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The Relationship Between the Supervisory Alliance and Novice Supervisees' Risk-Taking Behavior

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The Relationship Between The Supervisory Alliance And Novice Supervisees' Risk-Taking Behavior

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A Dissertation

Presented to

the Faculty of the Morgridge College of Education

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

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by

Aleis Pugia, M.Ed., MA

August 2021

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ABSTRACT

Supervisee risk-taking is the process by which supervisees take the new skills and interventions they learn in supervision and implement them in therapy with clients. Risk-taking overlaps with many of the skills supervision is intended to develop: clinical decision-making, supervisee self-efficacy, supervisee skill development, and clinical reflection (Bambling & King, 2014; Ellis et al., 2014; Rousmaniere et al., 2016; Wilson et al., 2016). Risk-taking has not been examined before the in the supervision literature, however, it is an important process to understand as it represents a process bridging supervision and clinical practice. The current study was an exploratory study intended to examine whether the strength of the supervisory relationship facilitates novice supervisee risk-taking in therapy. Results of the study did not find a significant relationship between the supervisory alliance and supervisee risk-taking. However, survey responses and interviews with participants illuminated the types of behaviors novice supervisees consider risky and how they make decisions around taking risks with clients. Their responses suggest that novice supervisees take risks with their clients as they try to meet their clients' needs in the moment. Analysis found that 77.8% (n=7) of supervisees interviewed decided to take a risk to benefit either the client, therapeutic relationship, or treatment goals. Furthermore, results from the interviews revealed that for 88.9% (n=8) of supervisees, the risk was worth taking and increased their desire to take more risks in

the future. Future research is recommended to understand how supervision can help supervisees make meaning of these risks.

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Chapter One: Introduction

The American Psychological Association (APA) and the Association of State and Provincial Psychology Boards (ASPPB) value supervision as an integral part of the education and training of both students and professionals in the psychological field. Given that supervision is the primary means through which psychologists' clinical judgment is developed, the ASPPB and APA have denoted supervision as a distinct part of the professional practice that requires its own guidelines and training. Utilized with fidelity, supervision serves as a training tool, helps develop psychologists' professional identities, and serves as a gatekeeper to the profession (Falender & Shafranske, 2014). While supervision has been defined as a training tool necessary to build trainees' competencies in clinical practice, little research exists on the most effective means of delivering supervision and developing skills with supervisees. The most recent edition of the APA Ethical Principles and Code of Conduct (American Psychological Association, 2010) addresses supervision only indirectly referring to supervision as a means to ensuring competency as a licensed psychologist (Codes 2.01, 2.05, 9.07) and as a solution for psychologists to engage in when they are faced with a situation outside their bounds of competency (American Psychological Association, 2010). While these codes implicitly place emphasis on the importance of supervision in training, they do not provide explicit guidelines around what is considered competent supervision and how that supervision is delivered. In response, in 2015 the APA published *Guidelines for*

Clinical Supervision in Health Service Psychology outlining guidelines for clinical supervision of trainees (American Psychological Association, 2015) and denoting research on the effectiveness and outcomes of supervision as a priority for the field.

Most research on supervision has focused on the supervisory relationship and supervisee development (Watkins, 2017b). Tsong and Goodyear (2014) outlined three ways in which supervision research has focused on measuring the impact of supervision: "1) Supervisee development: affective/personal, conceptualization, and skills/interventions, 2) Supervisee/client relationship and interactions, and 3) Treatment outcomes [for clients]" (p. 190). Most studies on supervision outcomes have focused on the first two outcomes as separate processes, but few studies have examined the link between them (Watkins, 2017b). As such, it is difficult to determine how and if what supervisees are learning in supervision translates to their behaviors, decisions, interventions, and rapport with clients in therapy. This link and the process through which it occurs are essential to examine because while the purpose of supervision is to support supervisee development, the broader purpose of training and supervision in general is to improve clinical practice that leads to greater client outcomes. Watkins (2011a) stated:

> If we cannot show that supervision affects patient outcomes, then how can we continue to justify supervision? The benefits of supervision on supervisees alone are not necessarily sufficient; while valuable, they at best only provide us with an indirect link to patient outcome (p. 238).

Thus, to contribute to the field of psychotherapy research, future research on supervision needs to more directly investigate the applied effect of translating supervisee development to the therapy room.

Purpose and Justification for the Current Study

This study's primary focus is on risk-taking, specifically, the process by which novice supervisees take the new skills and interventions they learn in supervision and implement them in therapy with clients. This is an important process to understand because if supervisees do not apply what they are learning in supervision to therapy with clients, then it is unclear whether supervision is actually having a positive effect on supervisee development. Supervisee risk-taking was identified as a variable of interest in this study as it represents a process bridging supervision and clinical practice. Furthermore, it overlaps with many of the skills supervision is intended to develop: clinical decision-making, supervisee self-efficacy, supervisee skill development, and clinical reflection (Bambling & King, 2014; Ellis et al., 2014; Rousmaniere et al., 2016; Wilson et al., 2016). As defined in the current study, taking a risk in therapy involves making an informed hypothesis about what is happening in therapy, formulating an intervention that would test out this hypothesis (e.g., asking a question to explore the area more, trying out a novel intervention or skill), and doing this all while not being 100% confident that the hypothesis or intervention is correct and still trying it anyway. This builds on Stone and Mason's (1995) definition of risk, where they describe risk as reflective of one's uncertainty about the consequences of an action weighted by the importance of the actions. Furthermore, risk-taking requires that supervisees demonstrate openness, self-reflection, humility, and trust in one's clinical judgment (Smith, 2011). Long-term, this has implications for supervisees as they transition from the training role to licensed professionals. If a supervisee develops the habit of trying out hypotheses and

making informed risks in therapy when they are in training, then it is likely that they will continue this skill as a professional, thereby continuing a trajectory of continued development (Mason, 2005; Rabinor & Stiver, 2000). Therefore, the factors in supervision that facilitate supervisee risk-taking in therapy with clients are of special interest in this study.

Research on the conditions that facilitate supervisee development have focused on a variety of factors (e.g., supervisory alliance, supervisee competence, supervisee identity development, supervisee demoralization; Watkins & Scaturo, 2013). However, the supervisory alliance is one of the most widely researched variables of interest with regard to supervisee development and outcomes. “Research across the last two decades increasingly regards the supervisory alliance as a highly robust (if not the most robust) empirical variable of substantial import within supervision scholarship” (Watkins, 2014, p. 43). The supervisory alliance captures both the real relationship between the supervisor and supervisee, as well as the tasks and goals of supervision, and is the relational vehicle through which supervision is delivered (Wampold & Imel, 2015; Watkins et al., 2015). As such, it is intimately intertwined with the process and content of supervision itself. The supervisory alliance has been linked to a variety of factors in supervision, including supervisee self-efficacy, supervisee anxiety, supervisee satisfaction with supervision, supervisee stress and coping skills, supervisee work satisfaction, supervisee burnout, supervisee outcomes, therapeutic alliance, and client outcomes (Moldovan & David, 2013; Rieck et al., 2015; Watkins, 2014). Mutchler and Anderson (2010) found that supervisee reports of the supervisory alliance accounted for 20% of the variance in

supervisee performance with clients. A strong supervisory alliance is associated with positive outcomes for supervisees. However, a negative supervisory alliance (e.g., confrontational criticism, the direct attribution of blame, unclear agendas, and instructive, rather than interactive learning processes) is associated with increased supervisee anxiety, self-doubt, and decreased self-efficacy (Schofield & Grant, 2013). As over 50% of supervisees have reported a negative supervisory experience in their training (Ellis et al., 2014), it is essential to understand more about the link between the supervisory alliance and how that connects to supervisees translating the skills they learn in supervision to their work with clients.

The supervision literature has looked at several different elements of the supervisory process related to both the supervisory alliance and risk-taking. Supervisee competence, therapist self-efficacy, supervisee learning/relearning, and supervisee anxiety have been studied in association with the supervision process (Angus & Kagan, 2007; Inman et al., 2014; Marmarosh et al., 2013; Rousmaniere et al., 2016; Wrape et al., 2015). Therapist [supervisee] self-efficacy refers to a supervisee's belief about their ability to perform a task as a therapist (e.g., build rapport, use an intervention, navigate a rupture; Lent et al., 2009). In the supervision literature, therapist self-efficacy has been studied as an important element in supervisees developing their identity as a therapist (Briggs & Miller, 2005; Lent et al., 2009; Wagner & Hill, 2015). Similarly, supervisee anxiety is conceptualized as a component influencing both therapist self-efficacy and the supervisee's ability to engage with the supervisory and therapeutic processes (Mehr et al., 2015). However, none of these studies have made an explicit link between risk-taking

and their variables of interest. Furthermore, in the psychotherapy literature, therapist risk-taking has been proposed as a concept/framework in some qualitative studies but no empirical studies exist that measure the presence nor impact of risk-taking in therapy sessions. Mason’s (1993) framework on relational risk-taking, authoritative doubt, and safe uncertainty is the most related framework when discussing risk-taking in relationships for both the clinical practice and supervision process, although this framework has not been empirically tested.

The primary purpose of the current study is to examine the link between the strength of the supervisory alliance and whether supervisees take a risk in their therapy session with clients. Since the implied purpose of supervision is to impact how supervisees approach their clinical interventions with clients, it is essential to examine the process and factors that facilitate the supervisee translating the skills they have learned in supervision to their therapy with clients. While a few studies have looked at the conditions necessary to take risks in relationships, no study thus far has examined the process through which a supervisee decides to act on these conditions and take a risk by trying out new skills. The implication for not taking risks in therapy and not translating the knowledge learned in supervision to clinical practice may be poorer client outcomes, the supervisee’s reduced confidence and self-efficacy in their skills, and stagnant supervisee development.

Further, the current study aims to examine the moderators that may influence the supervisee’s ability to take a risk and apply the knowledge they learned in supervision to their therapeutic work with clients. Moderating variables are those that affect the

direction or strength of the relationship between a predictor variable and outcome variable (Baron & Kenny, 1986). In the current study, it was thought that moderating variables might effect the strength and direction of the supervision alliance on risk-taking. No literature examining the supervision process has considered contextual variables (i.e., supervisee's self-efficacy and level of anxiety) as an impact on the supervision alliance and supervisee risk-taking. Supervisors and supervisees would likely benefit from understanding the variables that influence whether the supervision process is translating into applied practice in therapy.

Overall, until this study, no empirical evidence has been conducted on whether the strength of the supervisory relationship facilitates novice supervisee risk-taking in therapy. This study was designed to address this gap in the literature.

Research Hypotheses

Table 1
Hypotheses, Variables, and Statistical Procedures

Hypothesis	Variables	Statistics
Hypothesis 1: There will be a positive correlation between the strength of the supervisory alliance and supervisees' willingness to take risks with clients.	Supervisory Working Alliance Inventory – Supervisee/Trainee Form (SWAI – T): completed by supervisees Risk-taking Experiences Questionnaire; completed by supervisees	Pearson's r correlation
Hypothesis 2: Supervisees' level of self-efficacy will be a moderator of the relationship between the strength of the supervisory alliance and supervisees' willingness to take risks with clients.	Supervisory Working Alliance Inventory – Supervisee/Trainee Form (SWAI – T): completed by supervisees Counselor Activity Self-Efficacy Scales (CASES); completed by supervisees	Simple Linear Regression, Interaction Term

It is expected that there will be a positive correlation between supervisees' self-efficacy and risk-taking.	Risk-taking Experiences Questionnaire; completed by supervisees	
Hypothesis 3: Supervisees' level of anxiety will be a moderator of the relationship between the strength of the supervisory alliance and supervisees' willingness to take risks with clients. It is expected that there will be a negative correlation between supervisees' anxiety and risk-taking.	Supervisory Working Alliance Inventory – Supervisee/Trainee Form (SWAI – T): completed by supervisees Anticipatory Supervisee Anxiety Scale (ASAS); completed by supervisees Risk-taking Experiences Questionnaire; completed by supervisees	Simple Linear Regression, Interaction Term

Methodology

The following is a brief overview of the methodology that was used to address the research hypotheses outlined above. See Chapter Three for a more thorough description. Participants in this study included novice supervisees who were in their first or second practicum experience. In order to assess the effect of the supervisory alliance on supervisee risk-taking, the study used convenience sampling by recruiting supervisees from various master's and doctoral level training programs throughout the United States. Supervisee anxiety and supervisee self-efficacy were examined as potential moderators of this relationship.

The study utilized a nonexperimental, associational research design and assessed participants only once. Study participation had two stages. First, supervisees completed an online survey that included a demographic questionnaire, a risk-taking questionnaire, validated supervision measures of the supervisory alliance, anxiety, and self-efficacy as a

novice supervisee. Second, after completing the online measures, nine supervisees participated in a follow-up interview with the principal investigator.

Three validated supervision measures were used to assess the strength of the supervisory alliance (Supervisory Working Alliance Inventory, SWAI-T; Efstation et al., 1990), supervisee anxiety (Anticipatory Supervisee Anxiety Scale, ASAS; Singh & Ellis, 2000; Tosado, 2004), and supervisee self-efficacy (Counselor Activity Self-Efficacy Scale, CASES; Lent et al., 2003). All three of these measures were included in the online survey.

The supervisee's willingness to take a risk primarily was measured by an online survey designed by the principal investigator and grounded in concepts from Mason's (1993) Relational Risk-Taking model. In the semi-structured interview with the principal investigator, the supervisee was asked to elaborate on a moment in which they took a risk with a client and what this experience was like for them. This information was used to understand in more depth what risk-taking looked like for novice supervisees and under what circumstances it occurs.

Definitions

Supervision. Supervision is the process through which a supervisor works with a therapist-in-training to build the therapist's competence, decision-making skills, and self-efficacy as a professional (Bernard & Goodyear, 2019).

Supervisor. The supervisor is the experienced therapist who is supervising and training the supervisee. They give feedback on the supervisee's skills and interactions with their clients, as well as help supervisees build their clinical judgment as a

professional. Their role is multifaceted; they are an educator, fellow professional, and evaluator (Bernard & Goodyear, 2019).

Supervisee. The supervisee is a therapist-in-training who is receiving supervision from a supervisor. The supervisee holds dual roles. In addition to learning from the supervisor in a learner capacity, they are also therapists working with their own clients. Therapists-in-training who are involved in supervision are commonly called supervisees or trainees in the literature. However, they also are called clinicians or therapists depending on whether the emphasis is on their work with clients or as a learner in the supervision process (Bernard & Goodyear, 2019). The current study will use the term supervisee.

Novice Supervisee. A novice supervisee is a supervisee who is completing their first or second practicum or clinical field experience, as a therapist. As they were expected to have no prior clinical training prior to these field experiences, most novice supervisees were at the master's level. However, some doctoral students who entered their program without a clinical master's in their field also were considered novice supervisees.

Supervisory Alliance. The supervisory alliance refers to the working relationship between the supervisor and supervisee. It encompasses the bond, goals, and tasks of supervision, as well as the real relationship between the supervisor and supervisee that exists outside of supervisory tasks (Wampold & Imel, 2015). The supervisory alliance is both supportive and educational, as well as hierarchical and evaluative in nature (Bernard & Goodyear, 2019)

(Supervisee) Risk-taking. The operational definition of supervisee risk-taking does not exist in the literature as a distinct concept. However, this study builds on and expands beyond Mason's (1993) Relational Risk-taking framework to operationalize supervisee risk-taking. Supervisee risk-taking refers to when a supervisee takes a risk by trying out a novel behavior (e.g., a new intervention or skill in session with a client, asking a question about the process of therapy or the supervisee's relationship with the other person). What distinguishes risk-taking from trying new behaviors in general is that risk-taking involves some level of anxiety on the supervisee's end about whether the risk will be successful and how the outcome will impact them. Supervisee risk-taking can take place in either therapy with a client or in supervision with a supervisor. However, this study will focus on the risks that supervisees take with clients and whether and how supervision facilitates that risk-taking.

Therapist Self-Efficacy. Therapist self-efficacy is referred to as clinical self-efficacy and counselor self-efficacy in the supervision literature. It refers to a therapist's belief and confidence in themselves to be therapeutically beneficial to their clients (Lent et al., 2009).

Supervisee Anxiety. Supervisee anxiety refers to the anxiety supervisees have when engaging in the supervision process (Mehr et al., 2015). This can be both in relation to supervisees' work with their clients as well as in relation to their experience in supervision.

Summary

This chapter provided an overview of the current study while highlighting the importance of the supervisory alliance for both supervisee and client outcomes. The strength of the supervisory alliance is one of the greatest predictors of supervisee development (Bernard & Goodyear, 2019; Ladany & Inman, 2012; O'Donovan et al., 2011; Watkins et al., 2015; Watkins & Scaturo, 2013). A strong supervisory alliance can create a secure base where supervisees can disclose their concerns, build their confidence as they try novel skills and interventions, and practice clinical decision making (Angus & Kagan, 2007; Guttman, 2020; Ladany et al., 2013; Rousmaniere & Ellis, 2013; Watkins & Scaturo, 2013). Conversely, a negative supervisory alliance is associated with supervisee demoralization, disempowerment, higher levels of supervisee anxiety, and lower levels of supervisee self-efficacy (Briggs & Miller, 2005; Wilson et al., 2016).

