the extent of their experience during graduate school, as well as in the extent of their psychology-related work experience prior to graduate school (see Table 1). With regard to their level of experience during graduate school, a range of one to eight years of graduate school was reported. Most participants were between their second and sixth years: 15 reported being in their second year, 38 in their 3rd year, 27 in their 4th year, 24 in their fifth year, and 11 in their 6th year. With regard to practicum experience, 16% reported being on their first practicum, 40% on their second, 29% on their 3rd, 4th, or 5th practicum, and 15% on internship. While participants reported a large range of number of hours of practicum experience (15 to 6000 hours), the mean number of hours was 1590 (mode=2000 hours). Most trainees (92%) reported having had eight or fewer supervisors during their graduate training (mean number of supervisors=5.0; range= 1 to 26).

With regard to level of psychology-related work experience prior to graduate school, trainees reported a range of 0 to 18 years of prior work experience (mean=2.7 years; mode=0 years; 75% of trainees had three or fewer years of experience prior to graduate school). During this time, most trainees (91%) reported having had four or fewer supervisors (mean=1.8 supervisors; range=0 to 20 supervisors).

Measures

Barrett-Lennard Relationship Inventory for Supervisory Relationships. Specific aspects of the supervisory relationship that were examined with this measure were empathic understanding, regard, unconditionality, congruence, and

willingness to be known. Barrett-Lennard (1962), the author of the measure designed to assess these variables, defined them as follows:

Empathic understanding is thought to be "...a process of desiring to know the...changing awareness of another person, of reaching out to receive his communication...and of translating his words and signs into experienced meaning that matches at least those aspects of his awareness that are most important to him at the moment" (p.3). Regard is defined as the "...affective aspect of one's response to another" (p.4). This may include positive or negative feelings. Unconditionality is defined as "...the degree of constancy of regard felt by one person for another who communicates self-experiences to the first" (p.4). Congruence is thought to be the "...absence of conflict or inconsistency between his total experience, his awareness, and his overt communication" (p.4). An individual rating high on "willingness to be known" is thought to be "...guided in his self-communication by an open awareness of the other's present desire to experience and know him as a person" (p.5). Thus sharing information about oneself may not receive a high rating on this scale if it is not stimulated by the other, but instead is stimulated by one's own need to share information. A total score of facilitative conditions was used in the analyses, and was obtained by summing all five of the subscale scores.

The Barrett-Lennard Relationship Inventory (1962) was initially written to assess facilitative conditions in the therapy relationship, and was later revised to focus on the supervisory relationship. Reliability and validity of the Barrett-Lennard Relationship Inventory have been assured in several ways. Barrett-Lennard assured content validation of the original Relationship Inventory by asking five trained judges to classify each item in terms of whether it was a positive or negative indicator of the variable, and to what extent (-5 to +5), or

whether it was irrelevant to the variable in question. There was perfect agreement between judges on all but four items (three of which were then eliminated) on whether items were positive or negative indicators. An item analysis was conducted (N=40), and one item was discarded as a result, since it had been interpreted in two different ways by participants (Barrett-Lennard, 1962). The author then found support for predictive validity by noting relationships between ratings on the scale and other variables that are theoretically relevant, such as client personality change, as assessed using six different measures from both therapist and client perspectives. In other words, if Rogers' theory is accurate that these facilitative conditions are necessary ingredients of therapy to produce client change, one would expect a significant relationship between ratings on these variables and client change. Barrett-Lennard also found that each of the five variables are differentiated though related aspects of the therapy relationship, and each had adequate internal reliability.

Investigators later shortened the questionnaire and re-worded it to read "supervisor" instead of therapist, in an attempt to rate facilitative conditions of the supervisory relationship. Reliability (Cronbach's alpha coefficient of internal consistency) for the short form of the Barrett-Lennard Relationship Inventory for Supervisory Relationships was found to be .92 (Schacht, Howe, & Berman, 1988).

Counseling Self Estimate Inventory. In order to obtain a rating of trainee self efficacy, trainees also completed the Counseling Self Estimate Inventory (COSE) (Larson et al. 1992). The construct measured by the instrument is trainees' expectancy for success in the therapy situation. The measure initially consisted of sixty-seven items describing different therapist behaviors that cross

theoretical orientations and would be understandable to beginning trainees. Items were generated based on the authors' and colleagues' supervisory and therapy experiences, descriptions of therapist behaviors from counseling textbooks, and research regarding therapist responses. Participants are asked to rate their level of confidence (using a six-point Likert scale) in performing various behaviors. Construct validity was explored through a factor analysis that yielded five factors which were minimally correlated with each other (<.30). These factors were labelled: microskills (e.g., conciseness and clarity of counselor responses as well as tracking of client), process (therapist behavior over a series of responses, such as clarification of the problem and development of goals), difficult client behaviors (e.g., ability to respond to suicidal, unmotivated, or silent clients), cultural competence (working with clients of different cultures), and awareness of values (counselor's insight into his/her own biases). Only items with factor loadings above .40 were retained, leaving 37 items. These items were internally consistent (α=.93), suggesting that the measure taps a general underlying construct. For this reason, a total score may be used as an overall measure of self-efficacy (and indeed, this is the score that was utilized in the present study). Internal consistencies for the five factors were as follows: microskills: α=.88, process: α=.87, difficult client behaviors, α=.80, cultural competence, α=.78, and awareness of values: α=.62. Item-total correlations in general ranged from .32 to .65 except for three items.

Convergent validity was examined by showing a moderate correlation between scores on the COSE and scores on a measure of self-concept (the Tennessee Self Concept Scale). It was predicted that these constructs would be moderately related but not identical, since self concept is a more enduring trait, whereas self efficacy as measured on the COSE is sensitive to experiences that

would be expected to alter self efficacy (e.g., trainees who have had more experience and more supervision show higher scores on the COSE; p<.001). In fact, although test-retest reliability after three weeks was high (.87), trainees' ratings after one semester of counseling experience increased significantly. Thus the COSE is sensitive to differences in trainee experience.

Further evidence of convergent validity was the negative correlation of COSE ratings to state and trait anxiety. This relationship was predicted due to Bandura's theory that anxiety decreases individuals' perceptions of self-efficacy. Finally, COSE scores also correlated with participants' perceptions of their problem-solving ability. The authors predicted this relationship since they see part of the therapist's role as helping clients to solve problems.

Finally, discriminant validity was shown by a minimal relationship of COSE scores to aptitude, achievement, personality type, defensiveness, and faking. The authors also found support for criterion validity of the COSE by showing that COSE scores and anxiety scores significantly predicted external judges' ratings of trainees' performance of microskills, and accounted for 29% of the variance.

Psychotherapy Process Inventory. Trainees also completed the "Patient Participation" and "Resistance" subscales from the Psychotherapy Process Inventory (PPI; Baer et al. 1980). The Patient Participation subscale is comprised of items focusing on the patient's degree of engagement in the therapy, including level of motivation, self-disclosure, and satisfaction with the process. The resistance subscale is comprised of items tapping into the patient's negative feelings toward the therapist, such as hostility, competitiveness, or resistance.

Scores on Patient Participation were found to be significantly correlated with therapy outcome as measured by a 7-point Likert-type item completed by

the therapist (Baer et al. 1980). Participation scores were also predictive of global change in impairment over the course of therapy (Gorin, 1993).

Along with the factor scores of patient participation and resistance, investigators have calculated a measure of Patient Involvement in the therapy relationship by subtracting the Resistance subscale score from the Patient Participation subscale score (Gomes-Schwartz, 1978; Kolb et al. 1985). Previous studies have found Patient Involvement to be predictive of improvement in therapy as rated by both therapist and patient (Gomes-Schwartz, 1978; Kolb et al. 1985). Research has also suggested that scores on Patient Involvement are not correlated to pre-existing patient variables such as pre-therapy scores on the SCL-90R, locus of control as assessed by the Internal-External Locus of Control Scale, and extraversion-introversion and neuroticism/anxiety scores from the Eysenck Personality Inventory (Kolb et al. 1985). Since the Patient Involvement score incorporates both the concepts of participation and resistance, it was used as the primary index of therapy outcome. However, since Patient Participation has also been related to outcome, this construct was also explored.

Items on the PPI were written based on the clinical literature as well as on conversations with clinicians. Criteria for item inclusion were as follows: "1) capability of eliciting differences among therapist raters, 2) minimizing the degree of inference required for rating, 3) coverage of a broad range of theoretical positions and concepts framed in nontechnical language, and 4) focus on concepts common to a variety of theoretical positions" (Baer et al. 1980, p.564). Items are rated on frequency or intensity using a 5-point Likert-type scale. All items were indeed found to stimulate differential ratings by therapists (a minimum of three scale points were used on all items, and many items showed ratings on all five scale points).

Reliability (alpha coefficients) for the patient participation subscale was .92, and reliability of the resistance subscale was .87. Length of treatment prior to completion of the PPI did not affect scores (Baer et al. 1980).

Demographic data. Participants also completed a demographic information questionnaire. Trainees provided general background information pertaining to themselves, their supervisor, and their client. Items regarding trainee background included: theoretical orientation, gender, age, ethnicity, and nature of graduate program. Trainees also indicated their level of training in several ways: by indicating their year in graduate school, extent of practicum experience, the number of supervisors they have had during graduate school, number of supervisors prior to graduate school, and the extent of related work experience prior to graduate school.