This chapter also highlighted the lack of research on supervisee risk-taking with clients and risk-taking in general. The current study examined whether the supervisory alliance is related to the supervisee's willingness to take a risk and what moderating variables, such as supervisee anxiety and supervisee self-efficacy, may influence this relationship. Single administration questionnaires were used to gather demographic information about supervisees and validated measures were given to assess the strength of the supervisory alliance, the supervisee's anxiety, and the supervisee's self-efficacy. Risk-taking was assessed by asking supervisees about their experience taking risks via a questionnaire and a follow-up interview. Based on a review of the literature of the supervisory alliance, it was hypothesized that there would be a positive relationship

between the strength of the supervisory alliance and the supervisee's willingness to take a risk. Further, it was hypothesized that the supervisee's level of anxiety and self-efficacy might moderate the relationship between the supervisory alliance and supervisee risk-taking.

The following chapter reviews the relevant literature related to the supervision process and risk-taking. An overview of the factors found to facilitate supervisee learning is reviewed, culminating in a review of the supervisory alliance. Elements of the supervisee's experience in supervision, such as supervisee anxiety and therapist self-efficacy, are discussed as moderating variables between the supervisory alliance and risk-taking. Finally, the lack of both conceptual and empirical research on supervisee risk-taking in supervision is considered.

Chapter Two: Literature Review

This chapter begins with a brief review of the processes and factors in supervision that promote supervisee learning and development. Next, this chapter reviews the supervisory alliance, one of the primary variables found to lead to supervisee development across all forms of supervision. With attention towards the supervisory alliance, the chapter will consider the internal elements of a supervisee's experience, including anxiety and self-efficacy that influence the supervisee's behavior in supervision and their work with clients. Finally, the chapter examines risk-taking, both in the context of the supervisory alliance and therapeutic alliance, and the overlap between the conditions necessary for supervisees to take risks.

Factors That Facilitate Learning in Supervision

To understand the rationale for studying the relationship between the supervisory alliance and risk-taking, it is important to describe how supervision facilitates supervisee development. Supervision is a multifaceted and integral part of the training of novice therapists. It is intended to be a secure base for supervisees to develop and form their identity as a therapist. Likewise it is an educational process, a place for learning and relearning to occur, the potential for a corrective affective experience, an opportunity for an evaluative process that serves as a gatekeeper for the profession, and ultimately a benefit to the clients with whom the supervisee is working (Bernard & Goodyear, 2019;

Watkins & Scaturo, 2013). The clinical skills, judgments, and beliefs that supervisees carry into the rest of their careers often are developed in supervision. As such, the legacy of a supervision experience has the ability to impact hundreds of clients over a therapist's career (Schofield & Grant, 2013). However, despite the potential for supervision to be beneficial, Falendar (2018) estimated that over half of supervisees have received inadequate or harmful supervision at some point in their development. This can have significant negative ramifications for supervisees' work with clients through their professional careers (Rousmaniere et al., 2016; Wilson et al., 2016; Wrape et al., 2015). Most importantly, ineffective supervision can influence supervisees' sense of safety with their supervisor.

Ellis et al. (2014) found that ineffective supervision can engender feelings of distress and self-doubt in supervisees. This finding is supported by Wilson et al.'s (2016) & Rousmaniere et al.'s (2016) meta-analyses of other literature on ineffective supervision. This is especially prevalent when the supervisory alliance is weak, creating an environment when supervisees do not feel like they can have open, honest discussions, be vulnerable about their areas of growth, and voice their doubts. Furthermore, Ellis et al. (2014) found that ineffective supervision can impede supervisee development and harmful supervision can lead to psychological distress in the supervisee. If supervisees do not believe supervision is a place for vulnerability about their areas of growth, this will increase their reluctance to take risks.

Research has also examined the elements of effective supervision, both process and content, that facilitate supervisee growth and trying out new skills with clients.

Consensus among studies suggests that an emphasis on three common factor domains is seen across supervision. They include “the supervisor’s (and supervisee’s) way of being, the supervisor–supervisee relationship, and supervision skills and techniques” (Watkins, 2017b, p. 142). These three domains converge to promote supervisee learning and relearning. These common factors align with a learning-based model of supervision proposed by Watkins and Scaturo (2013) in which supervision is viewed as an adult educational process. Fife et al. (2014) suggested that these common factors converge to form a Supervision Pyramid, which describes the conditions necessary for learning and relearning to occur. The Supervisor and Supervisee Way of Being are the foundation of supervision, followed by the Supervisory Relationship. Next, the success of Supervision Skills and Techniques build on the strength of the Supervisory Relationship. Finally, if all the conditions below are met, Learning and Relearning is able to occur in supervision. Other models of common factors in supervision are similar, with the supervisory alliance, emphasis on skills and techniques, and supervisee autonomy/identity development as essential criteria for learning to occur in a supervision environment (Bernard & Goodyear, 2019; Goodyear, 2014; Milne, 2009; Marks et al., 2010; Pearsall, 2011; Watkins & Scaturo, 2013). These theories suggest that supervision is most effective when viewed as a learning process in which supervisees are encouraged to try out new techniques and learn from the results.

A reflective learning cycle in supervision is created by a facilitative environment that encourages trying out novel behaviors and learning from them. Of all the common factors, the supervisory alliance is seen as one of the most crucial elements of strong

supervision to facilitate this learning (Watkins, 2017a). The supervisory alliance is viewed as a "powerful mediator that is entirely foundational in instigating supervisee change" (Watkins, 2017b, p. 203), with a strong supervisory alliance creating a secure base for supervisees to try out novel skills and techniques.

Supervisory Alliance

Research on common factors and effective supervision has consistently identified the supervisory alliance as one of the most integral predictors of supervision outcomes. The supervisory alliance between the supervisor and supervisee is one of the most widely studied elements of supervision in regard to supervisee development. Callahan, Love, and Watkins (2019) claim that it "appears to be supervision's most robust and empirically supported common factor" (p.154). The supervisory alliance has been studied in regard to processes and outcomes of supervision ranging from the formation of goals, supervisee satisfaction with supervision, supervisee therapeutic alliance with clients, client outcomes, and supervisee skill development (DePue et al., 2020; Inman & Ladany, 2008; Ladany & Inman, 2012; Rieck et al., 2015).

Supervisees have consistently cited the supervisory relationship as a critical event influencing their development. A study by Bell, Hagedorn, and Robinson (2016) found that foundational conditions such as trust, empathy, respect, and genuineness are necessary to build a strong supervisory alliance. Watkins and Scaturo (2013) suggested these conditions allow the supervisory alliance to facilitate empathy, genuineness, positive regard; aid alliance rupture/repair; facilitate remoralization in the supervisee; enable supervisee readiness/preparation; provide a secure base; and provide corrective

affective experiences for the supervisee. Several studies identify the supervisory qualities that predict stronger supervisory alliance and supervisee outcomes. Supervisory qualities such as engagement, warmth, support, concreteness, acceptance, positive regard, empathy, genuineness, and reflectivity have been found to be predictors of supervisee outcomes across supervision approaches (McCarthy et al.,1994; Watkins 2017a). Supervisory interpersonal skills (i.e., empathy, non-defensive, supportive, instructive, providing honest feedback, demonstrating caring, modeling and demonstrating a genuine interest in supervisee learning goals) were found to predict supervisee rated supervisory alliance and supervision outcomes (Bambling & King, 2014; Bell et al., 2016; Holloway, 1992; Kennard et al., 1987; Shanfield et al., 1992). Furthermore, in a study of 33 supervisees receiving CBT-based supervision, it was found that higher levels of experience, unconditional self-acceptance, and self-efficacy that the supervisor had were associated with better outcomes for supervisees (Moldovan & David, 2013). Supervisor qualities have a direct effect on supervisee's perception of their own competence, which impacts supervisee outcomes and willingness to try out new techniques.

In addition to supervisor qualities, there are several components of the supervision relationship itself that are related to the strength and quality of the supervisory alliance. First is the "real relationship", first coined by Frank (2005). The real relationship is described as the personal relationship that exists outside of supervisory tasks. This includes interactions such as greetings, friendly interest, self-expression, warmth, trust, liking, and expressing feelings about events affecting the supervisee (Wampold & Imel, 2015; Watkins, 2011, 2015ab, 2017ab). It exists from the first moment of contact to the

end of supervision. Despite operating silently, it is suggested that the real relationship perhaps contributes more to outcomes than the supervisory alliance as it encapsulates many of the facilitative supervisor qualities valued by supervisees (e.g., warmth, support, genuineness, acceptance, positive regard) (Gelso, 2011; Watkins, 2011; Watkins et al., 2015). The quality of the real relationship between supervisor and supervisee is a core element in whether supervisees feel supported in trying out novel skills with their clients.

A second essential component of the supervisory alliance is the hierarchical structure of the supervisory relationship and the inherent power dynamics created between the supervisor and supervisee. By the nature of its purpose, the supervisory relationship is inherently educational, hierarchical, and evaluative (Bernard & Goodyear, 2019; Corey et al., 2010; Page & Worsket, 2015; Watkins, 2017b). This power differential between supervisor and supervisee has the potential to negatively impact the supervisory relationship more than any other aspect of supervision. "Negative supervision events often centered on aspects of power, such as dismissing participants' thoughts and feelings, or supervisors exploring their own agenda" (Wilson et al., 2016, p. 346). Briggs and Miller (2005) suggest that anxiety around evaluation by supervisor can exacerbate novice supervisees' natural self-deprecation, leading to lower self-efficacy. Additionally, this power differential between supervisor and supervisee can be heightened when the supervisor and supervisee come from different cultural backgrounds. A supervisor's ability to demonstrate cultural competence is significantly related to their ability to navigate this power differential. Crockett and Hayes (2015) found that "perceived supervisor multicultural competence is significantly related to the

development of supervisee counseling self-efficacy and satisfaction with supervision" (p. 258). In an article examining his experiences in supervision as a queer supervisee, Hagler (2020) expands on how a supervisors' multicultural competence is related to the power differential in the supervisory relationship. Hagler (2020) describes a supervisor's cultural competence as "expressions of empathy, validation, and humility" (p. 76) and willingness to discuss cultural issues as significant factors in creating an affirming supervision experience. Thus, the strength of the supervisory alliance is related to the supervisor's ability to navigate power differentials in the relationship.

Furthermore, the power differential in the supervisory relationship is associated with how much the supervisee is willing to disclose about themselves and their clinical decision-making. A sense of safety in the supervisory relationship determines whether supervisees share their feelings regarding their performance, which has a significant influence on their personal development. Honest supervisee disclosure is essential as most supervision is based on supervisee self-report of how they are doing with clients rather than direct observation. A study of 221 supervisees by Hutman and Ellis (2019) found that supervisees' perceptions of the supervisory relationship and their supervisor's multicultural competence were inversely related to supervisee non-disclosure, or withholding of information in supervision. Several case studies on supervisee experiences in supervision support these findings and suggest that the security and vulnerability felt in the supervisory relationship is associated with a supervisee's decision to disclose important personal and clinical information in supervision (Constrastano, 2020; Guttman, 2020; Hagler, 2020). These studies reinforce that the supervisee's sense of safety in the

supervisory relationship affects their ability to disclose important aspects of the clinical process to their supervisor, which ultimately impacts their development as supervisee and willingness to take risks.

There are aspects of the hierarchical structure of the supervisory relationship that the supervisor can attend to, however, in order to reduce some of the power differential and anxiety supervisees feel. Regarding supervisee self-disclosure, Staples-Bradley et al. (2019) suggest that supervisors who focus on fostering a positive supervisory alliance, modeling self-disclosure, and setting clear expectations about the purpose of self-disclosure can help reduce supervisee anxiety by reframing self-disclosure as a leaning moment rather than an opportunity for evaluation. Furthermore, in a survey of 257 mental health trainees, Gibson et al. (2019) found that " an interpersonal approach to supervision was significantly associated with less withholding of clinically related and supervision-related material" (p. 114). Briggs and Miller (2005) suggested that a focus on supervisee strengths and successes rather than deficits can "create a climate of comfort and safety, which contributes to therapist confidence….and thus therapist competence" (p. 201). This can help mitigate the impact of the hierarchical structure and power differential in the supervisory relationship.

Overall, this research demonstrates that how the supervisory alliance is facilitated has a strong influence on supervisee development as a clinician. Ladany et al. (1999) caution that supervisee rated satisfaction with supervision does not necessarily mean that supervisees are competent therapists. However, it could be suggested that supervisee satisfaction with the supervisory alliance creates a facilitative environment in which

supervisees are more open to growth and taking risks. The patterns, structures, and content of the supervisory relationship are parallel to those in the therapeutic relationship and the techniques used to build the therapeutic alliance are the same as those used for supervision: empathy, unconditional positive regard, and respect (Bell et al., 2016). As found by Tracey et al. (2012), if a supervisee sees skills modeled from the supervisor that encourage self-disclosure, trying out novel behaviors, or asking questions to explore an unknown area more, then they are more likely to take a similar orientation and repeat these behaviors in therapy with their clients.

Therapist Self-Efficacy and Anxiety

The previous research has suggested that internal elements of the supervisee's experience, such as self-efficacy and anxiety, are related to the supervisory alliance and influence the degree to which supervisees are open to new experiences. Several studies, including the Supervision Pyramid model proposed by Fife et al. (2014), suggest that a strong supervisory alliance is a prerequisite foundation for the more concrete outcomes of supervision to occur, such as learning skills and techniques. Especially for novice supervisees who can come to supervision with high levels of anxiety and self-doubt about their ability to help clients, the supervisory alliance can serve as a secure base for supervisees to try out and safely struggle with novel behaviors (Mollon 1989; Watkins, 2012). Marmarosh et al. (2013) suggested that "this felt security allows supervisees to be free to take risks in treatment, learn from their mistakes, develop their own therapeutic voice, and integrate a clear professional identity" (p. 179). Other studies corroborate this statement, finding that stronger supervisory relationships exemplifying this secure base

have been found to be associated with lower supervisee anxiety and shame and higher self-efficacy, personal agency, and stronger therapeutic identity development in supervisees (Angus & Kagan, 2007; Inman et al., 2014; Rousmaniere et al., 2016; Wrape et al., 2015).

Therapist self-efficacy (i.e., counselor self-efficacy or clinical self-efficacy) is based on Bandura's (1977, 1986, 1997) theory of perceived self-efficacy, which refers to an individual's belief in themselves to perform a specific task. At the supervisee level, therapist self-efficacy (TSE) refers to a therapist's belief in their ability to be therapeutically beneficial to their clients and to perform specific therapeutic interventions and build an alliance with their clients (Briggs & Miller, 2005; Lent et al., 2009; Wagner & Hill, 2015). TSE encompasses the confidence that supervisees have in their abilities as well as action on the supervisee's part. It has been suggested for novice supervisees that TSE is intimately tied to supervisees' trajectory of development and competence. "Anxiety, shame, and self-doubt are common aspects of the [supervisee] development process, particularly early on" (Watkins et al., 2015, p. 225) and novice supervisee have a tendency towards being self-critical (Briggs & Miller, 2005). It is suggested that if supervisors reinforce this self-deprecation, therapists can "lose their sense of self-efficacy as a therapist, and their competence suffers accordingly" (Briggs & Miller, 2005, p.199). Conversely, a strong supervisory alliance can foster supervisees' confidence and trust in themselves, leading to higher TSE, and leading supervisees to be more likely to try new skills and ways of relating to their clients (Angus & Kagan, 2007). Several studies have found that the supervisory alliance accounts for the most variance in TSE (Kozina et al.,

2010; Marmarosh et al., 2013; Wagner & Hill, 2015). Thus, when examining the relationship between the supervisory alliance and risk-taking, it is helpful to consider the influence of TSE on a supervisee's decision-making.

Furthermore, supervisee self-efficacy has been linked to supervisee anxiety in supervision. Mehr et al. (2015) conducted a study of 201 psychology doctoral students examining the relationship between their supervisory alliance, self-efficacy, anxiety, and disclosure. They found relationships between higher supervisory alliance and lower supervisee anxiety and between lower supervisee anxiety and higher TSE (Mehr et al., 2015). This is consistent with several other studies that also found an inverse relationship between supervisee self-efficacy and anxiety in supervision (Larson et al., 1992; Spielberger et al., 1983), an inverse relationship between supervisory alliance and supervisory anxiety (Mehr et al., 2010; Rousmaniere et al., 2016; Wrape et al., 2015), and a direct relationship between supervisory alliance and supervisee self-efficacy (Angus & Kagan, 2007; Marmarosh et al., 2013; Wagner & Hill, 2015). These findings suggest that the supervisory alliance, anxiety, and therapist self-efficacy are interrelated concepts in regard to supervisee development.

Relational Risk-taking

The supervisory alliance, anxiety, and therapist self-efficacy have been established as factors that influence the supervisee's decision making with clients. It was implied by Mason (1993) that risk-taking is related to these intra- and interpersonal factors of the supervisee's experience; however, a closer look at risk-taking is needed to fully understand the overlap between these concepts and their impact on supervisee

decision making. There is limited research on risk-taking in psychotherapy literature in general, and it is even more sparse in the supervision literature. Risk-taking in psychotherapy has primarily focused on risky behaviors that clients engage in (Buckelew et al., 2008), especially related to substance abuse treatment, and what therapists can do to manage or treat these behaviors with their clients. Limited research exists on the risks supervisees take in their relationships with either clients or supervisors (Smith, 2011). However, the process of supervisees taking risks with clients is acknowledged as an important way to facilitate growth and build supervisees' identities and skills sets as clinicians (Mason, 2005; Rabinor & Stiver, 2000; Smith, 2011; Stone & Mason, 1995). Risk is inherently present in any difficult conversation individuals have with others they are helping and when developing new skills and trying out novel behaviors, as is seen in supervision. Smith (2011) explained "the need to challenge and to raise uncomfortable questions within a context of attempting to move things on in helpful ways" (p. 60) is an inherent part of development in any domain. The act of asking about a topic that is difficult, asking for or receiving constructive feedback, or exploring an area a supervisee is uncertain about is a risk that is often necessary to increase the supervisee's skillsets and perception of a situation. It is through taking these risks in relationships that supervisees are able to grow and expand. Rabinor and Stiver (2000) explained that "clinicians are encouraged to take risks in their work to develop connections that are growth fostering for themselves as well as their patients" (p. 247). They elaborated that taking risks in the therapeutic relationship or supervisory relationship can provide an opportunity to develop greater connection with the other person. In supervision, a supervisory relationship that

models and promotes risk-taking helps build an orientation in supervisees that emphasizes having a healthy curiosity towards "their own and others' views without having to compete for truth or feel as if they are entering into a debate over what is right and wrong" (Smith, 2011, p. 61). Rabinor and Stiver (2000) suggested these relationships are based on mutuality and authenticity, conditions necessary for a strong therapeutic relationship.

While research is scarce on risk-taking in supervision, many of the concepts related to risk-taking overlap with the conditions necessary for a strong supervisory alliance, therapist self-efficacy, and anxiety in supervision. Mason's (1993) model of Relational Risk-taking is the most cited framework on risk-taking in supervisory relationships. Rooted in systems therapy, the model conceptualizes relational risk-taking as a process rather than content. It emphasizes how supervisees negotiate the power dynamics in their relationships when the relationship is stuck (Hardman, 2006). As noted above, power dynamics are inherent in the hierarchical relationships of supervision and therapy. While supervisors can demonstrate qualities like empathy, confidentiality, and trustworthiness to minimize the power dynamics and anxiety around evaluation, supervisees are ultimately required to take a risk in their relationship with their supervisor or client as they try out novel behaviors. As such, relational risk-taking is an essential component of supervision that should be directly addressed, developed, and encouraged in supervisees via the supervisory relationship (Mason, 2005). Furthermore, Stone and Mason (1995) studied the relationship between risk-taking and attitudes based on one's belief system. They found that risk is assessed based on one's beliefs about the

consequences of a situation and one's ability to influence them. For supervisees, these beliefs about one's abilities are similar to supervisee's perceived sense of self-efficacy, suggesting a relationship between TSE and risk-taking.

Relational risk-taking is predicated on the concepts of safe uncertainty and authoritative doubt (Hardman, 2006; Mason, 1993; Stone & Mason, 1995). Safe uncertainty refers to the orientation in which people enter a relationship. Like the supervisory relationship, safe uncertainty is based on Bowlby's (1958) idea of having a secure base to return to when trying out novel behaviors (risk-taking) (Watkins & Scaturo, 2013). (Un)certainty is a spectrum representing one's curiosity about a situation and openness to other perspectives (Mason, 1993). In therapy, this uncertainty can influence the decisions and interventions supervisees make with their clients. Likewise in supervision, it can impact whether a supervisee is reflective, curious, and open to feedback that challenges them to grow and develop. Mason (1993) suggested that uncertainty is an unavoidable part of life and one of the primary challenges supervisees are forced to grapple with.

> [Certainty] can involve going into a session aiming to prove or disprove the hypothesis, rather than owning a position of uncertainty which orients a therapist to explore with a family, ideas and meanings which they bring. It is possible to have strong beliefs and still be consistent with a stance of 'not knowing'. (Mason, 1993, p. 191)

Uncertainty, like humility, is an essential foundational block for risk-taking (Stone & Mason, 1995). Without the humility and openness to other possibilities, the option of taking a risk and trying a novel behavior is not viable. Safety, also a spectrum, refers to the degree with which people feel comfortable acknowledging their uncertainty to others (Mason, 1993). In supervisory relationships, this degree of safety is essential for

supervisees to have open discussions with supervisors about their strengths and areas of growth. With unsafe uncertainty, a supervisee may have the humility to recognize their areas of growth but not feel safe enough to acknowledge these doubts (Stone & Mason, 1995). This can result in the supervisee acting like an expert with a client and assuming they understand prematurely. Mason (1993) stated, “If one of the central aims of therapy is to open up the idea of the existence of other possibilities, an expansion of emotional space, then it is clearly counterproductive to be in a position of premature certainty” (p. 191).

Building on safe uncertainty, authoritative doubt, means “the therapist owning their expertise (both knowledge and curiosity) in the context of safe uncertainty” (Hardman, 2006). It means understanding that one does not know everything and having the courage to reach out for help or ask about the gap in one’s knowledge. As a novice therapist and supervisee, this involves tuning into internal cues/social cues that signal that you might be missing the bigger picture. In psychotherapy literature, this is similar to the concepts of cultural curiosity, humility, and acting on cultural opportunities embedded in a multicultural orientation towards therapy (Davis et al., 2018). It also overlaps with the curiosity and confidence needed to navigate ruptures and repairs the therapeutic and supervisory alliances (Watkins & Scaturo, 2013). In all of these concepts, it is suggested that therapists need to have a balance of expertise and confidence in themselves to recognize the limits of one’s perspective and have the courage to ask about this (Davis et al., 2018; Mason, 1993; Watkins & Scaturo, 2013). Mason (1993) pointed out that authoritative doubt does not mean that the supervisee or therapist gives up their expertise

and training as these are valuable skills they bring to therapy and supervision. However, it means that they are open to collaboration with a supervisor or client.

Critical self-reflection in supervisees, which parallels the reflexivity process, and the knowledge of self required for safe uncertainty and authoritative doubt, is necessary for risk-taking (Guiffrida, 2015). From a constructivist view, Guiffrida (2015) suggested anxiety and discomfort are good and supervisors should encourage supervisees to embrace anxiety as a necessary condition for change. Rather than trying to prevent or minimize supervisee mistakes, the constructive supervisor seeks to "help supervisees normalize these experiences so they can openly reflect on them rather than try to hide them or explain them away" (Guiffrida, 2015, p. 42). Thus, the process of supervisee development involves taking relational risks and engaging in critical self-reflection to learn from the outcomes of these risks. The supervisory alliance can encourage this risk-taking by creating an environment of empathy, asking reflective questions, and implementing reflective based activities.

When risk-taking does not occur in an environment of empathy and emphasis on learning, demoralization can occur in supervisees. Demoralization, which is tied to supervisee anxiety and TSE, is an inherent part of training and supervision where a supervisee's struggles with safe uncertainty and authoritative doubt play out. Watkins (2012) suggested that remoralization of supervisees is one of the primary tasks of supervision needed to increase TSE and encourage risk-taking. He suggested that developing a sense of self-efficacy and autonomy as a supervisee is created not by not failing but by failing and making mistakes and dealing with the demoralization that

follows in productive ways that allow supervisees to try again. As such, a strong supervisory alliance "….characterized by trust, respect, openness, genuineness, and facilitation in which the supervisee is able to expose therapeutic doubt, questions, and failings in an atmosphere of safety, support, and confidence" (Watkins, 2012, p. 193) is necessary for remoralization and the subsequent increase of TSE. This is consistent with literature on safe uncertainty, which suggests that safe certainty cannot be created in supervision by trying to contract and outline all the details of supervision ahead of time; rather supervisees need to learn how to persevere through unexpected changes (Mason, 1993; Rabinor & Stiver, 2000). Furthermore, in order for remoralization of supervisees to be successful, Watkins (2012) suggested it requires active participation of both the supervisor and supervisee, an emphasis on learning and growth, and recognition of the hierarchical relationship and the anxiety it provokes in new supervisees. Thus, remoralization is a process that links the strength of the supervisory alliance to risk-taking (e.g., supervisee autonomy) via TSE and anxiety.

Conclusion

The current state of supervision literature suggests a need to better understand the supervision elements that influence supervisee development and decision-making. Across theoretical orientations, the supervisory alliance has been found to be one of the strongest predictors of supervisee development (Watkins, 2014; DePue et al., 2020). A strong supervisory alliance is related to lower levels of therapist anxiety and higher levels of therapist self-efficacy (Moldovan & David, 2013; Rieck et al., 2015). The presence of these factors is associated with more effective supervision and a facilitative learning

environment. However, little research has been conducted to understand how a facilitative learning environment in supervision impacts supervisees' clinical decision making with clients. If supervision is to be considered helpful, then development cannot stop at the supervisee level; supervisees must translate the knowledge they are learning in supervision to their work with clients. Supervisees' decisions around whether to translate their learned knowledge to novel behaviors with clients involve mental calculations about the riskiness of the decision (e.g., the potential outcomes, benefits, and consequences). While risk-taking in supervision has not been empirically studied, Mason's (1993) model of Relational Risk-taking overlaps with many of the concepts already connected to supervision outcomes: the supervisory alliance, supervisee anxiety, and therapist self-efficacy. Thus, risk-taking represents a potential missing link in the literature, as an understanding of this process can help supervisors adjust supervision to meet supervisees' developmental needs better and bolster supervisees' clinical decision-making.

The next chapter describes the methodology of the current study, which examines the relationship between the supervisory alliance and risk-taking. The study also investigated the effect of therapist self-efficacy and supervisee anxiety as moderating variables between the supervisory alliance and risk-taking. A detailed description of the procedures used to gather data, as well as the sample, are described. The next chapter also outlines the instruments used to measure the supervisory alliance, therapist self-efficacy, supervisee anxiety, and risk-taking. Finally, the chapter outlines the statistical methods used to analyze the data to answer the research questions.

Chapter Three: Methodology

The following chapter highlights the research design, sample characteristics, measures, and procedures used for this study. The purpose of this study is to examine the relationship between the supervisory alliance and supervisee risk-taking. Research on the supervisory alliance has shown the strength of the supervisory alliance to be the greatest predictor of client outcomes (Watkins, 2017b). Assuming that risk-taking is a facilitative behavior in a supervisee's development as a therapist, it was expected that the supervisee's willingness to take a risk would be positively related to the strength of the supervisory relationship. It was hypothesized that supervisees with lower levels of anxiety and higher levels of self-efficacy also would have stronger alliances with their supervisor and would be more willing to take risks. The overall methodology of this study aims to address the research hypotheses described in Chapter One.

Design

A non-experimental, associational research design was used to assess the relationship between the strength of the supervisory relationship and supervisees' willingness to take risks. This design also was used to assess the effects of the moderating variables (supervisee anxiety and supervisee self-efficacy) on this relationship. Non-experimental studies do not control for independent variables and do not utilize random selection (Gliner et al., 2009). This study did not control for the type of interventions

used in supervision to facilitate supervisee risk-taking. Instead, the study examined the relationship between supervision processes and supervisee risk-taking as it naturally occurs in pre-existing supervision relationships. Given that supervisee risk-taking is a new concept in the supervision literature, a correlational design was the most appropriate to explore the initial conceptualization of risk-taking. Finally, in order to provide more context to risk-taking behavior than a correlational design would be able to provide, interviews with participants about their risk-taking with clients were conducted.

To ensure a robust sample, convenience sampling was utilized. Although it has its disadvantages compared to random sampling, convenience sampling is a commonly used method of sampling in psychotherapy-related research (Gliner et al., 2009). One of the most significant critiques of convenience sampling is that it does not provide a diverse representation of the population the opportunity to participate in the study and therefore is not generalizable to the entire population of interest (i.e., all novice supervisees in clinical mental health related training programs; Gliner et al., 2009). To mitigate this concern, participants were recruited from various types of clinical training programs (e.g., counseling psychology, social work, clinical mental health) and clinical settings (e.g., community mental health, hospital, college counseling center).

Participants

Participants in this study included supervisees of various demographic backgrounds who were working with clients in a clinical setting (e.g., practicum, internship) under supervision. Inclusion criteria for the study included supervisees who were at least 21 years of age, in their first or second year of field experience, and

currently enrolled in a master's or doctoral level graduate program, and working with at least one client. Supervisees were required to have at least one month of supervision to ensure that the supervisory alliance had time to develop.

Survey Participants. Overall, 111 persons responded to the invitation to participate in the study. There were 10 persons who did not meet inclusion criteria for participation (i.e., completed more than two years of clinical training, had not worked with any clients) and were removed from the study. Another 36 people did not complete either the SWAI-T or Risk-Taking Experiences Questionnaire (specifically the four Risk Willingness items) and were removed from the study as these measures assessed the independent and dependent variables and were necessary for data analyses. As the Risk Willingness items were at the end of the survey, any persons who reached this part of the survey and completed these items also completed the entire survey. A total of 65 participants who met criteria and completed all parts of the survey were included in the final sample. The 65 participants exceeded the number of participants (with medium effect size, alpha level set at 0.05, and desired statistical power of 0.80) that was calculated through a priori power analysis with G*Power.

The sample in this study attempted to mirror the demographics of masters-level counselors in training (Gender: 82.52% Female, 17.39% Male; Race/Ethnicity: 18.39% African American/Black, 0.85% American Indian/Native Alaskan, 2.11% Asian American, 7.89% Hispanic/Latino, 0.14% Native Hawaiian/Pacific Islander, 2.21% Multiracial, 59.75% White; Council for Accreditation of Counseling and Related Educational Programs, 2018). Final sample demographics were close to the

demographics of master's counselors nationally but under-represented participants who identified as African American/Black (4.6%) and over-represented participants who identified as White (70.8%) and Asian (12.3%). Table 2 describes the demographics (gender, race/ethnicity) of the participants, as well as their educational experience (type of college, state located in, field of study, degree, year in program). Survey participants also described their clinical and supervision experience to offer context on the types of supervision and settings in which supervision occurred (See Table 3).

Table 2
Survey: Demographic & Educational Experience

		n (%)	*Mean*	*SD*
Age			26.14	4.52
Gender	Cisgender female	56 (86.2%)		
	Cisgender male	9 (13.8%)		
Race/Ethnicity	White/Caucasian	46 (70.8%)		
	Asian	8 (12.3%)		
	Hispanic/Latino	5 (7.7%)		
	African-American/Black	3 (4.6%)		
	Multiracial	3 (4.6%)		
Type of college or university in which program is located	Private	43 (66.2%)		
	Public	22 (33.8%)		
State in which program is located	Colorado	41 (63.1 %)		
	Michigan	8 (12.3%)		
	Arizona	4 (6.2%)		
	Indiana	3 (4.6%)		
	California	2 (3.1%)		
	Florida	2 (3.1%)		
	Louisiana	2 (3.1%)		
	Utah	2 (3.1%)		
	Virginia	1 (1.5%)		
Field of Study	Counseling Psychology	42 (64.6%)		
	Social Work	8 (12.3%)		
	Clinical Psychology	5 (7.7%)		
	School Psychology	5 (7.7%)		
	Clinical Mental Health Counseling	3 (4.6%)		
	Marriage & Family Therapy	1 (1.5%)		

	Sport & Performance Psychology	1 (1.5%)
Degree Level	MA/MS/M.Ed.	48 (73.8%)
	MSW	8 (12.3%)
	PhD	4 (6.2%)
	Ed.S.	3 (4.6%)
	PsyD	2 (3.1%)
Year in Program	Second	48 (73.8%)
	First	13 (20%)
	Third	4 (6.2%)

Table 3

Survey: Clinical and Supervision Experience

		n (%)	*Mean*	*SD*
Total supervised clinical training experience (years)			0.99	0.46
Current clinical training setting	Community Mental Health	28 (43.1%)		
	School/School Counseling	9 (13.8%)		
	Private Practice	8 (12.3%)		
	Hospital/VA/Medical Clinic	5 (7.7%)		
	College Counseling	4 (6.2%)		
	Residential Treatment Center	4 (6.2%)		
	Outpatient Clinic	3 (4.6%)		
	Addiction Agency	1 (1.5%)		
	Correctional Setting	1 (1.5%)		
	Department Training Clinic	1 (1.5%)		
	Employee Assistance Program (EAP)	1 (1.5%)		
Current clinical training experience level	Second clinical training experience	49 (75.4%)		
	First clinical training experience	15 (23.1%)		
	Third+ clinical training experience	1 (1.5%)		
Supervision Settings	Both Individual and Group Supervision	39 (60.0%)		
	Individual Supervision only	21 (32.3%)		
	Group Supervision only	5 (7.7%)		
Amount of supervision received	Group (hours/week)		1.62	1.41
	Individual (hours/week)		1.60	2.19
	Time in each meeting (hours/meeting)		1.41	0.92

Foci of supervision session	Case presentation/ conceptualization	52 (80%)		
	Interpersonal Process	44 (67.7%)		
	Skill Development/role play	36 (55.4%)		
	Evaluation	28 (43.1%)		
	Note/report writing	23 (35.4%)		
	Case management/paperwork	20 (30.8%)		
	Other: general questions	1 (1.5%)		
Experience with current supervisor	Length of time supervised (years)		0.39	0.23
	Number of sessions received		19.75	17.67

Interview Participants. Interview participants were selected from the 65 survey participants. To ensure the interviewees were as diverse and representative of the sample as possible, quota sampling, using gender and racial demographics from the demographic questionnaire were used to select participants for the follow-up interview. While not a specific aim of the quota sampling, efforts also were made to select interviewees from diverse fields, degrees, states, and institutions (private versus public). Final interview demographics were close to the demographics of the survey participants but under-represented participants who identified as female (77.8%) or Asian (0%). Descriptive statistics of the interview participants' demographics and educational background are displayed in Table 4. For information on the interview participants' clinical and supervision experience, see Table 5.