Items regarding trainees' supervisors included: trainees' perception of their supervisor's theoretical orientation, as well as their supervisor's gender, and number of months they have been supervised by this supervisor. They also reported the number of hours per week that they are supervised with the participating supervisor. This last variable may be important since there is some data that suggests that degree of weekly contact with the supervisor may be related to trainees' assessment of the quality of supervision (Allen et al. 1986). Finally, trainees completed one Likert-type item assessing satisfaction with supervision. The item was "How satisfied do you feel with this supervision?" Trainees were asked to rate their degree of satisfaction (1=not at all satisfied, to 7= entirely satisfied).

Items pertaining to trainees' clients included: number of sessions trainees have seen the client they are rating, and diagnostic category of client. Trainees

were also asked how s/he thinks the client would rate him/her as a therapist (from 1=ineffective to 7=highly effective).

Procedure

The author contacted the Directors of Clinical Training at midwestern graduate programs in clinical and counseling psychology to explain the study and request permission to distribute questionnaires to students. Copies of questionnaires were sent to directors who requested them, and in one instance, it was necessary to obtain IRB approval from that institution. If directors were willing to participate, they were asked whether this investigator may enlist participation in person at the school, or whether s/he preferred that questionnaires be distributed in students' mailboxes. Five out of the nine participating training directors preferred that this investigator leave questionnaires in trainees' mailboxes. When this was the case, training directors were asked for lists of students who might currently be doing a psychotherapy practicum or internship. While some directors offered lists of students who they knew met this criterium, others offered lists of students who would be *likely* to meet this criterium (e.g., all students except for first year students). Once a list of names was obtained, packets were placed in those students' campus mailboxes. Packets included a Barrett-Lennard Inventory for Supervisory Relationships, a Counseling Self-Estimate Inventory, two subscales of the Psychotherapy Process Inventory, and a demographic information sheet. Trainees were also given self-addressed, stamped envelopes to mail the forms back to this investigator. Introducing the questionnaires was a cover letter explaining the procedures, and enlisting trainees' participation in a study aimed at better understanding the supervisory and therapy relationships. The cover letter also outlined what would be asked of them (in terms of time and effort) and indicated that their involvement would be

strictly voluntary. It was also made clear that responses to all questionnaires would be confidential (names were not requested), and that their supervisors would not have access to their responses. They were also told that their supervisors would not be judged in any way based on the trainees' responses; in other words, no one in the agency would have access to individual responses. Trainees were told that their supervision and supervisor would in no way be affected if they chose not to participate in the study.

Trainees were asked to rate their current primary supervisor on the Barrett-Lennard Inventory for Supervisory Relationships. If trainees had more than one primary supervisor, trainees were asked to choose the supervisor that they deem as most central to their training. Trainees were asked to choose a current patient to rate on the patient involvement scale (PPI) who was an adult being seen in outpatient psychotherapy once a week. The therapy with the chosen client should be supervised by the primary supervisor whom the trainee was rating on the Relationship Inventory. The chosen client should also have been seen for as close to three sessions as possible (since the research suggests a relationship between measures taken at the third session and ultimate outcome (Orlinsky & Howard, 1994)). Exclusion criteria were: 1) evidence of psychotic symptoms, 2) active suicidal ideation/behavior or other cause for needing a more structured, crisis-oriented therapy, and 3) mental retardation.

Within one week following initial distribution of packets, pink reminder slips were placed in students' mailboxes. Since students on internship usually do not visit their campus mailboxes regularly and often are out of state, packets were mailed directly to their home addresses, as were reminder post cards. At some schools, training directors were willing to give interns' addresses to this investigator for that purpose; at other schools, directors preferred (for reasons of

confidentiality) that this investigator leave packets with him/her to be mailed. The return rate using this method (distributing packets to students with no personal contact) was much lower (approximately 15%) than when this author was able to visit the schools in person (resulting in approximately a 59% return rate).

When training directors allowed visitation by the author, one of two procedures was followed, depending on the training director's preference: at one university, the author personally visited each psychotherapy practicum class, briefly explained the study and solicited student participation. At three large professional schools, the author set up a table in the student lounge over a period of three days, and offered to compensate students with snacks if they were willing to complete the packet of questionnaires. This method proved to be the most successful, and may account for the higher proportion of Psy.D. students in the sample. The return rate was also higher using this method because only those students who qualified for the study could be targeted (i.e., this investigator could make sure before giving the student the packet that s/he met criteria for inclusion in the study). In addition to being able to mail the packet back to this investigator, trainees at the professional schools also had the option of dropping the completed packet off to this investigator in the student lounge.

CHAPTER III

RESULTS

Characteristics of Supervisors and Patients

Since the focus of this study was to explore the relationship among facilitative conditions in the supervisory relationship (hereafter referred to as the supervisory relationship), trainee self efficacy, and patient involvement in the therapy relationship, trainees were asked to rate both a supervisory and a therapy relationship, as well as to provide some basic information about their primary supervisor and about the patient that they selected for the study.

Trainees' supervisors. According to trainees, approximately half of the supervisors rated were male ($\underline{n}$=60), and half were female ($\underline{n}$=62). Trainees described their supervisors' orientations as varying, including Psychodynamic (52%), Cognitive-Behavioral (21%), Humanistic/Existential (10%), Eclectic (7%), Family Systems (5%), Cognitive (2%), and Other (2%). Most trainees (89%) reported meeting with their supervisors one to two hours a week, with a range of .50 to 8.5 hours/week. At the time of questionnaire completion, most trainees (77%) had been supervised by the supervisor they were rating for two to four months ($\underline{M}$=3.7 months, $\underline{SD}$=2.5 months).

Trainees' patients. According to trainees, patients they rated fell into a variety of diagnostic categories, including mood disorder (43%), adjustment disorder (19%), personality disorder (16%), anxiety disorder (12%), substance abuse (3%), or Other (7%). At the time of questionnaire completion, while trainees' reports of how many times they had met with their clients ranged from 1

65

to 95 times, most trainees (86%) had seen their clients between 2 and 10 times ($\underline{M}$=7.6; $\underline{SD}$=11.2)

Hypothesis 1: Supervisory Relationship, Trainee Self Efficacy, and Patient
       Involvement

      The primary focus of this study was to test the hypothesis that the trainee's experience of an empathic, accepting supervisory relationship (i.e., a relationship high in facilitative conditions) will lead to greater patient involvement in the therapy relationship (which has been shown to be related to positive therapy outcome), via the mediating mechanism of increased trainee self efficacy (See Figure 1).

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trainee self efficacy

a   b

c

supervisory relationship   patient involvement
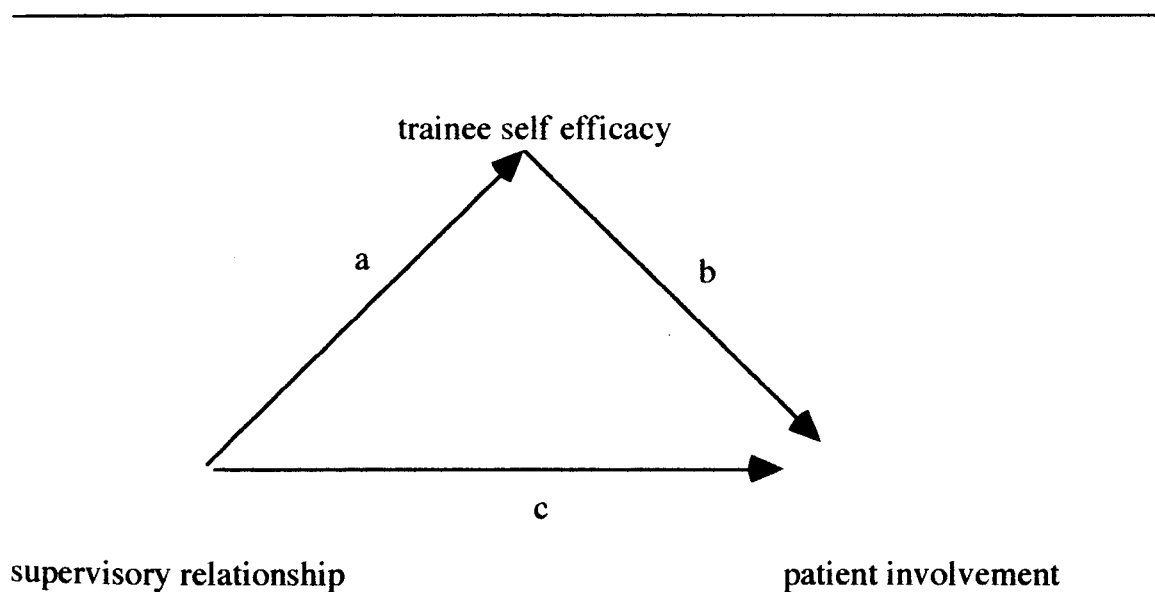
Figure 1. Hypothesized relationships among the supervisory relationship, trainee self efficacy, and patient involvement in the therapy relationship.