Based on quota sampling, thirteen people were invited to participate in a follow-up interview. Two people did not respond to this invitation. Two others signed up for an interview but did not show up and did not respond to further attempts to contact them. Nine participants completed the interview.

Table 4

Interview: Demographic & Educational Experience

		n (%)	*Mean*	*SD*
Age			25.22	2.91
Gender	Cisgender female	7 (77.8%)		
	Cisgender male	2 (22.2%)		
Race/Ethnicity	White/Caucasian	6 (66.7%)		
	African-American/Black	1 (11.1%)		
	Hispanic/Latino	1 (11.1%)		
	Multiracial	1 (1.5%)		
Type of college or university in which program is located	Private	5 (55.6%)		
	Public	4 (44.4%)		
State in which program is located	Colorado	4 (44.4%)		
	Michigan	3 (33.3%)		
	Arizona	1 (11.1%)		
	Florida	1 (11.1%)		
Field of Study	Counseling Psychology	3 (33.3%)		
	Social Work	3 (33.3%)		
	Clinical Mental Health Counseling	1 (11.1%)		
	Clinical Psychology	1 (11.1%)		
	School Psychology	1 (11.1%)		
Degree Level	MA/MS/M.Ed.	3 (33.3%)		
	MSW	3 (33.3%)		
	Ed.S.	1 (11.1%)		
	PhD	1 (11.1%)		
	PsyD	1 (11.1%)		
Year in Program	Second	5 (55.6%)		
	First	4 (44.4%)		

Table 5

Interview: Clinical and Supervision Experience

		n (%)	*Mean*	*SD*
Total supervised clinical training experience (years)			0.61	0.43
Current clinical training setting	Community Mental Health	2 (22.2%)		
	Hospital/VA/Medical Clinic	2 (22.2%)		
	School/School Counseling	2 (22.2%)		
	College Counseling Center	1 (11.1%)		
	Employee Assistance Program (EAP)	1 (11.1%)		
	Private Practice	1 (11.1%)		

Current clinical training experience level	First clinical training experience	5 (55.6%)		
	Second clinical training experience	4 (44.4%)		
Supervision Settings	Both Individual and Group Supervision	6 (66.7%)		
	Individual Supervision only	3 (33.3%)		
	Group Supervision only	0 (0%)		
Amount of supervision received	Individual (hours/week)		2.06	2.27
	Group (hours/week)		1.33	0.90
	Time in each meeting (hours/meeting)		1.22	0.36
Foci of supervision session	Case presentation/conceptualization	7 (77.8%)		
	Interpersonal Process	6 (66.7%)		
	Evaluation	5 (55.6%)		
	Skill Development/role play	4 (44.4%)		
	Note/report writing	3 (33.3%)		
	Case management/paperwork	3 (33.3%)		
Experience with current supervisor	Length of time supervised (years)		0.28	0.18
	Number of sessions received		15.56	15.80

Measures

Demographic Questionnaire: Demographic information was collected from supervisees through a self-report measure. The questionnaire contains 23 questions overall. The questionnaire included items regarding the supervisee's age, gender, ethnicity/race, and educational background. It also focused on the supervisees' experiences in supervision including, their current setting (e.g., community mental health, college counseling center, hospital), the frequency with which they met with their supervisor, the average duration of their supervision meetings, the format in which supervision occurred (i.e., individual, group), the length of their relationship with their supervisor, the number of supervision meetings that occurred at the time the measure was administration, and the primary focus of supervision. This information was used to describe the sample (See Appendix A).

Supervisory Working Alliance Inventory – Supervisee/Trainee Form (SWAI – T). The strength of the supervisory alliance from the supervisee's perspective was measured using the Supervisory Working Alliance Inventory – Trainee Form (SWAI – T, Efstation et al., 1990). The SWAI is widely used as a measure of the supervisory alliance and assesses both the process and content of the supervisory alliance (Watkins, 2014). The supervisee form (SWAI – T) has 19 items and two subscales (Rapport and Client Focus). The Rapport Subscale assesses the strength of the supervisory relationship while the Client Focus Subscale examines the specific skills the supervisor emphasizes during supervision. Each item is rated from 1 (almost never) to 7 (almost always). To obtain a score for this subscale, the 12 items are averaged (with higher scores indicating stronger rapport in the supervisory alliance). Evidence by Patton and Kivlighan (1997) suggests the composite score of these two subscales can be used to report the supervisee's overall rating of the supervisory alliance. For this study the total score on the SWAI – T was calculated to assess the supervisees' perceptions of the supervisory alliance.

The initial factor analysis of the SWAI – T demonstrated high internal consistency for the Rapport subscale ($\alpha = .90$) and acceptable internal consistency for the Client Focus subscale ($\alpha = .77$) (Efstation et al., 1990). Other studies have also reported high internal reliability for the Rapport subscale ranging from 0.90 to 0.95 and ranging from 0.77 to 0.91 for the Client Focus scale (Gunn & Pistole, 2012; Phillips et al., 2017). In a review of SWAI – T uses, Patton and Kivlighan (1997) report that the high correlations between the two factors have led several researchers to combine the subscales into one composite score. Grossl et al. (2014) reported an internal reliability of

0.96 for this composite score on the SWAI – T. Finally, SWAI-T has been shown to be acceptable to use with supervisees of varying levels of experience and backgrounds (Patton et al., 1992; see Appendix B).

Counselor Activity Self-Efficacy Scale (CASES). The supervisee's level of self-efficacy was measured by the Counselor Activity Self-Efficacy Scale (CASES; Lent et al., 2003). CASES is widely used as a self-report measure of supervisee self-efficacy (Israelashvili & Socher, 2007). It is grounded in Hill and O'Brien's (1999) helping skills training model, which is commonly used to train novice therapists, and Bandura's (1997) theory of self-efficacy (Lent et al., 2003). Compared to the Counseling Self-Estimate Inventory (COSE, Larson et al., 1992), CASES has been validated with supervisees from countries outside the United States, assesses skills more applicable to novice therapists, and more adequately captures the constructs of Bandura's (1997) theory of self-efficacy (Greason & Cashwell, 2009; Lent et al., 2003).

CASES has six subscales which assess self-efficacy in three domains: a) Helping Skills Self-Efficacy (subscales: Exploration Skills, Insight Skills, Action Skills), b) Session Management Self-Efficacy (subscale: Session Management), c) Counseling Challenges Self-Efficacy (subscales: Client Distress, Relationships Conflict). Lent et al. (2003) suggested that the first two domains assess supervisee self-efficacy in relation to more basic counseling skills while the third domain, Counseling Challenges Self-Efficacy, tends to capture supervisee self-efficacy in relation to more advanced counseling skills. As a risk in therapy might require utilizing a wide spectrum of counseling skills, the composite score of all three domains on the CASES was used to

determine participants' self-efficacy. Participants rate each of the 41 items on a ten-point Likert scale, ranging from 0 (no confidence at all) to 9 (complete confidence). There are no reverse coded items on CASES. Each subscale score is calculated by averaging the item responses within that subscale, with higher scores indicating higher levels of self-efficacy. A total score also is calculated by averaging the score of all the items in the measure. A higher total score indicates higher levels of self-efficacy.

Lent et al.'s (2003) development of CASES found a good factor structure for self-efficacy and high reliability of the overall measure ($\alpha = .97$), as well as each of the subscales (exploration skills = 0.79, insight skills = 0.85, action skills = 0.83, session management = 0.94, relationship conflict = 0.92, client distress = 0.94). They also reported a two-week test-retest reliability of 0.75. Other studies also found high internal consistency of 0.96 for the total score (Greason & Cashwell, 2009; Kissil et al., 2013; Mesrie et al., 2018) and ranging from 0.88 to 0.93 for each of the three domains (Lee et al., 2016). Lent et al. (2003) reported convergent validity with another widely used measure of supervisee self-efficacy, the Counseling Self-Estimate Inventory (COSE; Larson et al., 1992), with a correlation of 0.76 between the measures. Finally, Lent et al. (2003) found significant gains ($p < 0.001$) between students' scores at the beginning of their practicum experience and at the end. They also found significant differences ($p < 0.05$) between total scores on CASES when comparing students of various levels of counseling experience, with students with higher levels of counseling experience tending to report higher self-efficacy. These differences suggest that CASES is sensitive to

changes in supervisees' levels of self-efficacy over the course of their development (see Appendix C).

Anticipatory Supervisee Anxiety Scale (ASAS): The supervisee's level of anxiety in supervision was measured by the Anticipatory Supervisee Anxiety Scale (ASAS; Singh & Ellis, 2000; Tosada, 2004). The ASAS is a self-report measure that asks questions about the supervisee's anxiety in supervision related to their fear of evaluation and their confidence in their ability to be an effective therapist. The ASAS was adapted from Ellis et al.'s (1993) Supervisee Anxiety Scale (SAS) by conceptualizing supervisee anxiety as more state-dependent (situational anxiety). Compared to the SAS, which measures anxiety after a supervision session, the ASAS is grounded in supervision research that suggests supervisee anxiety is better captured by "assessing trainees' anxiety just prior to the supervision session (i.e., "conceptualizing anxiety as anticipatory rather than recollected anxiety assessed after the session"; Tosado, 2004, p. 9).

The ASAS has 28 items, and all items start with the same sentence stem: "In anticipation of my upcoming supervision session, I…" (e.g. "…feel anxious about how my supervisor might evaluate me"). The ASAS includes specific items that ask about the supervisees' confidence in their skills, their relationship with their supervisor, and their performance as a therapist. Each item is scored on a nine-point Likert scale from 1 (not at all true) to 9 (completely true), with higher scores indicating higher levels of anxiety. There are two reverse coded items (i.e., "In anticipation of my upcoming supervision session, I feel calm", "In anticipation of my upcoming supervision session, I feel relaxed"). To score the ASAS, reserved coded items are scored first, then items are

summed. Higher total scores indicate higher levels of supervisee anxiety in supervision. Cross validation by Tosado (2004) supported a good unidimensional factor structure with a reliability of 0.97. Tosado (2004) reported strong construct validity with another widely used measure of anxiety, the State-Trait Anxiety Scale (STAI; Spielberger et al., 1983), with significant correlations of r = 0.55 ($p < 0.0001$) on the State Anxiety scale and r = 0.16 ($p < 0.0001$) on the Trait Anxiety Scale (see Appendix D).

Risk-taking Experiences Questionnaire: The supervisee's willingness to take a risk was measured by an online questionnaire that asked supervisees to describe a time in which they took a risk with a client. A review of the literature revealed that no measures of risk-taking in supervision exist. Furthermore, there were no instruments found that measure constructs that overlap with risk-taking. A questionnaire was created to measure risk-taking for this study. The questionnaire items are grounded in constructs highlighted in Mason's (1993) Relational Risk-taking model, specifically, the concepts of safe uncertainty and authoritative doubt. The model emphasizes that risk-taking is both an affective (e.g., feelings of doubt, anxiety, incompetence, courage), as well as a cognitive experience (e.g., curious orientation, inquiring about the gaps in one's knowledge). The items in the questionnaire target both the supervisee's emotional and cognitive experience of taking a risk with their client. Items four to seven capture the various components supervisees consider internally (e.g. their anxiety, their confidence in a successful outcome, the riskiness of the behavior, and the difficulty of the risk) when determining how willing they are to take the risk. Together, these questions represent the

multidimensional affective and cognitive factors supervisees consider when deciding whether to take a risk.

The questionnaire included ten questions that ask the supervisee to describe a moment in which they took a risk with a client at their clinical site, their willingness to take the risk, their difficulty taking the risk, their anxiety taking the risk, their confidence that the risk would be successful, and their reflection on the success of the risk. For the purposes of this study, the supervisee's ratings on items four to seven were aggregated to represent their overall willingness to take the risk. This aggregate score is called Risk Willingness. Risk Willingness items were reverse coded and then the average of questions four to seven was used in data analysis to measure risk-taking. Higher scores represent higher willingness to take a risk. These questions were measured on a seven-point Likert scale from 1 to 7, with anchors provided at both ends, as well as for the neutral condition (see Appendix E).

Risk-taking Experiences Interview. Furthermore, as risk-taking is a new concept, nine participants participated in a semi-structured interview with the principal investigator after completing the online questionnaire. The information collected from this qualitative interview was used to understand in more depth what risk-taking looked like for novice supervisees and under what circumstances it occurred. As with the Risk-taking Experiences Questionnaire, this interview was designed by the principal investigator and is grounded in Mason's (1993) Relational Risk-taking model. In alignment with Mason's (1993) concepts of authoritative doubt and safe uncertainty, it also asks questions about the supervisee's affective and cognitive experience taking the

risk. Furthermore, based on the findings from Stone and Mason's (1995) study on risk, the items ask about the supervisee's beliefs about the consequences of taking a risk and their ability to influence these consequences (see Appendix F).

Procedure

This study was approved by the University of Denver Institutional Review Board (IRB) prior to data collection with any participant (#1481276-1, see Appendix G). Participants were recruited from various master's and doctoral level programs across the United States through solicitation via electronic requests. Specifically, once IRB was approved by the University, the principal investigator contacted training directors of various graduate level clinical mental health related training programs across the United States and asked permission to recruit students to participate in the study. Students were recruited by sending out an email to the program's listserv (see Appendix I), which contained a link to the survey. The survey included an explanation of the study and the impact on participants (see Appendices H). The information about the study clarified that their participation would include filling out online measures as well as a potential follow-up interview. As part of participants' consent to the entire study, they were asked to provide an email address to coordinate the interview and/or receive an electronic gift card for their participation.

After completing the online surveys, selected participants were emailed and asked if they were interested in completing a follow-up interview. Participants who agreed to be interviewed were sent an email with a link to an online calendar. The calendar offered several different 15-minute time slots in which the participants could sign up to complete

the interview. When selecting a time, the participants were asked to provide their first name, email address, and phone number so the principal investigator could coordinate interview logistics with them. Interviews were conducted until the responses to each interview question reached saturation, and themes started to repeat. For those participants completing the interview, information was gathered via an online video conferencing application (Zoom). These interviews were recorded so that the principal investigator could later transcribe and code the responses to the questions.

For all participants, the median completion time of the informed consent document, Demographic Questionnaire, SWAI-T, CASES, ASAS, and Risk-taking Experiences Questionnaire was 19.32 minutes. The follow-up interview took an average of 18.11 minutes to complete. For those participants who completed the online questionnaire and entered their email address, they were entered into a drawing to receive a $10 gift card for their time. Participants had a one in three chance of receiving a $10 gift card. Twenty-four participants received a $10 gift card for completing the survey. Also, the nine participants who completed a follow-up interview each received a $5 gift card for their extended participation. Gift cards were delivered electronically to the email address the participant provided when signing the consent form. Participants' contact information and consent forms were stored separately from their data in a password-protected electronic dataset. All participant names collected in the process of coordinating the interview were immediately deleted after the interview and all information gathered from the interviews were de-identified. No other identifying information or contact information were gathered for any purpose.

Summary

This chapter outlined the research design, participants, measures, and study procedures used to examine the hypotheses of this study. The study utilized a nonexperimental, associational design with convenience sampling to examine the relationship between the supervisory alliance and novice supervisees' willingness to take risks. The final sample included 65 valid participants who completed the survey and 9 participants who also completed a follow-up interview. The online survey included a demographic questionnaire, the SWAI- T, CASES, ASAS, and Risk-taking Experiences Questionnaire. This information was used to answer the study's research hypotheses. Quota sampling was used to recruit nine participants to complete the follow-up Risk-Taking Experiences Interview. These interviews were designed to provide more information on the context of risk-taking behavior and the circumstances under which it occurs. The next chapter will review the results of the study.

Chapter Four: Results

The following chapter reviews the statistical analyses and results of this study. The first section addresses the three hypotheses in the study. The second section examines the qualitative responses (n= 65) provided on the survey. These responses were reviewed to understand times in which participants took a risk with a client and the factors that went into this decision. The third section analyzes responses from the Risk-taking Experiences Interview Questionnaire (n=9) to provide greater context into supervisees' risk-taking. Finally, other findings that are relevant to better understanding risk-taking in this exploratory study are reviewed.