In order to explore these relationships, sums were computed on the Relationship Inventory, on the COSE, and on the Patient Participation and Resistance subscales of the PPI. A Patient Involvement score was computed by subtracting the resistance subscale score from the participation subscale score (as per Gomes-Schwarz, 1978). As noted previously, Patient Involvement was viewed as the most comprehensive index of outcome since it incorporated both the constructs of participation and resistance. Thus, the mediational model was tested first using Involvement as the outcome variable. However, because Patient Participation has also been related to outcome, a second set of analyses was conducted to examine the mediational model using Participation as the outcome variable. Table 2 presents means, standard deviations, and reliabilities (Cronbach's alpha) for each of the key variables.

Table 2

Descriptive Statistics and Reliabilities of Predictor and Criterion Variables.

	Supervisory Relationship	Trainee Self Efficacy	Patient Participation	Patient Involvement
M	189.55	160.21	47.24	26.52
SD	22.70	19.92	8.74	11.98
α	.94	.91	.89	.88

Baron and Kenny (1986) explain that three steps are required to test a mediational model such as the one proposed in the present study. In order to conclude that there is support for the entire mediational model, a particular outcome must be found at each of the three steps. Specifically, the following three steps must be examined. First, the independent variable (supervisory relationship) must significantly affect the hypothesized mediator (trainee self efficacy) ("a" in Figure 1). Second, the independent variable (supervisory relationship) must significantly affect the dependent variable (patient involvement or patient participation in the therapy relationship) ("c" in Figure 1). And finally, the hypothesized mediator (trainee self efficacy) must affect the dependent variable (patient participation/involvement). This last step is supported if the IV-DV relationship ("c") is weaker when the mediator is added into the regression. These three steps were examined with regard to the current data ($\underline{N}$=122) as described below, first using patient involvement as the DV, and next using patient participation as the DV.

First, in order to see whether the supervisory relationship affected trainee self efficacy, the supervisory relationship was entered as the predictor in a regression in which trainee self efficacy was used as the criterion. The resulting Beta of .267 was statistically significant ($\underline{p}$=.003; $\underline{R}^2$=.071). Thus a significant relationship between the degree of facilitative conditions within the supervisory relationship and trainee self efficacy (relationship "a" in Figure 1) as measured by these instruments was found (see Table 3).

Second, when the supervisory relationship was entered into a regression with patient involvement as the criterion, the resulting Beta of .216 was also statistically significant ($\underline{p}$=.017; $\underline{R}^2$=.047). That is, a significant relationship was found between the trainee's experience of the supervisory relationship and patient

involvement in the therapy relationship. Thus the second step of Baron and Kenny's (1986) model was supported.

Finally, Baron and Kenny's (1986) model states that the hypothesized mediator (trainee self efficacy) must be predictive of the dependent variable (patient involvement). In addition, the relationship between the supervisory relationship and patient involvement ("c" in Figure 1) must weaken when trainee self efficacy is added into the equation. Although the relationship of supervision and patient involvement weakened once self efficacy was added into the regression (the Beta of the supervisory relationship-patient involvement relationship decreased from .216 to .186, and the significance level dropped from .017 to .046), trainee self efficacy was not predictive of patient involvement (Beta=.111; p=.23). Thus this last step that tests to see whether trainee self efficacy functions as a mediator received mixed support. While self efficacy was not predictive of patient involvement, its addition to the equation did weaken the relationship between supervision and patient involvement.

Baron and Kenny (1986) state that the sign of perfect mediation is that the formerly statistically significant relationship between the IV and DV becomes no longer significant once the mediator is added into the regression. The authors note, however, that perfect cases of mediation are rare, since there are usually many variables impacting relationships in the social sciences.

In order to investigate whether the *decrease* in the supervisory relationship-patient involvement relationship once self efficacy was introduced into the regression was statistically significant, the simple zero-order Pearson correlation coefficient of the supervisory relationship with patient involvement (r=.216) was compared to the partial correlation coefficient of that relationship while controlling for trainee self efficacy (pr=.182) as suggested by Meng, Rosenthal, and Rubin

(1992). If the model is supported, the partial correlation should be significantly smaller than the simple zero-order correlation. In other words, the strength of the IV-DV relationship weakens once the mediator is taken into account. A z-value was calculated, as was the one-tailed probability that represented the likelihood that the two coefficients were equivalent. The partial correlation coefficient (i.e., the correlation of the supervisory relationship with patient involvement when self efficacy was controlled) was significantly smaller than the correlation coefficient of the IV-DV relationship when self efficacy was ignored ($\underline{p}$=.011).

Since patient participation was the scale originally used in research, and since it too has been found to be related to therapy outcome, Baron and Kenny's (1986) three steps were also examined using patient participation as the DV as an additional test of the model Similar results were found, except that each step of the process was supported (including finding a significant relationship of trainee self efficacy to patient participation). In other words, the supervisory relationship was predictive of trainee self efficacy ($\underline{\text{Beta}}$=.267, $\underline{p}$=.003; $\underline{R}^2$=.071), and the supervisory relationship was predictive of patient participation ($\underline{\text{Beta}}$=.241, $\underline{p}$=.007; $\underline{R}^2$=.058). In addition, results indicate that trainee self efficacy was predictive of patient participation ($\underline{\text{Beta}}$=.24; $\underline{p}$=.008), and that the relationship of supervision and patient participation weakened once self efficacy was added into the regression ($\underline{\text{Beta}}$=.177 compared to $\underline{\text{Beta}}$=.241 without self efficacy; $\underline{p}$=.051, compared to $\underline{p}$=.007 without self efficacy in the equation). This change in the strength of relationship "c" (Figure 1) was statistically significant ($\underline{p}$=.010), as indicated by comparing the simple zero-order Pearson correlation coefficient of the supervisory relationship with patient participation ($\underline{r}$=.241) to the partial correlation coefficient ($\underline{pr}$=.178) while controlling for self efficacy (as previously

Table 3

Summary of Three Step Regression Process to test Mediational Model Using
Patient Involvement as the Dependent Variable

Step One: Regression of Trainee Self Efficacy onto the Supervisory Relationship
         ($\underline{N}$=122)

Variable	R^2	B	SE B	Beta	t	p
Supervisory Relationship	.071	.234	.077	.267	3.03	.003**

Step Two: Regression of Patient Involvement onto the Supervisory Relationship
         ($\underline{N}$=122)

Variable	R^2	B	SE B	Beta	t	p
Supervisory Relationship	.047	.114	.047	.216	2.42	.017*

Step Three: Summary of Multiple Regression Analysis of Variables Predicting
          Patient Involvement ($\underline{N}$=122)

Variable	B	SE B	Beta	t	p
Trainee Self Efficacy	.067	.055	.111	1.21	.229
Supervisory Relationship	.098	.049	.186	2.02	.046*

Note. *=$p<.05$; **=$p,.01$. R^2 for step three= .058; signif. F = 028*.

Table 4

Summary of Three Step Regression Process to test Mediational Model Using Patient Participation as the Dependent Variable

Step One: Regression of Trainee Self Efficacy onto the Supervisory Relationship (N=122)

Variable	R^2	B	SE B	Beta	t	p
Supervisory Relationship	.071	.234	.077	.267	3.03	.003**

Step Two: Regression of Patient Participation onto the Supervisory Relationship (N=122)

Variable	R^2	B	SE B	Beta	t	p
Supervisory Relationship	.058	.093	.034	.241	2.72	.007**

Step Three: Summary of Multiple Regression Analysis of Variables Predicting Patient Participation (N=122)

Variable	B	SE B	Beta	t	p
Trainee Self Efficacy	.106	.039	.242	2.70	.008**
Supervisory Relationship	.068	.034	.177	1.97	.051

Note. *=p<.05; **=p,.01; R^2 of step three=.113; p=.001**.

described). Thus this third and final step of the mediational model was supported using patient participation (See Table 4).

In sum, the hypothesized relationships were fully supported when patient participation was examined as the dependent variable, and were primarily supported when patient involvement was used as the dependent variable. Specifically, the supervisory relationship was significantly related to patient participation and patient involvement in the therapy relationship. The supervisory relationship was also significantly related to trainee self efficacy. Although self efficacy significantly predicted patient participation, and appeared to mediate the relationship between the supervisory relationship and patient participation in the therapy relationship, the support for self efficacy playing a mediating role was not as clear when patient involvement was examined. Although the relationship between supervision and patient involvement significantly weakened once efficacy was included in the regression, efficacy did not significantly predict patient involvement.

Hypothesis Two: The Supervisory Relationship and Trainee Satisfaction

It was hypothesized that trainees would be more satisfied with a supervisor who provided a high degree of facilitative conditions. Trainee satisfaction with his/her supervisor as measured on a seven-point Likert type scale was significantly correlated to the degree of facilitative conditions provided by the supervisor (as rated by the trainee on the Barrett-Lennard Relationship Inventory) ($\underline{r}=.485$; $\underline{p}=.000$). Thus facilitative conditions of the supervisory relationship accounted for 24% of the variance in trainee satisfaction ($\underline{p}=.000$). Thus, the hypothesis was supported that trainees who experienced their supervisors as providing higher degrees of facilitative conditions reported being more satisfied with supervision.

Hypothesis Three: Trainee Experience and Self Efficacy

Although the primary purpose of this study was to examine the relationship between the supervisory relationship and self efficacy, it was hypothesized that experience in the field would also relate to trainee self efficacy. Level of trainee experience was therefore examined to see how it might affect trainee self efficacy. Six different pieces of information regarding trainee experience were collected from each subject: number of practica completed to date, number of hours of practicum experience, number of years in graduate school, number of supervisors worked with during graduate school, number of years of psychology-related work experience prior to graduate school, and number of supervisors worked with prior to graduate school. In order to decide how to best utilize the six different variables, a principal components analysis with varimax rotation was executed. This analysis extracted two factors from the six original measures of trainee experience (see Table 5).

Factor one may be thought of as experience during graduate school, and consists of the first four variables. This factor accounted for 49% of the total variance, and its reliability (Cronbach's alpha) was .87. Factor two may be thought of as psychology-related work experience prior to graduate school, and consists of the last two variables. This factor accounted for 27% of the total variance, and its reliability was .69. For each factor, the scores on each measure of experience were converted to z-scores, and then those z-scores were added, and then divided by four (for Factor one) or by two (for Factor two) to calculate a factor score for each of the two factors. Thus one score was computed for experience during graduate school, and one score was computed for work experience prior to graduate school. A Pearson correlation coefficient of the two factor scores was computed, which suggested that the factors were independent from each other (r=.065; p=.497).

Table 5

Principal Components Analysis of Trainee Experience Variables

Initial Statistics:

Variable	Communality	Factor	Eigenvalue	Pct of Var	Cum Pct
Placement	1.000	* 1	2.946	49.1	49.1
Year School	1.000	* 2	1.597	26.6	75.7
#Supervisors	1.000	* 3	.707	11.8	87.3
Hours Exp.	1.000	* 4	.326	5.4	92.9
Work Exp.	1.000	* 5	.260	4.3	97.3
#Suprvsrs at work	1.000	* 6	.163	2.7	100.0

Factor Matrix:

	Factor 1	Factor 2
Placement	.867	-.236
Year School	.842	-.170
#Supervisors	.777	.235
Hours Exp.	.911	-.025
Work Exp.	-.013	.827
#Supervisors before grad school	.226	.879

Rotated Factor Matrix (Varimax rotation):

	Factor 1	Factor 2
Placement	.887	-.144
Year School	.855	-.082
#Supervisors	.748	.316
Hours Exp.	.909	.070
Work Exp.	-.099	.821
#Supervisors before grad school	.134	.898

In order to examine the relative contributions of level of trainee experience and the supervisory relationship to trainee self efficacy, all of these variables were entered into a stepwise multiple regression. Graduate school experience as measured by Factor one was entered first, and accounted for 14% of the variance. The supervisory relationship as measured by the Barrett-Lennard Relationship Inventory was entered second, and these two variables accounted for 22% of the

Table 6

Stepwise Multiple Regression Analysis of Factors Predicting Trainee Self Efficacy (N=122)

Variable	B	SE B	Beta	t	p
Grad Exp (Factor 1)	8.52	1.87	.38	4.57	.000
Supervisory Relationship	.22	.07	.26	3.24	.002
Work Exp (Factor 2)	5.85	1.83	.26	3.20	.002

Note. Grad Exp represents the factor score for the four variables measuring trainee experience during graduate school. Work Exp represents the factor score for the two variables measuring psychology-related work experience prior to graduate school. R^2=.29; p=.000.

variance. Experience prior to graduate school as measured by Factor two was entered third, and all three variables together accounted for 29% of the variance in trainee self efficacy ($\underline{F}$=14.86, $\underline{p}$=.000). Experience during graduate school, the supervisory relationship, and work experience prior to graduate school were all predictive of trainee self efficacy ($\underline{p}$=.000, $\underline{p}$=.002, and $\underline{p}$=.002 respectively), and each added unique information to the equation over and above the preceding variables (see Table 6). Thus, the hypothesis was supported that level of trainee experience would also have an impact on trainee self efficacy, yet experience alone did not account for all of the variance in self efficacy. Most importantly, even when experience level was included in the regressions, the separate impact of the supervisory relationship on self efficacy remained significant.

Thus as measured by the instruments used in this study, each variable added important information to predicting self efficacy. Caution should be exercised in interpreting the relative predictive power of the three variables *in general*, however, since the reliability coefficients of each measure were different (α=.87 for graduate school experience, α=.69 for work experience, and α=.92 for the Barrett-Lennard Relationship Inventory). Thus, for example, it is unclear whether work experience prior to graduate school is less predictive of trainee self efficacy than is graduate school experience because the relationship is indeed less strong, or whether it merely appears this way because the reliability of the work experience factor is lower, thus making it more difficult to detect significant relationships.

Exploratory Analyses

As previously described, the primary purpose of this investigation was to examine the relationships among the supervisory relationship, trainee self efficacy, and patient involvement in the therapy relationship. The results supported the hypothesis that facilitative conditions in the supervisory relationship are predictive both of increased patient involvement in the therapy relationship and of increased trainee self efficacy. Regardless of these significant findings, it is clear that not all of the variables impacting these relationships have been isolated, as can be easily demonstrated by the fact that not 100% of the variance has been accounted for. There are certainly other variables that impact the relationships studied here. For example, a relationship was noted between trainee experience and trainee self efficacy. Thus facilitative conditions within the supervisory relationship is not the only variable affecting trainee self efficacy, but extent of related experience also plays a role. Since it has been acknowledged that other variables may potentially affect these relationships, four other variables were examined in a preliminary way, in order to take steps toward beginning to isolate or rule out other variables that may impact the supervisory relationship, trainee self efficacy, or patient involvement. These four variables were: duration of the therapy relationship, duration of the supervisory relationship, trainee experience level, and patient diagnosis.

Duration of therapy and supervisory relationships. Since it was thought that the degree of time spent in a relationship may affect one's ratings of that relationship, these variables were investigated to see if and how they related to the three primary variables: supervisory relationship, trainee self efficacy, and patient involvement.

Pearson correlation coefficients were computed as preliminary investigations into whether further analyses should be conducted to understand potential effects of time in the relationship (see Table 7). The correlation coefficient between the number of times the trainee has seen the patient and patient involvement in the therapy relationship was not significant (r=.051; p=.577). Thus length of time in therapy did not seem to significantly influence patient involvement in the therapy relationship in this sample. This is consistent with the literature that suggests that patients form their attachments to the therapist fairly early on in therapy, so that ratings of patient involvement taken at the third session are predictive of therapy outcome down the line. Since this initial correlation was not significant, further analyses were not conducted.

The Pearson correlation coefficients between amount of time spent in supervision and the primary variables of interest also were not significant (see Table 7). Specifically, relationships were examined between number of hours spent in supervision each week and ratings of the supervisory relationship (r=.051; p=.578), trainee self efficacy (r=.000; p=.997), and patient involvement (r=.003; p= .976). Pearson correlation coefficients were also computed using number of months supervised by this supervisor instead of number of hours per week, and the following are the correlation coefficients of months of supervision with the primary variables of interest: supervisory relationship (r=-.160; p=.083), trainee self efficacy (r=.158; p=.086), and patient involvement (r= .003; p=.973). Thus it is evident that none of these relationships were statistically significant, suggesting that the number of months that the trainee has been working with the supervisor did not significantly predict ratings on the Barrett-Lennard Relationship Inventory, nor did it predict trainee self efficacy as measured by the COSE or patient

involvement as measured by the PPI. Since none of these relationships were statistically significant, no follow-up analyses were conducted.

Table 7

Correlation Coefficients of Duration of Supervisory and Therapy Relationships with Predictor and Criterion Variables

	Sup.Relationship	Self Efficacy	Patient Involvement
Times w/ Ct	-.15	.14	.05
Mo. Sup	-.16	.16	.00
Hrs/Wk Sup	.05	.00	.00

Note. None of these correlation coefficients were statistically significant. Times w/Ct represents the number of times the trainee has met with the client; Mo. Sup represents number of months trainee has been working with this supervisor; Hrs/Wk Sup represents number of hours per week the trainee meets with his/her supervisor; Sup Relationship represents facilitative conditions of the supervisory relationship as measured by the Barrett-Lennard Relationship Inventory; Self Efficacy represents trainee self efficacy as measured by the COSE; Patient Involvement represents patient involvement in the therapy relationship as measured by the PPI.

<u>Trainee experience.</u> Since some of the previous research has noted a relationship between trainee experience and preferences with regard to supervision (Heppner & Roehlke, 1984; Rabinowitz et al. 1986), and since level of trainee experience was found to be predictive of trainee self efficacy, experience was examined to see whether it may also impact patient involvement in the therapy relationship. A significant relationship was not found. That is, level of trainee experience (either prior to graduate school or during graduate school) was not predictive of patient involvement in the therapy relationship (<u>Beta</u>=.05, <u>p</u>=.56 for graduate school experience; <u>Beta</u>=-.15, <u>p</u>=.12 for work experience). In addition, even when trainee experience was entered first into the multiple regression, the ability to predict patient involvement from the supervisory relationship remained statistically significant (<u>Beta</u>=.21, <u>p</u>=.03).

Although trainee experience did not seem to have a direct effect on patient involvement, experience was also examined to see if it might moderate the two relationships explored: the supervisory relationship predicting trainee self efficacy, and the supervisory relationship predicting patient involvement in the therapy relationship. In other words, these relationships were explored to see if their strength altered as a function of trainee experience. Although it is difficult to determine this based on the current study, preliminary results suggest that this may be the case.