Survey Data: Relationships among Supervisory Alliance, Supervisee Risk-taking, Anxiety, and Self-Efficacy

Reliability of Measures. The reliability and descriptive statistics of each quantitative measure were analyzed and are displayed in Table 6. The SWAI-T ($\alpha = 0.96$), CASES ($\alpha = 0.96$), and ASAS ($\alpha = 0.98$) measures all demonstrated high reliability in this study, with results that were comparable to previous validation studies (SWAI-T: Grossl et al., 2014; CASES: Kissil et al., 2013; Lent, 2003; Mesrie et al., 2018; ASAS: Tosada, 2004). For this study, the composite scores on the SWAI-T ranged across the spectrum but the mean suggests most supervisees reported stronger rather than weaker supervisory alliances ($M = 5.65$, $SD = 1.08$). Scores on CASES also ranged

across the entire continuum but were typically above average, suggesting that supervisees perceived themselves as having some level of confidence in their clinical abilities (*M* = 6.31, *SD* = 1.05). On the ASAS, supervisees also reported a wide range of scores regarding anxiety in supervision, but the mean suggests that these supervisees had relatively low levels of anxiety (*M* = 3.24, *SD* = 1.83). The descriptive statistics on these measures show that while supervisees experiences vary, as a whole, they report above average supervisory alliances and self-efficacy, and below average levels of anxiety regarding their supervision.

The internal consistency of the Risk Willingness score on the Risk-taking Experiences Questionnaire was less reliable. Cronbach's alpha was only 0.48, which is significantly below the acceptable range of 0.70 to 0.80 (Bobko, 2001). Low reliability could be due to a low number of items for the Risk Willingness score and well as a small sample size. As the hypotheses are the primary foci of the study, quantitative analyses are still reported below. However, given the low reliability of the Risk Willingness score, the quantitative results from this study should not be interpreted as a reliable representation of supervisees' risk-taking behavior.

Table 6

Descriptive Statistics and Reliability of Measures

Variable Name	*Possible Instrument Range*	*N*	*Mean*	*SD*	*Min*	*Max*	*Reliability (α)*
SWAI-T Overall	1-7	65	5.65	1.08	1.60	7	0.96
CASES Overall	0-9	65	6.31	1.05	3.80	8.68	0.96
ASAS Overall	1-9	65	3.24	1.83	1	8.32	0.98
Risk Willingness	1-7	65	4.00	0.80	2.50	6.75	0.48

Note: Risk Willingness was computed as the composite score of items 4-7 on the Risk-taking Experiences Questionnaire; α = Cronbach's Alpha

Hypothesis 1 - Supervisory Alliance as a Predictor of Supervisee Risk-taking. A Pearson's r correlation coefficient was computed to assess the relationship between the strength of the supervisory alliance and the supervisee's willingness to take risks with clients. It was expected that there would be a positive correlation between these variables. The strength of the supervisory alliance was measured by the composite score on the SWAI-T, which has shown to be a valid and reliable measure of the supervisory alliance from the supervisee's perspective (Efstation et al., 1990; Grossl et al., 2014; Patton & Kivlighan, 1997). The supervisee's willingness to take a risk was measured by the composite score of four Risk Willingness items on the Risk-taking Experiences Questionnaire. The Risk-taking Experiences Questionnaire was created for this study and was grounded in the risk-taking concepts highlighted in Mason's (1993) Relational Risk-taking model.

A one-tailed test of significance was conducted to compute the correlation between the supervisory alliance and risk willingness. The analysis suggests there is not a significant relationship between the SWAI-T score and the Risk Willingness score ($r = -0.158$, $n = 65$, $p = 0.104$). Thus, the hypothesis that the strength of the supervisory alliance is positively associated with supervisees' willingness to take a risk was not supported.

Hypothesis 2 - Supervisee Self-Efficacy as a Moderator. It was expected that CASES would be a moderator of the relationship between SWAI-T and Risk Willingness ($\alpha = 0.05$). Specifically, it was predicted that supervisees with lower self-efficacy would endorse lower willingness to engage in risk-taking. The PROCESS v 3.4.1 extension in

SPSS was used to compute the moderating effect of the CASES scores on the relationship between SWAI-T and Risk Willingness scores. The supervisory alliance and supervisee self-efficacy were entered in the first step of the regression analysis. To avoid potential multicollinearity, these terms were mean centered (Bobko, 2001). In the second step of the regression analysis, the interaction term between the supervisory alliance and supervisee self-efficacy was entered.

The result of the analysis is shown in Table 7. The interaction term did not explain a significant increase in variance in supervisee risk-willingness ($\Delta R^2 = 0.01$, $F(1, 61) = 0.93$, $p = 0.34$). In other words, the results show no significant effect between the strength of the supervisory alliance and supervisees' willingness to take a risk when accounting for supervisee reported self-efficacy. Thus, the hypothesis that supervisees with lower self-efficacy would endorse lower willingness to engage in risk-taking was not supported.

Table 7
Supervisee Self-Efficacy as a Moderator with Risk Willingness as Dependent Variable

	Coefficient (SE)	*t-ratio*	*LLCI*	*ULCI*	*p*
Constant	-0.10 (0.14)	-0.70	-0.37	0.18	0.49
X_1: SWAI-T	-0.24 (0.14)	-1.67	-0.53	0.05	0.10
X_2: CASES	0.23 (0.15)	1.54	-0.07	0.53	0.13
X_1X_2: SWAI-T x CASES Interaction	0.14 (0.14)	0.97	-0.15	0.42	0.34

Note. SWAI-T and CASES scores were mean centered prior to analysis, LLCI = lower limit confidence interval, ULCI = upper limit confidence interval, Level of confidence for all confidence intervals is 95%

Hypothesis 3 - Supervisee Anxiety as a Moderator. It was expected that supervisee anxiety would be a moderator of the relationship between the supervisory alliance and supervisee risk-taking; specifically, that supervisees with lower levels of

anxiety in supervision would be more willing to engage in risk-taking ($\alpha = 0.05$). To measure supervisee anxiety, the overall score on the ASAS was used. Similar to examining self-efficacy as a moderator, the PROCESS v 3.4.1 extension in SPSS was used to compute moderating effect of the ASAS scores on the relationship between SWAI-T and Risk Willingness scores. In the first step of the regression analysis, the supervisory alliance and supervisee anxiety were entered and mean centered. The interaction term between the supervisory alliance and supervisee anxiety was entered in the second step of the regression analysis.

The results of the analysis are shown in Tables 8 and 9. The interaction term explained a significant increase in the variance in supervisee risk-willingness ($\Delta R^2 = 0.11$, $F(1, 61) = 8.61$, $p = 0.005$), suggesting that supervisee anxiety is a significant moderator of the relationship between the supervisory alliance on risk-taking. It was hypothesized that supervisees with lower anxiety would endorse higher willingness to engage in risk-taking. However, when examining the relationship between the supervisory alliance and supervisee risk-taking at low, medium, and high levels of supervisee anxiety, it was found that moderation only had a significant effect at high levels of supervisee anxiety ($p = 0.008$). For supervisees with higher levels of anxiety, as the supervisory alliance increased, supervisees' willingness to take a risk decreased. The hypothesis that supervisee anxiety is a moderator of the relationship between the strength of the supervisory alliance and supervisees' willingness to take risks with clients was supported. However, it was found only for supervisees with high levels of anxiety, not low levels of anxiety as predicted.

Table 8

Supervisee Anxiety as a Moderator with Risk Willingness as Dependent Variable

	Coefficient (SE)	*t-ratio*	*LLCI*	*ULCI*	*p*
Constant	-0.17 (0.12)	-1.37	-0.41	0.08	0.17
X_1: SWAI-T	-0.12 (0.15)	-0.80	-0.41	0.18	0.43
X_2: ASAS	-0.39 (0.14)	-2.76	-0.67	-0.11	0.008
X_1X_2: SWAI-T x ASAS Interaction	-0.26 (0.09)	-2.94	-0.44	-0.08	0.005*

Note. SWAI-T and ASAS scores were mean centered prior to analysis, LLCI = lower limit confidence interval, ULCI = upper limit confidence interval, Level of confidence for all confidence intervals is 95%, * = $p \leq 0.01$

Table 9

Conditional Effects of Supervisory Alliance on Supervisee Risk Willingness at Levels of Supervisee Anxiety with Risk Willingness as Dependent Variable

	Effect (SE)	*t-ratio*	*LLCI*	*ULCI*	*p*
Low Supervisee Anxiety	-0.14 (0.20)	0.70	-0.26	0.54	0.48
Medium Supervisee Anxiety	-0.12 (0.15)	-0.80	-0.41	0.18	0.43
High Supervisee Anxiety	-0.38 (0.14)	-2.77	-0.65	-0.10	0.008*

Note. Low Supervisee Anxiety = 1 *SD* below the mean, High Supervisee Anxiety = 1 *SD* above the mean, LLCI = lower limit confidence interval, ULCI = upper limit confidence interval, Level of confidence for all confidence intervals is 95%, * = $p \leq 0.01$

Survey Data: Supervisee Risk-taking with Clients

Coding and Reliability Analysis. Information gathered from the Risk-taking Experiences Questionnaire (i.e., open-ended questions one to three) was used to describe the types of experiences that novice supervisees considered risky. Using a process similar to data analysis for phenomenological research recommended by Moustakas (1994), answers from each question were coded and grouped into themes. All statements in which the supervisee described their risk-taking process were identified and kept for analyses. Examples of statements that were not kept as part of the analyses included information the supervisee gave on a client's background, their clinical setting, and the number of times they had met with the client. Next, for each question, statements were coded according to behaviors, thoughts, or feelings. The principal investigator compared

answers from all supervisees to identify whether they described similar phenomena. For each question, codes that referred to similar phenomena were grouped into larger themes that captured the essence of the supervisees' experiences (e.g., codes "used immediacy", "role played" were grouped into the theme "tried a new intervention").

A master's student in the Counseling Psychology program conducted a reliability check of these themes. The principal investigator sent the master's student the data for the three risk-taking questions. The master's student received a list of the themes that were generated for each question. They were asked to code each response according to the identified themes for each question. They also were provided with two additional codes (No Theme; Other Theme) if they did not believe an answer aligned with any of the themes the principal investigator identified or to indicate if the master's student identified a theme that the principal investigator did not. After comparing results, the master's student and principal investigator discussed any discrepancies in coding and recoded renewed agreement when possible. For item three (How did you make the decision on whether to take the risk?), the themes "Learning Opportunity" and "Decided in the moment" were identified from responses previously coded as "Other". Percent agreement was used to determine inter-rater reliability between coders. Reliability for each question on the survey ranged from 66.7% to 100%, with only 2 of the 25 themes falling below the recommended 70% agreement (Neuendorf, 2002). See Table 10.

Risk-taking Analysis. The first three items on the Risk-taking Experiences Questionnaire asked supervisees about a time in which they took a risk, which supervisees later used as a reference point answering the four Risk Willingness items on

the survey. These three questions provided context around what the risk was, why they considered it risky, and what factors they considered when deciding to take the risk. Analyses of these responses are shown in Table 10. These questions were open-ended, and most participants provided brief, one to three sentence answers for each question detailing a time in which they took a risk with a client. Some participants' answers indicated multiple factors that influenced their decision to take a risk, and these responses were coded for more than one theme.

The types of behaviors that participants considered risky varied widely across supervisees, with the most common types of risks supervisees reported including challenging a client (n = 15, 17%), trying a new intervention (n = 15, 17%), using silence (n = 9, 10.2%), and working with a high-risk client (n = 9, 10.2%). As a whole, the risks supervisees reported generally required them to be more directive with a client (e.g., challenged a client, discussed therapeutic process/gave interpersonal feedback, interrupted a client, set boundaries, use silence), process more emotional or interpersonal content (e.g., discussed therapeutic process/gave interpersonal feedback, processed emotion, self-disclosed), or try something unfamiliar (e.g., tried a new intervention).

Participants' reasons for why they considered the behavior risky or anxiety-provoking generally centered around feeling unprepared, trying something new, or worry about harming the client or therapeutic relationship. Fourteen supervisees stated that they considered the behavior risky when the risk involved something the supervisee felt unprepared to implement (15.9%). Similarly, thirteen supervisees identified trying something new as a reason why a behavior was risky (14.8%). Another thirteen

supervisees were worried about the client's reaction (14.8%). Overall, these responses reflect that uncertainty about the outcome is a common reason why supervisees considered a behavior risky.

Despite the supervisees' apprehension about taking the risk and its ultimate result, 63.1% (n = 41) of supervisees reported deciding to take the risk because they thought it would benefit the client or their own development as a therapist in some way (e.g., benefit to client, client not making progress, strong therapeutic relationship with client, benefit to therapeutic relationship, learning opportunity, alignment with treatment goals). Despite the prediction that supervisee risk-taking would be related to the quality of supervision, only 18.2% (n = 16) of participants directly stated that they were encouraged to take the risk because of the support of their supervisor or prior supervision they had received. Instead, responses suggested that risk-taking was often a decision that supervisees made independent of their supervisor and that supervisees calculated the decision to take the risk based on whether the benefits to the therapeutic process outweighed the potential consequences.

Table 10

Survey: Risk-taking Responses from 65 Participants

	n (%)	*Inter-rater Reliability*
Describe a time in which you took a behavioral risk in a therapy session to do something new or different with a client.		
Challenged client	*15 (17%)*	*100%*
Tried a new intervention	*15 (17%)*	*80.0%*
Used Silence	*9 (10.2%)*	*100%*
Worked with a high-risk client (e.g., SI, HI, psychosis)	*9 (10.2%)*	*88.9%*

Discussed therapeutic process/gave interpersonal feedback	*4 (4.5%)*	*100%*
Interrupted client	*4 (4.5%)*	*100%*
Set boundaries	*3 (3.4%)*	*66.7%*
Processed emotion	*2 (2.3%)*	*100%*
Self-disclosed	*2 (2.3%)*	*100%*
Other	*6 (6.8%)*	*100%*
Why did you consider this behavior risky or anxiety-provoking?		
Felt uncomfortable/unprepared/not confident	*14 (15.9%)*	*92.9%*
Had never tried intervention before	*13 (14.8%)*	*92.3%*
Worried about the client's reaction	*13 (14.8%)*	*92.3%*
Worried about damaging the therapeutic relationship	*7 (8.0%)*	*71.4%*
Worried about harming the client/wanting to protect the client	*6 (6.8%)*	*100%*
Worried about invalidating client	*5 (5.7%)*	*100%*
Worried about doing the "wrong thing"	*3 (3.4%)*	*100%*
Other	*15 (17.0%)*	*100%*
How did you make the decision on whether to take this risk?		
Benefit to client	*21 (23.9%)*	*95.2%*
Supported by supervisor/received prior supervision on client	*16 (18.2%)*	*100%*
Client was not making progress	*7 (8.0%)*	*100%*
Strong therapeutic relationship with client	*5 (5.7%)*	*100%*
Decided in the moment	*4 (4.5%)*	*100%*
Benefit to therapeutic relationship	*3 (3.4%)*	*66.7%*
Learning opportunity	*3 (3.4%)*	*100%*
Aligned with treatment goals	*2 (2.3%)*	*100%*
Other	*10 (11.4%)*	*88.2%*

Note: Cumulative percentages for responses to each question can equal greater than 100% as some participants provided more than one response to each question.

Impact of the Risk on Future Decisions. The final three questions on the Risk-taking Experiences Questionnaire centered around the supervisees' retrospective evaluations of how the risk influenced supervisees' future development. These questions asked supervisees to evaluate whether the risk was successful and whether they would be willing to take more risks in the future. See Table 11. For each question, a response of 4 was considered neutral on the scale, indicating that taking the risk had no impact (versus

negative or positive impact) on the question. For question 8 (Looking back, do you think the risk was worth taking?), answers ranged from 2 to 7; however, 87.7% of participants rated this answer as 5 or above, indicating that the majority of participants felt that risk was worthwhile to some extent (M = 5.86, SD = 1.20). Similarly, on question 9 (How did taking this risk impact your confidence in your ability as a therapist?), 84.6% answered 5 or above, suggesting that the risk positively impacted their confidence as a therapist (Range = 2-7, M = 5.37, SD = 1.11). Finally, 84.5% of participants stated that to some extent, taking this risk positively influenced whether or not they would take another risk in the future (Range = 3-7, M = 5.35, SD = 1.02). Taken together, these results suggest that for the majority of participants, the risk they described had a positive influence on the clinical situation, their confidence as a therapist, and their desire to take more risks in the future.

Table 11
Survey: Supervisees' Evaluations of Their Risk-taking Experiences

	Possible Item Range	*N*	*Mean*	*SD*	*Min*	*Max*
Looking back, do you think that the risk was worth taking?	1-7	65	5.86	1.20	2	7
How did taking this risk impact your confidence in your ability as a therapist?	1-7	65	5.37	1.11	2	7
How did taking this risk impact how willing you are to take another risk in the future?	1-7	65	5.35	1.02	3	7

Interview Data: Supervisee Risk-taking with Clients

Coding and Reliability Analysis. All interviews were recorded and transcribed with the participants' permission. Interview transcripts were de-identified, and

participants were renamed with a number. Transcripts of the interviews were reviewed using the same phenomenological processes to analyze, code, and identify themes as with the survey data. Themes were generated for each question of the interview protocol that captured the essence of the supervisees' experiences of taking a risk.