Trainee experience was divided into three groups based on participants' scores on factor one, the factor representing the four variables of experience gained while in graduate school. Participants were categorized as either novice therapists (scoring in the bottom third on the graduate school experience factor), intermediate therapists (scoring in the middle of the range), or advanced (scoring in the top third of the graduate school experience factor).

Individual regressions were conducted for each level of experience. At each level of experience, it was assessed how well the supervisory relationship could predict trainee self efficacy, and how well the supervisory relationship could predict patient involvement in the therapy relationship. Although it is difficult to draw definitive conclusions based on the current study (since this was not the focus, and therefore arrangements were not made, for example, to have adequate numbers of participants at each level of experience), it appears that the supervisory relationship may be even more important for beginning trainees than for intermediate and advanced trainees, both in terms of trainee self efficacy and in terms of patient involvement in the therapy relationship (See Table 8).

Since the sample size was reduced to one third of its original size in order to divide up the participants by level of experience, power was dramatically reduced, as was the ability to detect significant relationships. Even with this reduced sample size, however, the effect of the supervisory relationship on trainee self efficacy was so strong for beginning trainees that it remained statistically significant even with only 39 participants. The strength of this relationship was not strong enough to be statistically significant with the reduced number of participants at the intermediate and advanced levels of training.

Patient diagnosis. In order to assess whether patient diagnosis was related to patient involvement in the therapy relationship, a One-Way Analysis of Variance was conducted to test the null hypothesis that mean scores on the involvement variable were equivalent between groups of patients with varying diagnoses. The diagnoses of personality disorders and substance abuse were combined into one group in an attempt to equalize cell sizes (there were only four patients with a primary diagnosis of substance abuse) and because those two diagnoses were considered to be more severe than the others. Results of this

procedure indicated no significant differences in involvement scores between groups of diagnoses, $\underline{F}$ (4, 117)=1.49, $\underline{p}$=.21.

Although there was no evidence that patient diagnosis had a direct effect on patient involvement, the possibility that diagnosis may exert a moderating effect on the self efficacy-patient involvement relationship was explored. This was conducted in an exploratory way in an attempt to shed light on inconsistent results regarding patient involvement and patient participation. It will be recalled that self efficacy significantly predicted patient participation but not patient involvement. These two outcome variables were identical except that involvement takes into account the additional factor of resistance, a factor that may be highly dependent on patient variables and may at least in part be reflected in diagnosis. Indeed, preliminary analysis indicated that diagnostic groups differed in their level of resistance to therapy. Specifically, a one-way ANOVA revealed that mean trainee ratings of patient resistance significantly varied as a function of patient diagnosis, $\underline{F}$ (4, 117)=2.92, $\underline{p}$=.024. A Bonferroni post-hoc multiple comparison test was employed to adjust the level of significance for the number of comparisons made. This test indicated a significantly higher mean resistance score for patients diagnosed with personality disorders/substance abuse ($\underline{M}$ resistance score=23.79) than for patients diagnosed with adjustment disorders ($\underline{M}$ resistance score= 18.22; $\underline{p}$<.05).

To test for the possibility that diagnostic category may function as a moderator in the relationship between trainee self efficacy and patient involvement, regressions were run for each separate diagnostic category (mood disorders, anxiety disorders, adjustment disorders, personality disorders and substance abuse, and other), and the results were compared. Results supported the notion that the trainee self efficacy - patient involvement relationship was

Table 8

The Varying Effect of the Supervisory Relationship as a Function of Trainee Experience

Regression of Trainee Self Efficacy onto the Supervisory Relationship

Variable	R^2	B	SE B	Beta	t	p
Supervisory Relationship						
Beginners (n=39)	.23	.466	.138	.484	3.36	.002**
Intermediate (n=38)	.07	.227	.136	.269	1.68	.102
Advanced (n=39)	.08	.212	.117	.285	1.81	.078

Regression of Patient Involvement onto the Supervisory Relationship

Variable	R^2	B	SE B	Beta	t	p
Supervisory Relationship						
Beginners (n=39)	.09	.170	.088	.302	1.93	.062
Intermediate (n=38)	.01	.043	.089	.079	.48	.635
Advanced (n=39)	.01	.066	.087	.124	.76	.450

significant for some diagnostic groups (Adjustment disorders, p=04; Anxiety disorders, p=.03; Other, p=.04), yet was not significant for others (Personality disorders/Substance Abuse, p=.73; Mood disorders, p=.15). Thus it appears that diagnostic category may have played a moderating role in the relationship of trainee self efficacy to patient involvement, in that self efficacy is predictive of patient involvement for particular diagnostic groups but not others.

CHAPTER IV

DISCUSSION

Heppner and Roehlke (1984) remind us that "...the effectiveness of supervision should ultimately be evaluated in terms of client outcome" (p. 89). Although that statement was made in 1984, researchers still have not pursued that avenue of exploration. As Holloway & Carroll (1996) note, the effect of supervision on therapy continues to be primarily unknown. They suggest that future research focus on this question, since "Losing that perspective [effect on client] is a bit like viewing parenthood solely for the enrichment of parents" (p.54). The effect of the trainee's experience of supervision in affecting patient outcome has remained unknown.

The present study represents an initial attempt to explore this missing element of the supervision literature. Specifically, several hypotheses were tested regarding the supervisory relationship, trainee self efficacy, and patient involvement in the therapy relationship. The primary focus of this investigation was to explore the hypothesis that facilitative conditions offered by the supervisor would predict increased patient involvement in the therapy relationship via the mediating mechanism of increased trainee self efficacy. Secondary foci of this investigation included: exploring the relationship between facilitative conditions in supervision and trainee satisfaction, and understanding how experience level affects trainee self efficacy. Finally, exploratory analyses were conducted to begin to investigate in a preliminary way, whether other variables may affect the

relationships under study. The variables explored were patient diagnosis, trainee experience, duration of the therapy relationship, and duration of the supervisory relationship. The results of each of these investigations will be discussed in this chapter.

The Supervisory Relationship and Trainee Satisfaction

Theoreticians from a variety of backgrounds have noted the importance to trainee development, learning, and effectiveness as a clinician of a supportive, empathic supervisor (Brightman, 1984; Cohen, 1980; Duci, 1992; Fox, 1989; Friedman & Kaslow, 1986; Goin & Kline, 1974; Haesler, 1993; Heppner & Roehlke, 1984; Jarmon, 1990; Muslin & Val, 1989; Nelson, 1978; Sloane, 1986; Worthington, 1984). The previous research conducted on trainee preferences has consistently found that trainees do indeed prefer a supervisor who is supportive and empathic (Allen et al. 1986; Brightman, 1984; Cross & Brown, 1983; Friedlander & Ward, 1984; Gandolfo & Brown, 1987; Kennard et al. 1987; Ladany, 1993; Rabinowitz et al. 1986; Worthen & McNeil, 1996; Worthington, 1984; Worthington & Roehlke, 1979; Worthington & Stern, 1985). The results from this study corroborate those findings. Specifically, trainees who rated their supervisors as offering higher levels of facilitative conditions in supervision also reported being more satisfied with supervision. Although this finding may be somewhat intuitive (e.g., one might expect that trainees would enjoy working with someone who is empathic and accepting), it also highlights the importance of these qualities to the supervisory process. That is, regardless of potential variability on any number of other variables pertaining to supervision, the relationship of facilitative conditions to trainee satisfaction remained significant.

The Supervisory Relationship, Trainee Self Efficacy, and Patient Involvement

The theory of supervision tested in this study has been put forth by several different authors representing a variety of theoretical orientations. Authors writing from a more self psychological perspective have hypothesized that the most effective supervision is one in which teaching is done within the context of a supervisory relationship in which the supervisor is empathically attuned to the needs of the trainee (Sloane, 1986), is able to accept those needs (Cohler, 1989), and is able to create a safe climate in which the trainee feels able to disclose his/her perceived inadequacies (Muslin & Val, 1989). This empathic attunement and acceptance of the trainee is thought to result in increased self esteem (Brightman, 1984; Muslin & Val, 1989; Sloane, 1986), decreased anxiety (Elson, 1989; Jarmon, 1990), increased ability to empathize with clients (Muslin & Val, 1989; Sloane, 1986) and an increased ability to learn (Bernstein, 1989; Cohler, 1989). The trainee is then thought to be better equipped to return to his/her client, and is considered to be more able to offer the kinds of conditions to his/her client that his/her supervisor provided to him/her (Doehrman, 1976; Fox, 1989; Gardner, 1995). The ability of the trainee to work more effectively with his/her client is thought to ultimately lead to better therapy outcomes.

Authors from theoretical backgrounds other than self psychology have also written about optimal learning conditions that are relevant to the supervisory relationship. For example, authors from a client-centered background have noted the importance to learning of facilitative conditions within the teaching relationship (Rogers, 1957). Social learning theorists have similarly discussed the importance of a nurturant relationship in increasing the likelihood of attending behavior (Dowling & Frantz, 1975). Although the theoretical literature with

regard to optimal supervision has been plentiful, the empirical studies testing these theories have emerged only recently.