The same master's student who acted as a second coder with the survey data was also a second coder for the interview data. The master's student was sent the de-identified transcripts, along with the Risk-taking Experiences Interview protocol. Similar to the survey reliability check, the master's student received a list of the themes generated for each question and for No Theme and Other Theme options. After the master's student coded the themes independently, the master's student and principal investigator compared codes and discussed any discrepancies. One significant discrepancy was found for the question "What did you do in supervision, with your supervisor, to help you take this risk?" (initial inter-rated reliability was 33.3%). Discussion revealed the master's student coded anything the supervisee did in supervision to facilitate risk-taking, regardless of whether the participant identified supervision occurring before or after taking the risk. However, the principal investigator only included responses completed in supervision before taking the risk, as intended by the question. After clarification, the master's student recoded this question, leading to 100% agreement. Reliability on the themes within each question from the interview ranged from 66.7% to 100% agreement, with only one theme falling below the 70% agreement recommended by Neuendorf (2002). See Table 12.

Risk-taking Analysis. For most questions, participants indicated more than one factor they were considering when taking a risk. Eight of the participants indicated that processing emotion, trying a new intervention, trying a previously used intervention in a new situation, self-disclosing, and/or challenging a client are previous situations in which they have taken a risk. Four out of five supervisees who were in their first clinical training experience described situations as risky in which they were caught off guard and did not know what to do (i.e., unexpectedly processing the loss of a parent with a client when the supervisee thought they were going to be discussing treatment planning, not knowing whether to intervene in a group when a child unexpectedly talks about his father's death, expecting to just share a client's progress with a team and being told to challenge the client when the supervisee did not think it was appropriate, not knowing whether to trust a client's self-report of functioning in an intake). In comparison, three out of four supervisees who were in their second clinical training experience described risky situations as times in which they felt stuck and had an idea of what to do but did not know if the client would be receptive (i.e., using immediacy to comment on the client's anger towards therapy, self-disclosing to build rapport, challenging a client to think about the worst-case outcome for their situation).

Regardless of what the risk was, all supervisees across the two years of clinical experience described these events as risky because they did not know how the risk would impact the client or themselves. They reported worrying about a negative reaction from a client, about harming the client/wanting to protect the client, about doing the "wrong thing", and about damaging the therapeutic relationship. These are parallel to themes

found in the survey responses. One supervisee described their fear of harming the client by making a wrong decision, “It was, like, such a vulnerable time in her life, that I didn't want to do it wrong and exacerbate the trauma of that situation”. Another supervisee echoed this desire to protect a client by steering other group members away from a sensitive conversation, “Because, my instinct initially was to just, you know, stop that conversation right there. And then tell the kid ‘Careful what you're saying’ ”. Furthermore, four supervisees described feeling unprepared, which contributed to their perception of riskiness because they had less control over the situation (“I would say the risk of it is also just me not being professionally developed in that area and kind of just learning as I go”; “I feel like the risk was just like, having a conversation that I felt entirely unqualified to have”). All but one of the supervisees described feeling nervous/anxious/ worried/scared as the primary emotion they felt while taking this risk. Four supervisees also described secondary emotions such as self-doubt/unsure (“I guess a little uncomfortable because I mean, that's the nature for me, at least of taking a risk. You know, just feeling like - like doubting myself in this situation; so, like some self-doubt”) or unclear/confused/questioning (“Maybe a little bit, like a little bit of confusion. Just not knowing what the best way to provide that feedback would be”), which may be linked to lower levels of self-efficacy.

Seven of the supervisees decided to take the risk in the moment as a reaction to a situation that arose in the session. These supervisees described quickly assessing the situation and reacting in the moment; “Honestly, I guess just going with my gut if that makes sense”. Only two supervisees went into the session with a specific plan for taking

the risk. Furthermore, six of the nine supervisees reported having autonomy in deciding to take this risk, as this statement illustrates: “I was sort of like, ‘Put on your big girl pants. Like, we're gonna do this and see how it goes’ ”. When deciding to take the risk, supervisees reported being concerned about the impact on the client (n = 4, 44.4%), the therapeutic relationship (n = 1, 11.1%), and incorporating previous supervision they received on the client (n = 2, 22.2%). These were also themes found on the survey response and suggest that overall, supervisees have the client’s best interests on the top of their mind when deciding whether a risk is worth taking.

This study conceptualized a risk-taking event as something that supervisees discuss in supervision with their supervisor and develop a *specific* plan for executing in their next session with a client. However, only one supervisee described specifically planning their risk-taking with their supervisor ahead of time, and three participants cited doing nothing in supervision ahead of time to help them take this risk. Instead, six supervisees reported a strong supervisory alliance or general support they received in supervision (i.e., conceptualizing the client/discussing treatment goals, practicing/discussing possible interventions to use with the client) as factors that prepared them to take the risk. For example, one supervisee explained her general supervision as, “…just broadly, kind of analyzing this client and how she processes or doesn't process things”. However, this supervision was not specific to the client and/or the exact situation that necessitated risk-taking. Similarly, another supervisee stated, “I think my conversation around treatment goals made me feel much more comfortable around taking the risk because that supervisor is incredibly supportive”. While the supervisee and

supervisor may not have discussed the risk ahead of time, these supervisees often stated that they believed their supervisor would support them and use the risk as a learning moment, regardless of the outcome.

While this was not explicitly part of the interview protocol, five participants stated that they often processed the risk with their supervisor afterward. The supervision helped supervisees to understand if the risk was effective and what they could take away from this experience in the future. One of these supervisees stated,

> I definitely debriefed about it. One of the mistakes I made during the intervention is like I definitely pushed her too hard in like the processing sense of it…So I talked about that [with my supervisor]. I was like, "I know that I made that mistake." My supervisor was like, "Good". We talked about that. The big thing is I'm at the point where I can tell when I've made a mistake, but I don't know how to like not do it."

The other four supervisees reported similar reasons for processing the risk with their supervisor afterward. This suggests that instead of risk-taking being a planned, linear process, it is more cyclical. Follow-up supervision plays an essential role in processing the risk and helping the supervisee determine what to take from this risk for future sessions.

Supervisees often looked to their clients' reactions as an indicator of whether or not the risk was successful. Six supervisees who believed the risk benefited the client or therapeutic relationship deemed the risk successful. One supervisee stated taking the risk "diffused the situation, which is what I was looking for", while another supervisee stated,

> On the next call, I noticed a decrease in the shaking in her voice. She was smiling. When she hung up on the phone calls, she said, "Wow, that went a lot better." And after we role played, I asked her if she felt more ready to make another phone call and she said yes.

In each of these examples, the supervisee deemed the risk successful when it had the intended outcome and the supervisee had tangible evidence of a benefit to the client or therapeutic process. In contrast, if the supervisees believed the risk had a negative outcome, such as the therapeutic relationship was harmed or the client did not return to therapy, they deemed the risk unsuccessful.

Even if the risk was not successful, all supervisees except one thought the risk was worth taking because it either benefited the client/therapeutic relationship or was a learning moment for the therapist. One supervisee described risk-taking as an essential part of the developmental progress as a novice therapist, stating that therapists cannot grow unless they take a risk.

> I think in my opinion with most risks, that's just part of a learning experience. And if I were to deny myself taking any risks, then I would deny myself, like, the ability to learn. So, I don't regret taking the risk. I think it was important for me to understand and learn, you know, maybe some more the nuance behind self-disclosure and that kind of risk-taking. I think a lot of what we do as beginning clinicians is taking risks. If we just played it safe, then I don't think we would necessarily grow as much as we could.

Other supervisees described similar benefits that risks have both for them and the client that make risk-taking worthwhile (i.e., learning moment for therapist, benefited client, risk-taking is part of learning/development process, every interaction with a client is a risk right now). Another supervisee echoed these sentiments and described how the risk was worthwhile long-term, even though the client did not initially respond well to the supervisee's challenge, "I do think the risk was worth taking. I think it contributed to our relationship and the strength of our therapeutic relationship and where it is now". Thus, most supervisees agree that risk-taking is a beneficial, unavoidable, and necessary part of the development process.

Finally, eight of the participants reported they would take future risks based on the risk they described. Similar to the common reasons supervisees cited for whether a risk was successful or worth taking, 6 supervisees reported they would take future risks because it was a learning moment for the therapist or 4 who stated it would benefited the client.

The results of the interview analysis are shown in Table 12. For most questions, participants' answers fell into multiple themes, indicating there were multiple factors they considered when taking or evaluating the outcome of the risk. Participants could have more than one response for a question. The table indicates how many participants out of the nine gave each response (e.g. For "How did you feel about taking the risk?" 8 of the 9 participants reported feeling nervous/anxious/worried/scared and 4 of the 9 participants (also) reported feeling self-doubt/unsure).

Table 12
Interview: Risk-taking Responses from 9 Participants

	n (%)	*Inter-rater Reliability*
Describe a time in which you took a behavioral risk to do something new or different with a client.		
Processed Emotion	*3 (33.3%)*	*66.7%*
Tried a previously used intervention in a new situation	*2 (22.2%)*	*100%*
Tried a new intervention	*1 (11.1%)*	*100%*
Self-disclosed	*1 (11.1%)*	*100%*
Challenged a client	*1 (11.1%)*	*100%*
Other	*2 (22.2%)*	*100%*
What made this behavior risky to you?		
Felt unprepared	*4 (44.4%)*	*100%*
Worried about a negative reaction from the client	*2 (22.2%)*	*100%*
Worried about harming the client/wanting to protect the client	*2 (22.2%)*	*100%*
Worried about doing the "wrong thing"	*2 (22.2%)*	*100%*

Worried about damaging the therapeutic relationship	*2 (22.2%)*	*100%*
How did you feel about taking this risk?		
Nervous/Anxious/Worried/Scared	*8 (88.9%)*	*100%*
Self-Doubt/Unsure	*4 (44.4%)*	*75.0%*
Unclear/Confused/Questioning	*1 (11.1%)*	*100%*
Other	*1 (11.1%)*	*100%*
How did you decide to take the risk?		
Whose idea was it for you to take the risk?		
Made choice in moment	*7 (77.8%)*	*71.4%*
Received prior supervision on client	*2 (22.2%)*	*100%*
Was told to take risk	*1 (11.1%)*	*100%*
Other	*1 (11.1%)*	*100%*
What did you consider when trying to take the risk?		
Benefit to/impact on client	*4 (44.4%)*	*100%*
Previous supervision on client	*2 (22.2%)*	*50%*
Strong therapeutic relationship with client	*1 (11.1%)*	*100%*
Felt forced	*1 (11.1%)*	*100%*
Other	*2 (22.2%)*	*100%*
What choice did you feel like you had in taking the risk?		
Made choice on own	*6 (66.7%)*	*100%*
Did not have a choice	*1 (11.1%)*	*100%*
Other/Did not answer	*2 (22.2%)*	*100%*
What did you do in supervision, with your supervisor, to help you take this risk?*		
Conceptualized client/discussed treatment goals	*4 (44.4%)*	*80%*
Nothing	*3 (33.3%)*	*100%*
Good supervisory alliance	*2 (22.2%)*	*100%*
Practiced/discussed possible interventions to use with client	*1 (11.1%)*	*100%*
Other	*1 (11.1%)*	*100%*
Do you think the risk was successful?		
Yes	*6 (66.7%)*	*100%*
No	*2 (22.2%)*	*100%*
Unsure	*2 (22.2%)*	*100%*
Why or why not?		
Benefited client/therapeutic relationship	*6 (66.7%)*	*100%*
Client returned/did not return	*2 (22.2%)*	*100%*
Harmed client/therapeutic relationship	*2 (22.2%)*	*100%*
Learning moment for therapist	*1 (11.1%)*	*100%*
In retrospect, do you think that the risk was worth taking?		
Yes	*8 (88.9%)*	*100%*
No	*1 (11.1%)*	*100%*
Why or why not?		

Learning moment for therapist	*4 (44.4%)*	*100%*
Benefited client/therapeutic relationship	*4 (44.4%)*	*100%*
Harmed client	*1 (11.1%)*	*100%*
Did you take other risks based on this one?		
Yes	*8 (88.9%)*	*100%*
Other: Have not had a chance	*1 (11.1%)*	*100%*
Why or why not?		
Learning moment for therapist	*6 (66.7%)*	*83.3%*
Benefited client	*4 (44.4%)*	*100%*
Every interaction with a client is a risk right now	*1 (11.1%)*	*100%*

Note: Cumulative percentages for responses to each question can equal greater than 100% as many participants provided more than one response to each question.

Other Findings

Supervisory Alliance and Anxiety. To help determine whether this study's sample was similar to previous studies, an additional analysis was conducted to determine whether the supervisees' anxiety was significantly correlated with their supervisory alliance, as found in previous studies. Results showed a significant relationship between the SWAI-T score and the ASAS ($r = -0.528$, $n = 65$, $p < 0.01$). This is consistent with previous studies that found a strong correlation between SWAI-T and ASAS (Rousmaniere et al., 2016; Mehr et al., 2010; Wrape et al., 2015).

Supervisory Alliance and Self-Efficacy. Similarly, an analysis was conducted to assess the relationship between the supervisory alliance and supervisee self-efficacy. A significant relationship was found between the SWAI-T and CASES ($r = 0.457$, $n = 65$, $p < 0.01$). This is consistent with previous studies that have shown a strong correlation between SWAI-T and CASES (Kozina et al., 2010; Marmarosh et al., 2013; Wagner & Hill, 2015).

Summary

This chapter outlined the results of this study from both the online survey and the follow-up interviews. Quantitative results in this study should not be interpreted as representative of supervisees' risk-taking behavior as the dependent measure on which these analyses are based, the Risk Willingness, is not reliable. However, the qualitative results do provide some insight into supervisees' risk-taking. Analysis of supervisee responses on the Risk-taking Experiences Questionnaire found that novice therapists consider a variety of behaviors to be risky, regardless of where they are in their development (e.g., challenging a client, using silence, processing emotion). Supervisees reported worry about the impact on the client and feelings of anxiety, unpreparedness, and self-doubt as the primary factors that made these behaviors feel risky. Despite these apprehensions, however, the primary reason most supervisees decided to take the risk was because they felt it would benefit the client or therapeutic process.

Supervisees who participated in the Risk-taking Experiences Interview reported similar types of risks and reasons why these behaviors felt risky. Furthermore, while supervisees in the interview reported indirect ways supervision had prepared them to take the risk (e.g., previously conceptualizing the client or practicing a skill), most supervisees did not report a direct correlation between preparing for the risk in supervision ahead of time and enacting the risk with the client in session. Regardless of how the risk turned out, most supervisees considered the risk successful, stated it was worth taking, and reported that they would be willing to take more risks in the future. Supervisees described their risks as learning moments for them and their clients and described risk-taking as an

unavoidable and necessary part of the developmental process as a novice therapist. The next chapter will discuss the implications of the results for clinical practice and for future research.

Chapter Five: Discussion

This study was the first to examine risk-taking as a factor that influences novice supervisee's development as a therapist. The study focused on the link between the strength of the supervisory alliance and whether supervisees take a risk in therapy with their clients. While therapist risk-taking has been proposed as a theoretical framework by Mason (1993), until this study, no empirical research existed that examined the presence of risk-taking in therapy sessions or how and when novice therapists decide to take risks with clients. Previous studies have found that the supervisory alliance is linked to supervisees' development of a variety of skills that overlap with risk-taking, such as clinical decision-making, supervisee skill development, and clinical reflection (Bambling & King, 2014; Ellis et al., 2014; Rousmaniere et al., 2016; Wilson et al., 2016). This study sought to understand how supervisees' experiences of safety in the supervisory alliance influenced their affective (e.g., feelings of doubt, anxiety, incompetence, self-efficacy) and cognitive decisions (e.g., inquiring about the gaps in one's knowledge, trying to understand what clients need in the moment) to take a risk with clients.

Quantitative results, examining the relationships between the supervisory alliance, supervisee risk-taking, anxiety, and self-efficacy, unfortunately are not interpretable due to low reliability of the dependent measure (Risk-Willingness score). Therefore, discussion of the study's findings will focus primarily on the information from the

qualitative aspects of the study. Survey and interview results suggest that, in this study, the conceptualization of risk as it relates to novice supervisees' decision-making in session may need to be reconsidered. Analyses demonstrated that for most novice supervisees, risk-taking (e.g., trying out a new intervention, setting boundaries, using silence, discussing the therapeutic process) is an inevitable part of the developmental process. As a novice therapist, situations frequently arise in sessions that they feel unprepared for, but that they need to respond to in the moment in order to benefit the client or therapeutic process. Thus, in this study, supervision was not directly related to their *willingness* to take a risk. Supervisees reported the supervision support as a secondary factor when making the clinical decision on whether to take a risk compared to more client-oriented needs (e.g., alignment with treatment goals, benefit to client, benefit to therapeutic process, client not making progress). However, supervision may serve as a facilitative environment for how effective the supervisee's clinical decision making was, how risky the supervisee perceives their decision to be based on their ability to manage the consequences of the risk, and how open supervisees are to reflect on their risk-taking with their supervisor afterward. This is consistent with previous literature that suggests supervision can serve as a secure base for supervisees to safely try out novel behaviors and reflect on their clinical decisions afterward (Mollon 1989; Watkins, 2012). Supervisees with a secure base for supervision have been associated with higher personal agency in their therapeutic decisions and stronger therapeutic identity development, both elements that supervisees in this study discussed in the interviews when making in vivo risk decisions (Angus & Kagan, 2007; Marmarosh et al., 2013).