Since the bulk of the research to date has been focused on trainee preferences, there has been little investigation into whether the trainee's experience of an empathic, accepting supervisor also relates to the trainee's increased effectiveness as a clinician. Previous studies have found preliminary support, usually indirectly, for various pieces of the theory that a supportive supervisory relationship is instrumental in the trainee's professional development, both in allowing him/her to feel more confident as a therapist (Efstation, Patton, & Kardash, 1990; Hutt Scott, & King, 1983; Worthen & McNeil, 1996), and in helping the trainee to feel less anxious and more available for learning (Cresci, 1995). Only one study has investigated whether supervision affects trainees' ability to conduct effective therapy (Pierce & Schauble, 1970). These investigators concluded from their research that trainees' ability to offer facilitative conditions to their patients was dependent on their supervisors' ability to offer the same to them.

The specific hypothesis tested in the present study was that facilitative conditions offered in the supervisory relationship would predict increased patient involvement in the therapy relationship via the mediating mechanism of increased trainee self efficacy. Since both patient involvement and patient participation in the therapy relationship have been related to positive therapy outcome (Baer et al., 1980; Gomes-Schwartz, 1978; Gorin, 1993; Kolb et al. 1985), both variables were included in the focus of this investigation.

In testing this model, several noteworthy findings emerged. First, the supervisory relationship was found to be predictive of trainee self efficacy. Second, the supervisory relationship was also found to be predictive of patient

participation and patient involvement in the therapy relationship. This finding represents the first demonstration that the supervisory relationship is related to a therapy outcome variable. Finally, there was some support for the notion that self efficacy plays a mediating role in the supervisory relationship-patient participation/involvement relationship. Caution should be exercised in interpreting the findings, however, due to the nature of the outcome measure, as will be discussed. The following section discusses each of these findings in greater depth.

Supervisory relationship and trainee self efficacy. Facilitative conditions in the supervisory relationship as measured by trainees' ratings on the Barrett-Lennard Relationship Inventory were predictive of trainee self efficacy as measured by trainees' ratings on the Counseling Self Estimate Inventory. This is consistent with both the theories outlined in chapter one (e.g., Brightman, 1984; Muslin & Val, 1989; Sloane, 1986), and most of the research to date on similar topics (Efstation, Patton, & Kardash, 1990; Hutt Scott, & King, 1983; Worthen & McNeil, 1996). Thus trainees who experience their supervisor as being empathically attuned to them, as understanding and accepting them, and as genuinely and consistently offering a sense of positive regard for them tend to report feeling more confident in their abilities as a therapist.

The ability of the supervisory relationship to predict trainee self efficacy was the strongest for beginning trainees. This finding is consistent with the theoretical literature which suggests that the supervisory relationship is particularly important for the novice trainee who finds him/herself in a new learning situation, and whose self esteem with regard to the new task is not yet mature but is dependent on external sources to maintain it (Brightman, 1984). Theoretically, as trainees mature, they internalize mechanisms by which to maintain their self esteem from within, instead of relying solely on external feedback (Brightman,

1984). It is also consistent with the limited research to date that suggests that although support was important to trainees at all levels of training, it was especially important to novice therapists (Heppner & Roehlke, 1984; Rabinowitz et al., 1986).

Supervisory relationship and patient involvement/ participation in therapy. Trainees' ratings of facilitative conditions within the supervisory relationship were also predictive of trainees' ratings of patients' degree of involvement in the therapy relationship. Thus trainees who reported having a supervisor who was empathically attuned, accepting of the trainee, and communicated a consistent level of regard toward him/her, also reported having a client who was more involved in the therapy relationship. In other words, trainees who were able to be more involved in the supervisory relationship reported having clients who were more involved in the therapy relationship. The same relationship was found when patient participation was used as the criterion variable. As far as this author is aware, no other study has investigated this link between the supervisory relationship and patient participation/involvement in therapy. The only study that has examined a related topic of the supervisor's impact on the trainee's therapy was one in which supervisory facilitative conditions were predictive of facilitative conditions later offered by the trainee in his/her therapy relationship (Pierce & Schauble, 1970). It also supports the preliminary parallel process studies, which found similar experiences and communicative patterns in both the supervisory and therapy relationships (Doehrman, 1976; Friedlander, Siegel, & Brenock, 1989). It may be that experiencing facilitative conditions in supervision allowed trainees to offer the same to their patients, thus allowing patients to become more involved in therapy. In fact, previous research has shown that patients' level of involvement in

therapy was associated with patients' perceptions of their therapists' facilitative skills (Kolb et al. 1985).

The mediating mechanism of trainee self efficacy. The theoretical literature suggests that the supervisor must attend to the trainee's self esteem if s/he is to increase the trainee's effectiveness as a clinician. Thus the trainee's self efficacy as a therapist was hypothesized to be the mediating mechanism via which the supervisory relationship was thought to affect patient involvement. This study produced mixed results with regard to that hypothesis. While there was support for the notion that the supervisory relationship affected patient participation via the mediating mechanism of trainee self efficacy, this result was not as clear when patient involvement was utilized as the outcome variable. When patient involvement was examined, although the relationship between the supervisory relationship and patient involvement weakened significantly once trainee self efficacy was added into the regression, trainee self efficacy did not predict patient involvement. In other words, partial support was found for the hypothesis that a facilitative supervisory relationship increased patients' engagement in therapy via a mediating mechanism of increased trainee self efficacy. Since, however, this hypothesis was not fully supported when patient involvement was examined, caution must be exercised in interpreting the findings. Although it is unclear given the present data why the relationships differed depending on whether participation or involvement was examined, several hypotheses may be entertained, and perhaps tested in future research. First, it seems that although patient participation and patient involvement are both related to therapy outcome, they are not interchangeable variables. That is, the main difference between the two scores is that involvement takes into account ratings of patient resistance, as well. It seems that participation and involvement may be qualitatively different with respect to

how they are related to trainee self efficacy. Self efficacy may be more effective in facilitating positive engagement in the therapeutic process (and thus is related to participation), but it may be less effective in easing patient resistance (and consequently is not consistently related to involvement, which incorporates patient resistance).

This possibility would not be surprising given the theoretical literature, which suggests that increased self efficacy is one of many developments that occurs as a result of optimal supervision. The self psychological theories suggest that other developments that mediate the trainee's effectiveness as a clinician as a result of optimal supervision include decreased anxiety (Elson, 1989; Jarmon, 1990), increased ability to empathize with clients (Muslin & Val, 1989; Sloane, 1986) and an increased ability to learn (Bernstein, 1989; Cohler, 1989). Thus it is likely that several variables exist that mediate the relationship between supervision and patient involvement. Perhaps trainee self efficacy is sufficiently powerful to elicit positive engagement in therapy, yet other factors are necessary (in addition to self efficacy) in order to ease resistance. Future studies might try to isolate the additional factors that may aid a trainee not only to facilitate positive engagement in therapy, but also to respond effectively to hostile or "resistant" patients. Indeed, the efficacy-involvement link was the weakest with the personality disorders/substance abuse patients, who were rated by trainees as the most resistant. Thus a link between diagnosis and resistance is suggested. Although trainee self efficacy appears to be critical, it may not be sufficient to neutralize the resistance of some patients. This is not surprising, since patients diagnosed with personality disorders have had a lifetime of relating to others in their characteristic styles, and engaging in a therapy relationship with a confident therapist will not

suffice to counter their ingrained styles of relating (especially after a brief number of sessions).

Caution must be exercised in interpreting these results due to the limitations of this study. Conclusions might be drawn with more certainty if future research used additional outcome measures (other than just patient involvement/participation), that were completed from various perspectives other than just that of the therapist. Although the validity of therapist ratings has been established (Gurman, 1977), it would be interesting to look also at the patient's perspective of the therapy process and outcome as well. This would help to counter the potential problem of response bias that may have affected the results of the present study, given that all measures were completed by the trainee.

Trainee Experience

The supervisory relationship was found to be an important predictor of both trainee self efficacy and patient participation/involvement in therapy. Obviously, factors other than the supervisory relationship may influence both trainee self efficacy and effectiveness as a therapist. It was hypothesized that in addition to supervision, extent of experience in the field would also affect trainee self efficacy. Level of trainee experience was explored to see how it related to trainee self efficacy. While previous studies found support for the importance of the supervisory relationship to trainee self efficacy, as well as for a relationship between trainee experience and self efficacy (Larson et al. 1992), this investigation attempted to look at the both of these issues together. Several things were found from this investigation. First, the supervisory relationship, work-related experience prior to graduate school, and practicum experience during graduate school, were each found to be predictive of trainee self efficacy. In addition, each

variable added unique information to the equation over and above the preceding variables. Thus it may be that each experience adds a unique piece to a trainee's sense of self efficacy as a therapist. This finding suggests that it may be important in future research to consider both experience prior to graduate school and experience during graduate school when examining these kinds of issues.

Level of trainee experience was also examined to see whether it may impact other variables, such as the supervisory relationship and patient involvement in the therapy relationship. No significant relationships were found. That is, level of trainee experience (either prior to graduate school or during graduate school) was not predictive of ratings of the supervisory relationship, nor was it predictive of patient involvement in the therapy relationship.

The finding that trainee experience was not predictive of patient involvement in the therapy relationship is somewhat surprising. One might think given the theoretical literature that more advanced trainees would have a higher level of self efficacy, and therefore would be able to create a therapy environment more conducive to patient involvement. One explanation may be that as trainees gain more experience, they may be assigned more challenging cases. In other words, although trainees may have an increased ability to provide a good working environment, they may also be met with clients who are less willing to involve themselves in therapy. Trainees' increased ability coupled with more difficult clients may result in these two factors "canceling each other out," resulting in a lack of significant difference in patient involvement between trainees with different levels of experience. Future research might attempt to assess patients across trainee experience levels to explore whether this may be true (that more advanced trainees work with more challenging clients).

Other Factors

In addition to studying the primary hypotheses put forth in this investigation, three other variables were explored in a preliminary way to better understand what other factors may or may not be influencing the relationships under study. These variables were: patient diagnosis, duration of the therapy relationship, and duration of the supervisory relationship.

Patient diagnosis. Scores on patient involvement in the therapy relationship did not vary as a function of patients' diagnoses. This is consistent with the limited literature to date that involvement scores were not found to be related to pre-existing patient variables such as pre-therapy scores on the SCL-90R, locus of control as assessed by the Internal-External Locus of Control Scale, and extroversion-introversion and neuroticism/anxiety scores from the Eysenck Personality Inventory (Kolb et al. 1985). Even researchers using alternate measures of patient engagement in therapy found no relationship between the therapeutic alliance and patient diagnosis (Sexton, Hembre, & Kvarne, 1996). In some ways, if this finding is replicated in future research, this may be an encouraging result. Instead of seeing patients' ability to become involved in therapy as being solely dependent on their diagnosis, level of pathology, or symptom pattern, this finding highlights the critical roles of the trainee and supervisor in creating an optimal therapy climate. That is, although patients may vary with regard to what they bring to therapy, this result offers hope that the trainee, with the help of an optimal supervisory relationship, may be able to offer a therapy environment in which the patient might be more willing to engage in the relationship.

It may be, however, that diagnosis may not be the ideal descriptor of patient characteristics for this type of study. In other words, individuals within the same

diagnostic category may vary dramatically in their ability to be involved in a relationship. A striking example of this is the diagnostic category "personality disorders." Within this same category, there may be an individual diagnosed with avoidant personality disorder, as well as an individual diagnosed with dependent personality disorder. The individual with avoidant personality disorder might typically remain distant, if at all involved in the relationship, whereas the individual with dependent personality disorder might become very involved. Even if the specific diagnoses were separated, however, there may still be significant variations in ability to engage in a relationship within the same diagnosis. For example, Horner & Diamond (1996) found a difference in Rorschach responses between patients diagnosed with Borderline Personality Disorder who dropped out of therapy, and patients with the same diagnosis who did not drop out. The authors suggested that the differences in the Rorschach responses represented different levels of object relations development. For this reason, in future research, it would be important to examine other patient characteristics that might be more relevant to the question under study, such as level of relatedness.

As previously mentioned, although there was no support for diagnosis exerting a direct effect on patient involvement, it did appear that diagnosis may have moderated the relationship between trainee self efficacy and patient involvement, such that the efficacy-involvement link was significant for some diagnoses but not others.

Duration of the therapy relationship. Since clinicians might argue that patients who have been in therapy longer may be more involved in the relationship, the relationship of patient involvement to duration of therapy relationship was explored in this study. The results corroborated previous findings that patient involvement did not vary as a function of the duration of the therapy

relationship (Baer et al. 1980). While this finding may suggest that patient involvement is something that is decided and formed early on in treatment (as suggested by previous research, such as Sexton et al. 1996), the finding may also be an artifact of a sample lacking adequate variability in terms of length of the therapy relationship. This was largely due to the directions that asked trainees to rate a client whom they had seen for as close to three sessions as possible (since the research has found a consistent relationship between involvement at session three and outcome). Thus although there was a range in terms of number of times clients had been seen (1-95 times), most trainees (86%) chose a client whom they had seen for ten or fewer sessions. Thus in order to clarify the role of duration of therapy in terms of involvement, longitudinal research should be conducted to explore how patient involvement may change over the course of therapy.

Duration of the supervisory relationship. There was also some concern that since ratings of the supervisory relationship were being taken at various points during the semester, the amount of time the trainee had worked with the supervisor prior to questionnaire completion might affect the ratings. For this reason, amount of time spent in this supervisory relationship was investigated in terms of its impact on the primary variables of interest. Length of time spent in the relationship was assessed both by number of months the pair had worked together, and by number of hours per week that they typically met for supervision. This last variable was included because Allen et al. (1986) reported finding a relationship between supervisors described positively and amount of weekly contact. Contrary to Allen et al.'s findings, however, no relationships were found between duration or amount of contact with supervisor and any of the primary variables (facilitative conditions in supervision, trainee self efficacy, or patient involvement). It may be, that as might be the case with the therapy relationship, the engagement occurs

early on in the relationship, and thus facilitative conditions may not significantly change as a function of time in the relationship. The lack of significant relationship, however, might also have to do with the lack of variability in the sample. Although there was a range in terms of how long trainees had been supervised (1-15 months) and amount of weekly contact (0.5-8.5 hours), most trainees (77%) had been supervised for two to four months, and most (89%) met with their supervisors one to two hours a week. Again, longitudinal data would be helpful in answering this question more precisely.

<u>Summary</u>

The results of this study highlight the importance of the supervisory relationship both to trainee development and to the trainee's effectiveness as a clinician. The trainee's experience of the supervisory relationship was found to be predictive of the trainee sense of self efficacy. In addition, the quality of the supervisory relationship was predictive of patient engagement in the therapy relationship. Mixed support was found for the hypothesis that trainee self efficacy plays a mediating role between supervision and patient involvement. Although this hypothesis was fully supported when patient participation was examined, support was not clear when patient involvement was used in the model. It may be that trainee self efficacy functions as a mediator to increase positive patient engagement in therapy, yet it does not play a sufficiently large mediating role to neutralize resistance. Trainees who rated their supervisory relationship as consisting of a greater degree of facilitative conditions also reported being more satisfied with supervision. Although facilitative conditions within the supervisory relationship were predictive of trainee self efficacy, level of psychology-related experience, both prior to and during graduate school, was also predictive of trainee self efficacy, and is thought to contribute a unique dimension to this construct.

There were no significant differences in patient involvement as a function of patient diagnosis, and ratings of the supervisory and therapy relationship did not vary as a function of time spent in those relationships. Finally, level of trainee experience was not predictive of trainee ratings of either the supervisory or the therapy relationship.

Limitations of this Study and Directions for Future Research

Although this study provides preliminary support for the notion that facilitative conditions offered within the supervisory relationship are related both to trainee self efficacy and to patient involvement in the therapy relationship, longitudinal data would be necessary in order to state more conclusively that the supervisory relationship played a causative role in increasing trainee self efficacy and patient involvement in the therapy relationship. Given the nature of the present cross-sectional data, it is possible to present an argument that perhaps the relationship may have a different directionality than what has been proposed in this study. For example, one might argue that perhaps patient involvement in the therapy relationship affects trainee self efficacy, which then affects the supervisory relationship. One analysis that does not support that argument, however, was that the partial correlation coefficient of the supervisory relationship and trainee self efficacy was still significant even when patient involvement was controlled ($pr=.248$; $p=.008$). In other words, regardless of the level of patient involvement in the therapy relationship, a supervisory relationship high in facilitative conditions is related to a high level of trainee self efficacy with regard to performing therapist behaviors. This is not to say, however, that patient involvement might not also affect trainee self efficacy. Although the potential effect is not so great so as to eliminate the relationship observed between supervision and trainee self efficacy,

it could nonetheless be present. If so, however, it seems that its effect may not be very large, since the simple zero-order correlation coefficient of the supervisory relationship and trainee self efficacy when patient involvement is ignored is not that different from when it is controlled ($\underline{r}$=.267; $\underline{p}$=.003).

Other limitations resulting from the correlational nature of this study also have to do with the inability to know conclusively the directionality of these relationships given the present data. For example, one might argue that trainees who have a higher sense of self efficacy to begin with either 1) rate their relationships more positively, or 2) actually create relationships that are more involved. Thus instead of seeing the model as beginning with supervision, one might argue that it may begin with the trainee and his/her level of confidence. Although it is not possible given the present design to rule out these possibilities conclusively, several issues point to a lack of support for these arguments. With regard to the first possibility, the idea that trainees would rate their relationships based solely on their own sense of efficacy and without regard to the actual quality of the relationship would imply that the measures of the supervisory and therapy relationships lack validity, and are simply measures of trainee self efficacy. Studies done on each measure, however, provide support for their validity (Baer et al. 1980; Barrett-Lennard, 1962; Gomes-Schwartz, 1978; Kolb et al. 1985; Schacht et al. 1988).