The open-ended questions on the survey and interviews provided important context for supervisees' affective and cognitive experience of risk-taking. This study conceptualized risk-taking as part of a structured, linear process in supervision (the supervisee and supervisor discuss a client in supervision, they identify an intervention for the supervisee to try with the client in the next therapy session, then the supervisee tries the intervention with the client). The risk centers on the supervisee trying an intervention that they feel anxious about or that is new. The strength of the supervisory alliance impacts how willing the supervisee is to follow through on the risk. However, findings showed that supervisees described risk-taking as an intuitive reaction to a situation rather than a pre-meditated plan, developed ahead of time with the support of a supervisor. Thus, instead of a linear path, risk-taking may exist more as a self-reflective learning loop, as suggested by previous studies (Watkins, 2017a; Watkins, 2017b; Watkins & Scaturo, 2013). In interviews, five supervisees reported processing the risk with their supervisor afterward to help make sense of the risk and consolidate their learning for the future. Similarly, the majority of supervisees (88.9%), they stated that the risk positively impacted their confidence as a therapist and increased their desire to take more risks in the future. This suggests that rather than acting as a specific antecedent to risk-taking, supervision may serve as a secure base for supervisees to process their risk-taking throughout a self-reflective learning cycle.

Research by Fife et al. (2014) supports this theory. Fife et al.'s (2014) Supervision Pyramid framework conceptualizes the supervisory alliance as the foundation for higher level supervisee learning and re-learning to occur. Supervisees in the current study

reported that their desire to bring the risk to supervision was based on previous experiences of remoralization and demoralization in supervision, consistent with research by Watkins (2012). Even if the risk did not turn out as hoped, supervisees who had previously experienced supervision as remoralizing were more likely to process the risk with their supervisor. Supervisees who had poorer supervisory relationships and had experiences of demoralization in supervision were less likely to reflect on the risk in supervision. Thus, while the strength of the supervisory alliance may not impact how willing a supervisee is to take a risk in the moment, the supervisory alliance does influence the learning cycle and the supervisee's ability to process the impact of the risk.

Strengths

This study was the first exploratory examination of risk-taking in novice supervisees. While Mason's (1993) Relational Risk-taking model postulates the affective and cognitive experiences of risk-taking in supervision, it does not empirically examine the factors that facilitate risk-taking in supervision. This study was the first to explore what types of situations novice supervisees consider risky in a session with clients, why they consider the situation risky, and how they make the decision to take a risk. Furthermore, the study examined how a critical element of supervision, the supervisory alliance, is related to supervisee risk-taking with clients and how supervisee anxiety and self-efficacy moderate this relationship. An understanding of supervisee risk-taking is essential to understanding the factors that facilitate or hinder supervisees applying the knowledge gained in supervision to their clinical practice. The results of this exploratory

study provide ample directions for future research to better understand the decision-making processes supervisees throughout their development.

The study also had several notable methodological strengths. Most notable was the addition of the interview and open-ended questions on the survey. These qualitative pieces of data collection provided insight into the context and process surrounding supervisees' risk-taking beyond what was captured in the quantitative measure. As risk-taking has not been studied before, this context was essential to understand how risk-taking operates in clinical practice. The study also recruited students from diverse regions of the country, settings, and fields of study, which increased the generalizability of the results. Of the 65 participants included in the final sample, there was no missing data. This study utilized standardized measures in the supervision literature to assess the supervisory alliance (SWAI-T), supervisee self-efficacy (CASES), and supervisee anxiety (ASAS). The data from these measures demonstrated similar or better reliability than found in previous studies and similar correlations between scores on the SWAI-T and CASES and SWAI-T and ASAS, as found in previous studies.

Limitations

There were several limitations of the study. Most importantly, the low reliability of the Risk-Willingness score, which used to assess the dependent variable in this study made the quantitative results of this study uninterpretable. As risk-taking had not been studied before, there was no existing standardized measure of risk-taking available for use in this study. While the Risk-taking Experiences Questionnaire was grounded in Stone and Mason's (1995) concepts of safe uncertainty and authoritative doubt, a factor

analysis of the questionnaire was not conducted prior to the study to determine if the questionnaire accurately captured the construct of risk-taking. The Risk Willingness composite score from this measure, which was used to assess the outcome of all the hypotheses, only included four items and demonstrated low reliability ($\alpha = 0.48$). Having only four items limited the reliability of the measure, as fewer items lead to lower reliability for measures. The small sample size also likely contributed to the lower reliability of the measure. A more robust measure of risk-taking is needed to assess this relationship.

The quantitative data analysis used in this study was also a limitation. Given the low reliability of the Risk-Willingness score, alternative forms of data analyses may have been more appropriate for the quantitative results. Instead of using inferential analysis, such as Pearson's r correlation and moderation analysis for the hypotheses, descriptive statistics may have been more appropriate.

The length and order of the online questionnaire was also a limitation. The online questionnaire contained 121 items, over a third of which were from the CASES, and took a median time of 19.32 minutes to complete. Furthermore, the Risk Willingness items, which were required to participate in the study, were placed at the end of the questionnaire. Of the 101 eligible persons who started the questionnaire, over a third ($n = 36$) did not reach the end to complete the Risk Willingness items. It is likely these people experienced respondent fatigue in their attempt to complete the survey, and this caused a selection bias in terms of the participants who did complete the entire survey. Participants

who persevered to the end are likely more similar to each other and therefore limited the natural differentiation between participants.

To reduce the invasiveness of the study and to make it more feasible, the study only assessed the participant's risk-taking behavior at one point in time. Given that risk-taking is postulated to be part of the developmental learning cycle, repeated measures of a supervisee's risk-taking behavior over time might have provided a more complete picture of how risk decisions are made in different contexts, with different clients, at different points of development, and with different supervisors over the course of their development.

Furthermore, supervisees were asked about a time in which they took a risk at any point in their clinical work. Supervisees reported on an event that took place days to weeks earlier. Supervisees reported their memory of their affect and thought processes associated with this historical event, which may differ from how they experienced the event in real life. The intensity of the affect, factors they considered, assessment of their supervisory relationship, anxiety, and self-efficacy they reported at the time of the study may differ based on the outcome of the risk and the development they have experienced between taking the risk and reporting on it in the survey. Additionally, given that the survey was self-report, and no additional data were collected, it is possible that supervisees' answers reflected a self-serving bias that minimized how risky the intervention was or the intensity of the affect associated with taking the risk.

Recommendations and Future Study

Given that this is the initial study on supervisee risk-taking, several future studies are recommended to further understand the factors that facilitate supervisees' decision to take a risk with their clients. In terms of research methods, it is also recommended that a factor analysis be conducted for the Risk-taking Experiences Questionnaire to create a more robust and validated measure of supervisee risk-taking. Additionally, increasing the number of items and wording the same question in multiple ways would help strengthen the reliability of the measure. Future studies could include a larger sample size and a shorter questionnaire.

More qualitative studies are recommended to better understand the process of supervisee risk-taking and inform future conceptualizations of risk. As mentioned above, this study illuminated that risk-taking might exist as a cyclical, self-reflective loop process rather than a direct, linear path. In order to understand how supervision facilitates novice therapists' risk-taking with clients, it is recommended that future studies examine several cycles of the risk-taking process (supervision before the risk, taking the risk, processing the risk with the supervisor afterward, repeat) to see how risk-taking influences supervisees' development and clinical decision making over time. A longitudinal study of this nature could also assess if the willingness to, frequency of, or perception of risk changes over the course of supervisees' development. Similarly, a study that compares risk-taking in novice versus advanced supervisees (e.g., first and second year versus third and fourth year) could help supervisors understand how to support supervisees' clinical decision-making throughout their training. Participants for the interviews in this study were selected based on quota sampling around gender, race,

and year in program. A future study might select participants based on their level of anxiety in supervision and compare how participants with high versus low anxiety make decisions around risk. Similarly, on average, participants in this study reported relatively positive relationships with their supervisors. A future study might compare supervisees with weak versus strong supervisory alliances to see how the strength of the supervisory alliance affects their risk-taking and willingness to process risks in supervision.

Training Implications

Results from this study suggest that internal calculations about risk are a natural part of supervisees' clinical decision-making with clients. Thus, it is recommended that supervision includes explicit conversations about risk-taking as part of regular check-ins. For novice supervisees, normalizing risk as part of the growth process and encouraging supervisees to discuss their risk-taking decisions with supervisors is important. Supervisors should encourage their supervisees to discuss their risk-taking and express their doubts and failings, without fear of consequences. This will help strengthen supervisees' clinical decision-making so they are better equipped to make decisions in the moment as future risk opportunities arise with clients. For early trainees, the learning and relearning that occurs in supervision may focus on helping supervisees learn more interventions to use with clients so supervisees have more tools to pull from when faced with a future risk. For more advanced supervisees, the discussion about risk-taking may focus on the affective and cognitive factors the supervisees weighed when making the decision to help supervisees be more effective with future risk-taking opportunities.

Conclusion

This is the first empirical study of risk-taking in the supervision literature. It was predicted that supervision would be a facilitator of supervisees' risk-taking with clients. Unfortunately, given that the Risk-Willingness score has not demonstrated sufficient reliability yet, quantitative results from this study cannot be interpreted as representative indicators of supervisees' risk-taking behavior. However, survey responses and interviews with participants provided greater context around supervisees' risk-taking decisions and how they utilize supervision in this process. This study provides more understanding of risk-taking and points to future studies that could build on these results.

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APPENDICES

Appendix A: Supervisee Demographic Questionnaire

Instructions: Please respond to each of the following questions regarding your demographic information and your experience in supervision. Select the option(s) that best captures your experience. If none of the options apply, specify under "other". Thank you for your participation.

1. **Age: _________**

2. **Gender:**
   Cisgender Female — Cisgender Male
   Transgender — Gender identity (if not listed above) :______

3. **Race/Ethnicity**
   African-American/Black — Asian
   Hispanic/Latino — Native American
   Middle Eastern — Pacific Islander
   White/Caucasian — Multiracial
   Other: _________

4. **Type of university or college at which you are receiving your degree:**
   Private — Public

5. **State in which your program is located:**
   ____

6. **How would you best describe the clinical setting for the practicum where you are currently receiving supervision?**
   Community Mental Health — College Counseling Center
   Hospital/VA — Correctional Setting
   Private Practice — School Counseling
   Other: ____________

7. **Field of Study**
   Counseling Psychology — Clinical Psychology
   School Psychology — Social Work
   Other: _____________

8. **Current Degree Program**
   MA/MS MSW PhD PsyD Other: _________

9. **Year in your current degree program:**
   1 2 3 Other:____

10. **Current Field Experience Level:** (please choose the most appropriate).
    Field experience, practicum, and internship represent formal training experiences and are equivalent terms.
    First clinical training experience Second clinical training experience
    Other: ________________

11. **Total number of clinical training experiences you have had previously:**
    1 2 3+

12. **Total Supervised Clinical Training Experience:** Please enter both years and months.
    Ex: If you completed one full year of supervised practicum experience last year and have completed two months of supervised practicum this year, enter: 1 year, 2 months
    _____ years ______ months

13. **Total number of supervisors with whom you have worked previously?**
    1 2 3+

14. **Total number of supervisors with whom you work currently?**
    1 2 3+

15. **The format(s) in which supervision occurs?** (choose all that apply. Trainings do not count as supervision)
    Individual Group

16. **Approximate number of individual supervision hours per week you receive:**
    Enter the answer in intervals of hours *(e.g., 30 minutes = 0.5, 1 hour = 1)*
    Hours ______

17. **Approximate number of group supervision hours per week you receive:**
    Enter the answer in intervals of hours *(e.g., 30 minutes = 0.5, 1 hour = 1)*
    Hours ______

18. **Approximate amount of time you spend in each supervision meeting:**
    Enter the answer in intervals of hours *(e.g., 30 minutes = 0.5, 1 hour = 1)*
    Hours____________

19. **Is your supervisor licensed?**
    Yes No

    If yes, in what field are they licensed?
    Psychology Social Work
    School counseling Other:______________

20. **How long have you been supervised by this supervisor?** Please enter both years and months.
    Ex: If you have been supervised for 1.5 years, enter: 1 year, 6 months
    Ex: If you have been supervised for 6 weeks, enter: 0 years, 1.5 months
    _____ years ______ months

21. **Approximate number of supervision sessions you have received at your current practicum site at the time of this questionnaire:** *(e.g., 1, 2, 3…)*
    ____

22. **What is the primary focus of supervision meetings?** (choose all that apply)
    Case presentation/conceptualization Interpersonal Process
    Skill development/role play Evaluation
    Note/report writing Case
    management/paperwork
    Other: _______________________

23. **How many clients do you typically focus on during a supervision session?**
    ____

Appendix B: Supervisory Working Alliance Inventory – Supervisee/Trainee Form (SWAI – T)

Instructions: Please indicate the frequency with which the behavior described in each of the following items seems characteristics of your work with your supervisor. After each item, select the number corresponding to the appropriate point of the following 7-point scale.

	1 *Almost Never*	2	3	4	5	6	7 *Almost Always*
1. I feel comfortable working with my supervisor.	1	2	3	4	5	6	7
2. My supervisor welcomes my explanations about the client's behavior.	1	2	3	4	5	6	7
3. My supervisor makes the effort to understand me.	1	2	3	4	5	6	7
4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.	1	2	3	4	5	6	7
5. My supervisor is tactful when commenting about my performance.	1	2	3	4	5	6	7
6. My supervisor encourages me to formulate my own interventions with the client.	1	2	3	4	5	6	7
7. My supervisor helps me talk freely in our sessions.	1	2	3	4	5	6	7
8. My supervisor stays in tune with me during supervision.	1	2	3	4	5	6	7
9. I understand client behavior and treatment technique similar to the way my supervisor does.	1	2	3	4	5	6	7
10. I feel free to mention to my supervisor any troublesome feelings I might have about him/her.	1	2	3	4	5	6	7
11. My supervisor treats me like a colleague in our supervisory sessions.	1	2	3	4	5	6	7
12. In supervision, I am more curious than anxious when discussing my difficulties with clients.	1	2	3	4	5	6	7

13. In supervision, my supervisor places a high priority on our understanding the client's perspective.	1	2	3	4	5	6	7
14. My supervisor encourages me to take time to understand what the client is saying and doing.	1	2	3	4	5	6	7
15. My supervisor's style is to carefully and systematically consider the material I bring to supervision.	1	2	3	4	5	6	7
16. When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client.	1	2	3	4	5	6	7
17. My supervisor helps me work within a specific treatment plan with my clients.	1	2	3	4	5	6	7
18. My supervisor helps me stay on track during our meetings.	1	2	3	4	5	6	7
19. I work with my supervisor on specific goals in the supervisory session.	1	2	3	4	5	6	7

Appendix C: Counselor Activity Self-Efficacy Scale (CASES)

Instructions: The following questionnaire consists of three parts. Each part asks about your beliefs about your ability to perform various counselor behaviors or to deal with particular issues in counseling. We are looking for your honest, candid response that reflects your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There are no right or wrong answers to the following questions. Select the number that best reflects your response to each question.

Part I. Instructions: Please indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counseling **most** clients.

How confident are you that you could use these general skills effectively with most clients over the next week?	**No confidence At all**				**Some Confidence**			**Complete Confidence**		
1. **Attending** (orient yourself physically toward the client)	0	1	2	3	4	5	6	7	8	9
2. **Listening** (capture and understand the messages that clients communicate)	0	1	2	3	4	5	6	7	8	9
3. **Restatements** (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear)	0	1	2	3	4	5	6	7	8	9
4. **Open questions** (ask about questions that help clients to clarify or explore their thoughts or feelings)	0	1	2	3	4	5	6	7	8	9
5. **Reflection of feelings** (repeat or rephrase the client's statements with an emphasis on his or her feelings)	0	1	2	3	4	5	6	7	8	9
6. **Self-disclosure for exploration** (reveal personal information about your history, credentials, or feelings).	0	1	2	3	4	5	6	7	8	9
7. **Intentional silence** (use silence to allow clients to get in touch with their thoughts or feelings).	0	1	2	3	4	5	6	7	8	9

8. **Challenges** (point out discrepancies, contradictions, defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change).	0	1	2	3	4	5	6	7	8	9
9. **Interpretations** (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behavior, thoughts, or feelings).	0	1	2	3	4	5	6	7	8	9
10. **Self-disclosures for insight** (disclose *past* experience in which you gained some personal insight)	0	1	2	3	4	5	6	7	8	9
11. **Immediacy** (disclose *immediate* feelings you have about the client, the therapeutic relationship, or yourself in relation to the client).	0	1	2	3	4	5	6	7	8	9
12. **Information giving** (teach or provide the client with data, opinions, facts, resources, or answers to questions)	0	1	2	3	4	5	6	7	8	9
13. **Direct guidance** (give the client suggestions, directives, or advice that imply actions for the client to take)	0	1	2	3	4	5	6	7	8	9
14. **Role-play and behavior rehearsal** (assist the client to role-play or rehearse behaviors in session)	0	1	2	3	4	5	6	7	8	9
15. **Homework** (develop and prescribe therapeutic assignments for clients to try out between sessions)	0	1	2	3	4	5	6	7	8	9

Part II. Instructions: Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling **most** clients.