With regard to the second alternative explanation (that trainees with higher self efficacy to begin with create better relationships), this may be so, and in fact, is part of the theory of supervision (that trainees with a higher self efficacy are more able to create effective therapy relationships). The question then becomes one of the "chicken and the egg;" that is, did supervision affect trainee self efficacy or did trainee self efficacy affect supervision? Again, longitudinal data would be

necessary to answer this question conclusively, but preliminary data suggests that training at least affects self efficacy. For example, trainees' scores on the Counseling Self Estimate Inventory increased significantly following a semester of supervised training (Larson et al. 1992). It is possible, however, that the relationships described in this paper may not be unidirectional. For the purposes of this study, however, in order to better understand optimal training conditions, the focus was on the supervisor's role in effecting positive supervisory and therapy outcomes. This focus was limited in scope to the effect of the supervisory relationship; this study does not address in a comprehensive fashion other factors that may result in effective supervision.

As mentioned, the current study focused primarily on the supervisory relationship, and did not attempt to systematically examine other variables, such as other aspects of supervision, of the trainee, or of the patient. Another area of future research might be to identify further patient characteristics that might be more predictive of patient involvement in the therapy relationship than was diagnostic category. As was previously mentioned, the clinician will recognize that different patients falling into the same diagnostic category might have very different degrees of relatedness. Thus although patient diagnosis was a helpful preliminary step to investigate how patient characteristics might affect these relationships, it remains somewhat crude in its ability to differentiate patients on the most important variable: their ability and willingness to involve themselves in a relationship with another person. Although the focus of this study was different (in that it was searching to understand how supervision may be related to trainee development and the therapy relationship across individual differences in pathology), future research might endeavor to clarify this variable further in an attempt to elucidate the various pieces of this model.

Another potential limitation of the study involves the representativeness of the sample. Since the participants were those students willing to volunteer their time to complete the packets, it is unclear given the available data whether this self selection may have resulted in participants with particular characteristics which may not represent the entire graduate student population. For example, it is possible that those students who agreed to participate in the study may have more interest or investment in the supervisory process than students who declined to participate. If this were the case, it is unclear whether or how this may affect the results. For this reason, it would be important to replicate this study in order to gain a clearer understanding of the representativeness of the current sample.

Finally, as previously mentioned, future research might employ additional measures of therapy outcome, rated by both the therapist and the patient. In addition, replication of these results would add strength to the finding of significant relationships, since due to the number of analyses conducted, and the consequent potential for accruing alpha errors, the possibility of Type I error cannot be ruled out.

Implications of this Study

The results of this study provide important and encouraging information with regard to effective training of psychotherapists and optimal conditions for the trainee's therapy relationship. While debate continues with regard to what is considered to be the most effective theoretical orientation, there appear to be "common factors" of supervision that cut across theoretical orientations and create an optimal learning environment. Just as the common factors discovered with regard to psychotherapy are relationship-oriented, so may they be in supervision as well. Although this study provides only preliminary support for the theory of supervision outlined, and further research must be conducted to confirm these

findings, supervisors, trainees, and clients alike may benefit from increased attention placed on the supervisory relationship. If the primary goals of supervision are: 1) to help the trainee conduct optimally effective therapy with his/her client, and 2) to help the trainee develop professionally, including gaining an appropriate level of confidence in his/her abilities as a therapist, then this study may provide important clues as to how to achieve that outcome. We may take what we have learned as clinicians in terms of creating a safe, accepting environment in therapy, and apply that to the supervisory relationship, for it appears that how we behave in supervision may have a significant impact, not only on the trainee's level of satisfaction, but also in his/her confidence as a therapist, and in his/her patients' degree of involvement in the therapy relationship. This is not to say, of course, that supervisors should abandon teaching, refrain from constructive criticism, and become therapists for their trainees. It merely suggests that teaching may be optimally effective when done within a generally accepting relationship. This relationship is thought to bolster trainee's self esteem, which may in turn allow the trainee to integrate feedback in a more useful way, rather than needing to reject it due to the fragility of the self esteem.

APPENDIX A

COVER LETTER TO STUDENTS

Dear Fellow Graduate Student:

I am a graduate student in Clinical Psychology doing my dissertation on supervisory and therapy relationships. Since the subjects of my study are graduate students in Clinical and Counseling Psychology, I am writing to ask if you would be willing to fill out the enclosed packet of questionnaires. As a graduate student myself, I realize how busy you must be, and I would greatly appreciate your willingness to donate about 20 minutes to my dissertation research.

I am seeking participants who are currently seeing an adult client (18 or older) in weekly psychotherapy at their practicum, externship or internship. The client should meet the following criteria: 1) shows no evidence of psychotic symptoms, 2) is not suicidal or for another reason in need of a more structured, crisis-oriented therapy, and 3) is not mentally retarded. This client should be supervised by your primary supervisor.

Enclosed you will find several questionnaires tapping into your perceptions of your supervision, your view of yourself as a therapist, and your perspective on one of your therapy relationships. Clients and supervisors do not participate directly in this study; you are merely asked to rate both relationships on the forms provided.

In order to assure confidentiality of your responses, please do not put your name on your packet. Results will be gathered from many subjects and training sites, and will be reported as a group. In other words, no results specific to your site will be reported, and no feedback will be offered to anyone at your training site regarding ratings of particular supervisors.

Your participation is strictly voluntary, and your training will in no way be affected should you choose not to participate. If you do not qualify to participate in the study (e.g., if you are not doing a therapy practicum or internship, or if your clients do not meet criteria for inclusion), or if you choose not to participate, please drop the unmarked packet in the mail to me at this time. If you are willing to participate in the study, please complete the forms at your convenience and mail them back to me in the enclosed envelope. If at all possible, please complete the packet today while you are still thinking of it. If you are too busy to fill it out today, **please fill it out and return it some time in the next week.**

Thank you very much for your participation, and please feel free to call me at home should you have any questions, or if you would like a summary of the results of my study: (847) 866-7210. Results of this investigation should help us better understand the ingredients of effective supervision and therapy.

Sincerely,

Jessica Golub, M.A.

P.S.- If for some reason you are unable to complete the packet in the next week, but are willing to participate, please complete it as soon as you are able. Your input will still be valuable. Thanks.

APPENDIX B

DIRECTIONS TO STUDENTS

DIRECTIONS:

The enclosed questionnaires will ask you to rate your primary supervisor and one client on various dimensions.

In choosing a **supervisor** to rate, please rate your *current primary supervisor* of therapy cases. If you have more than one primary supervisor, please choose the supervisor you deem as most central to your training.

In choosing a **client** to rate, please rate an adult (18 and over) who:

- you currently see in weekly individual psychotherapy
- **is supervised by the supervisor you chose to rate**
- you have seen as close to <u>three</u> sessions as possible
- is not suicidal or for another reason in need of more structured, crisis-oriented therapy
- does not show evidence of psychotic symptoms
- is not mentally retarded

If you have more than one client who meets all of these criteria, please choose one randomly (e.g., flip a coin or put their names in a hat and draw one). Please <u>answer each question,</u> and be sure to complete the forms on your own, without consulting with others. Thank you again, and good luck in the rest of your training.

APPENDIX C

DEMOGRAPHIC INFORMATION SHEET

Please complete the following background information.

About Yourself:

Age: _____   Gender: M _____ F_____
Ethnicity: African-American___   Latino/Latina___
               Asian-American___   Native American___
               Caucasian___   Other (specify) _____

What is the nature of your program : Terminal M.A. or M.S.___   Ph.D.___   Psy.D.___
In which psychology department are you enrolled?   Clinical ___   Counseling ___

Your theoretical orientation most closely resembles (please only check *one*):
     Behavioral____   Family Systems____
     Cognitive____   Humanistic/Existential____
     Cognitive-Behavioral____   Psychodynamic____
     Eclectic____   Other(specify)_____

Which of the following describes your current placement (please check only *one*):
     First practicum___   Second practicum___   Third, Fourth, or Fifth practicum___
     Internship___
How many years have you been in graduate school (including this one)? _____
Approximately how many supervisors have you had during your entire graduate training? _____
Approximately how many hours of practicum experience have you completed (see key below)_____
          Key: One year of half time practicum (i.e., 20 hours/week)=1000 hrs
               One full time summer practicum= 500 hrs
How many years of psychology-related work experience have you had prior to graduate school?
_____
If you worked in the field prior to graduate school, *approximately* how many supervisors did you have during this time   (i.e., prior to graduate school)?_____

About Your Primary Supervisor at Your Current Practicum Site:

Please rate your primary supervisor of therapy cases or the supervisor most central to your training.

From what you know so far of your primary supervisor's theoretical orientation, it seems to most closely resemble (please only check *one*):

Behavioral____	Family Systems____
Cognitive____	Humanistic/Existential____
Cognitive-Behavioral____	Psychodynamic____
Eclectic____	Other(specify)_____

Your primary supervisor's gender: M ____ F____
How many months have you been supervised by the supervisor you are rating? _____
How many hours a week do you generally meet with this supervisor? _____
How *satisfied* do you feel with this supervision (please circle one number below):

not at all   **completely**
1   2   3   4   5   6   7

About Your Client:

Please make sure the client you choose to rate fits the criteria listed in the directions (second page of packet).

How many times have you seen the client you are rating? _____
How do you think this *client* would rate *you* as a therapist (please circle one number):

Ineffective   **Highly effective**
1   2   3   4   5   6   7

How would you describe your client's primary diagnostic category (please only check *one*):

Mood disorder____	Personality disorder____	Adjustment disorder____
Anxiety disorder____	Substance Abuse____	Other (specify)_____

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