How confident are you that you could use these specific tasks effectively with <u>most</u> clients over the next week?	No confidence At all				Some Confidence					Complete Confidence
1. Keep sessions “on track” and focused.	0	1	2	3	4	5	6	7	8	9
2. Respond with the best helping skill, depending on what your client needs at a given moment.	0	1	2	3	4	5	6	7	8	9
3. Help your client to explore his or her thoughts, feelings, and actions.	0	1	2	3	4	5	6	7	8	9
4. Help your client to talk about his or her concerns at a “deep” level.	0	1	2	3	4	5	6	7	8	9
5. Know what to do or say next after your client talks.	0	1	2	3	4	5	6	7	8	9
6. Help your client to set realistic counseling goals.	0	1	2	3	4	5	6	7	8	9
7. Help your client to understand his or her thoughts, feelings, and actions.	0	1	2	3	4	5	6	7	8	9
8. Build a clear conceptualization of your client and his or her counseling issues.	0	1	2	3	4	5	6	7	8	9
9. Remain aware of your intentions (i.e., the purposes of your interventions) during sessions.	0	1	2	3	4	5	6	7	8	9
10. Help your client to decide what actions to take regarding his or her problems.	0	1	2	3	4	5	6	7	8	9

Part III. Instructions: Please indicate how confident you are in your ability to work effectively, over the next week, with each of the following client types, issues, or scenarios. (By “work effectively”, we are referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain your poise during difficult interactions and, ultimately, to help the client to resolve his or her issues).

How confident are you that you could work effectively, over the next week, with a client who…	No confidence At all	Some Confidence	Complete Confidence

1. … is clinically depressed.	0	1	2	3	4	5	6	7	8	9
2. … has been sexually abused.	0	1	2	3	4	5	6	7	8	9
3. … is suicidal.	0	1	2	3	4	5	6	7	8	9
4. … has experienced a traumatic life event (e.g., physical or psychological injury)	0	1	2	3	4	5	6	7	8	9
5. … is extremely anxious.	0	1	2	3	4	5	6	7	8	9
6. … shows signs of severely disturbed thinking.	0	1	2	3	4	5	6	7	8	9
7. … you find sexually attractive.	0	1	2	3	4	5	6	7	8	9
8. … is dealing with issues that you personally find difficult to handle.	0	1	2	3	4	5	6	7	8	9
9. … has core values or beliefs that conflict with your own (e.g., regarding religion, gender, roles).	0	1	2	3	4	5	6	7	8	9
10. … differs from you in a major way or ways (e.g., race, ethnicity, gender, age, social class).	0	1	2	3	4	5	6	7	8	9
11. … is not “psychologically-minded “or introspective.	0	1	2	3	4	5	6	7	8	9
12. … is sexually attracted to you.	0	1	2	3	4	5	6	7	8	9
13. … you have negative reactions toward (e.g. boredom, annoyance).	0	1	2	3	4	5	6	7	8	9
14. … is at an impasse in therapy.	0	1	2	3	4	5	6	7	8	9
15. … wants more from you than you are willing to give (e.g., in terms of frequency of contacts or problem-solving prescriptions).	0	1	2	3	4	5	6	7	8	9
16. … demonstrates manipulative behaviors in-session.	0	1	2	3	4	5	6	7	8	9

Appendix D: Anticipatory Supervisee Anxiety Scale (ASAS)

As a part of the agreement to use this measure, the authors of the Anticipatory Supervisee Anxiety Scale (ASAS) (Ellis & Singh, 2000; Tosada, 2004) have asked that this measure not be published. However, a brief overview of the measure is provided below. A more detailed description of the measure is provided in Chapter Three.

The ASAS includes 28 items measured on a nine-point Likert scale from one (not at all true) to nine (completely true). The measure asks supervisees to think about possible feelings or experiences they have during supervision. All items ask them to reflect their current feelings about their upcoming supervision session and start with the sentence stem, “In anticipation of my upcoming supervision session, I…”. Items are summed with higher scores indicating higher levels of anxiety.

Appendix E: Risk-taking Experiences Questionnaire

Instructions: Please answer the following questions about a specific time in your training in which you took a risk in a session with a client.

For the purposes of this study, risk-taking is defined as:

1. When a therapist (you) takes a risk by trying out a novel behavior *(e.g., trying an intervention that you had not previously tried with a client, asking a question about the process of therapy or the therapeutic relationship with the client).*
2. Risk-taking involves some level of anxiety on the therapist's (your) end about whether the risk will be successful and how the outcome will impact you.
3. The risk occurs in a session with a client.

1. **Describe a time in which you took a behavioral risk in a therapy session to do something new or different with a client.** *(e.g., sat with silence when you would normally say something; challenged or interrupted a client)*

2. **Why did you consider this behavior risky or anxiety provoking?**

3. **How did you make the decision on whether to take this risk?**

	1	2	3	4	5	6	7
4. **What level of risk was this behavior for you?**	*Low Risk*			*Medium Risk*			*High Risk*
5. **How anxious were you when you took this risk?**	*Very anxious*			*Neutral*			*Not at all anxious*
6. **How confident were you that you could**	*Not*			*Neutral*			*Very*

Question	1	2	3	4	5	6	7
successfully enact this new skill/intervention?	*confident*						*confident*
7. How difficult was it for you to take this risk?	1 *Not difficult*	2	3	4 *Moderately difficult*	5	6	7 *Extremely difficult*
8. Looking back, do you think that the risk was worth taking?	1 *Not worthwhile/ negative outcome*	2	3	4 *Neutral*	5	6	7 *Very worthwhile/ positive outcome*
9. How did taking this risk impact your confidence in your ability as a therapist?	1 *Significantly impaired my self-confidence*	2	3	4 *Did not change*	5	6	7 *Significantly improved my self-confidence*
10. How did taking this risk impact how willing you are to take another risk in the future?	1 *Would not take a risk again*	2	3	4 *Takes risks with the same frequency as before*	5	6	7 *Takes risks more frequently*

Appendix F: Risk-taking Experiences Interview Questions

These questions will be asked to the supervisee during a follow-up, semi-structured interview with the principal investigator to understand more qualitatively what a risk looks like to a novice supervisee.

For the purposes of this study, risk-taking is defined as:

1. When a therapist (you) takes a risk by trying out a novel behavior *(e.g., trying an intervention that you had not previously tried with a, asking a question about the process of therapy or the therapeutic relationship with the client).*
2. Risk-taking involves some level of anxiety on the therapist's (your) end about whether the risk will be successful and how the outcome will impact you.
3. The risk occurs in a session with a client.

1. **Describe a time in which you took a behavioral risk to do something new or different with a client.** *(e.g., sat with silence when you would normally say something; challenged or interrupted a client)*

2. **What made this behavior risky to you?**

3. **How did you feel about taking this risk?**

4. **How did you decide to take the risk?** (i.e., Whose idea was it for you to take the risk? What did you consider when deciding to take the risk?)

5. **What choice did you feel like you had in taking the risk?** (i.e., Did you take the risk because your supervisor suggested it so you felt like you had to?)

6. **What did you do in supervision, with your supervisor, to help you take this risk?** (e.g., skill development in supervision, role plays)

7. **Do you think the risk was successful? Why or why not?** (i.e., Do you believe that it had a positive outcome? Why?)

8. **In retrospect, do you think that the risk was worth taking? Why or why not?**

9. **Did you take other risks based on this one? Why or why not?**

Appendix G: University of Denver IRB Approval

DATE:	October 18, 2019
TO:	Aleis Pugia, M.Ed., MA
FROM:	University of Denver (DU) IRB
PROJECT TITLE:	[1481276-1] The Relationship Between the Supervisory Alliance and Novice Supervisees' Risk-taking Behavior
SUBMISSION TYPE:	**EXPEDITED NEW PROJECT**
APPROVAL DATE:	October 18, 2019
NEXT REPORT DATE:	October 18, 2020
RISK LEVEL:	Minimal Risk
REVIEW TYPE:	Expedited Review
ACTION:	**APPROVED**
REVIEW CATEGORY:	Expedited Category # 6 & 7

Category 6: *Collection of a data from voice, video, digital, or image recordings made for research purposes.*

Category 7: *Research on group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.*

Thank you for your submission of the **New Project** materials for this project. The University of Denver Institutional Review Board (IRB) has granted Full Approval for your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in

accordance with this approved submission. The IRB determined that the criteria for IRB approval of research, per 45 CFR 46.111, has been met.

This submission has received an Expedited Review based on applicable federal regulations. This project has been determined to be a Minimal Risk project. Please note that the following documents were included in the review and approval of this study:

- Consent Form - Pugia Implied Consent_10.02.19.docx (UPDATED: 10/2/2019)
- Consent Waiver - Pugia Appendix A Waiver of Written Consent_10.02.19.docx (UPDATED: 10/2/2019)
- DU - IRB Application Form - DU - IRB Application Form (UPDATED: 08/14/2019)
- Letter - Pugia Recruitment Email_10.02.19.docx (UPDATED: 10/2/2019)
- Other - Pugia Qualtrics Survey Preview_10.02.19.pdf (UPDATED: 10/2/2019)
- Other - Pugia Appendix N Research Involving the Internet_8.29.19.docx (UPDATED: 08/29/2019)
- Proposal - Pugia IRB Expedited Application_Part One 10.02.19.docx (UPDATED: 10/2/2019)
- Questionnaire/Survey - Pugia Demographic Questionnaire.docx (UPDATED: 10/2/2019)
- Questionnaire/Survey - Pugia Risk-taking Interview.docx (UPDATED: 08/27/2019)
- Questionnaire/Survey - Pugia Risk-taking Questionnaire.docx (UPDATED: 08/27/2019)
- Questionnaire/Survey - Pugia ASAS Questionnaire.docx (UPDATED: 08/27/2019)
- Questionnaire/Survey - Pugia CASES Questionnaire.docx (UPDATED: 08/27/2019)
- Questionnaire/Survey - Pugia SWAI-T Questionnaire.docx (UPDATED: 08/27/2019)

Informed Consent Process
Please remember that informed consent is a process beginning with a description of the project and assurance of participants understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant.

A **Waiver of Written Documentation of Informed Consent**, per 45 CFR 46.117(b), has been granted by the IRB, as the following information was provided to document the consent procedure:

1. That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject

wants documentation linking the subject with the research, and the subject's wishes will govern; or

2. That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

Implementation of Changes to Previously Approved Research
Prior to the implementation of any changes in the approved research, the investigator must submit any modifications to the IRB through completing an amendment form and await approval before implementing the changes, unless the change is being made to ensure the safety and welfare of the subjects enrolled in the research. If such occurs, a Reportable New Information (RNI) Form should be submitted, via the IRBNet system, within five days of the occurrence indicating what safety measures were taken and provide an updated protocol and/or consent, if applicable.

Unanticipated Problems Involving Risks to Subjects or Others (UPIRTSOs)
Any incident, experience or outcome which has been associated with an unexpected event(s), related or possibly related to participation in the research, and suggests that the research places subjects or others at a greater risk of harm than was previously known or suspected must be reported to the IRB. UPIRTSOs may or may not require suspension of the research. Each incident is evaluated on a case by case basis to make this determination. The IRB may require remedial action or education as deemed necessary for the investigator or any other key personnel. The investigator is responsible for reporting UPIRTSOs to the IRB within 5 working days after becoming aware of the unexpected event. Use the Reportable New Information (RNI) form within the IRBNet system to report any UPIRTSOs. All NONCOMPLIANCE issues or COMPLAINTS regarding this project must also be reported.

Continuation Review Requirements
Based on the current regulatory requirements, this expedited project does not require continuing review. However, this project has been assigned a one-year review period requiring communication to the IRB at the end of this review period to either close the study or request an extension for another year. The one-year review period will be posted in the Next Report Due section on the Submission Details page in IRBNet. During this one-year period, a staff member from the Office of Research Integrity and Education (ORIE) may also conduct a Post Approval Monitoring visit to evaluate the progress of this research project.

PLEASE NOTE: This project will be administratively closed at the end of a one-year period unless a request is received from the Principal Investigator to extend the project. Please contact the DU HRPP/IRB if the study is completed before the one-year time period or if you are no longer affiliated with the University of Denver through submitting a Final Report to the DU IRB via the IRBNet system. If you are no longer

affiliated with DU and wish to transfer your project to another institution please contact the DU IRB for assistance.

Study Completion and Final Report

A Final Report must be submitted to the IRB, via the IRBNet system, when this study has been completed or if you are no longer affiliated with the University of Denver. The DU HRPP/IRB will retain a copy of the project document within our records for three years after the closure of the study. The Principal Investigator is also responsible for retaining all study documents associated with this study for at least three years after the project is completed.

If you have any questions, please contact the Institutional Review Board at (303) 871-2121 or through IRBAdmin@du.edu. Please include your project title and IRBNet number in all correspondence with the IRB.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Denver (DU) IRB's records.

Appendix H: Online Implied Consent Form

Project Title: The Relationship between the Supervisory Alliance and Novice Supervisees' Risk-taking Behavior
IRBNet #: 1481276-1
Principal Investigator: Aleis Pugia, M.Ed., MA
Faculty Sponsor: Maria Riva, Ph.D.

You are being asked to participate in a research study. Your participation in this research study is **voluntary** and you do not have to participate. This document contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate.

The purpose of this form is to provide you information that may affect your decision as to whether or not you may want to participate in this research study. Please read the information below and ask any questions you might have before deciding whether or not to give your permission to take part. If you decide to be involved in this study, this form will be used to record your permission.

Purpose

You are invited to participate in a research study that examines the relationship between therapists-in-training's experiences taking risks with their clients and their supervision experiences. The researcher in this study is interested in better understanding the relationship between clinical supervision and therapists'-in-training risk-taking behavior.

If you agree to be part of the research study, you will be asked to complete an online, self-report questionnaire, comprised of five measures for a total of 121 questions. Questions will asked about your demographic information, past and current supervision experiences, your relationship with your current supervisor at your practicum site, your confidence in your clinical skills, and about your feelings regarding an upcoming supervision session (e.g., "In anticipation of my upcoming supervision session, I feel anxious about how my supervisor might evaluate me"). You will also be asked about a time in which you took a behavioral risk with a client in therapy and your reflections on that experience (e.g., "Describe a time in which you took a behavioral risk in a therapy session to do something new or different with a client"). The majority of the questions are asked in a scaled format, with answers ranging from a strong negative response (e.g., "almost never", "not true at all", "no confidence at all") to a strong positive response (e.g., "almost always", "completely true", "complete confidence"). The questionnaire will be administered once online and is expected to take 15 - 20 minutes to complete.

After completing the online surveys, some participants will be randomly selected for a follow-up interview with the principal investigator. The interview will ask follow-up questions about your experiences taking risks with clients (e.g., "What choice did you feel like you had in taking the risk?"). The follow-up interview includes nine questions

and is expected to take ten minutes to complete. After being selected for the follow-up interview, chosen participants will be sent a link to an online calendar to indicate their availability for an interview. When signing up via the online calendar, the participants will be asked to provide their first name, phone number, and email address. This information will be used to coordinate the interview between the researcher and participant. This information will only be seen by the researcher and will not be visible to other participants. After participation in the interview, the first name and phone number of the participant will be immediately destroyed. The email address will only be used to provide participants with compensation for participation and will be destroyed immediately after. Participants will be selected for an interview until data collection reaches saturation. While an exact amount will not be known until data is collected, it is estimated that approximately 10-15 participants will be selected for an interview.

Participating in this research study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. You may choose not to answer any survey question for any reason without penalty. You will not receive any negative consequences for ending participation at any time throughout the study.

Risks or Discomforts

The researcher has taken steps to minimize the risks of this study. Potential risks, stress, and/or discomforts of participation may include discomfort due to answering questions that you do not want to answer. If any questions cause discomfort, you can choose to either skip those questions or stop participation in the study at any time. Other potential risks include breach of confidentiality (see Limits to Confidentiality section below).

The follow-up interviews will be audio-recorded so the principal investigator can later review and code the responses to the questions. Audio recordings will be transcribed and will not include any identifying information (e.g., name, name of supervisor, name of site). These audio recordings will be immediately destroyed after being transcribed. While interview recordings will be de-identified and destroyed after the study is complete, potential risks include the sharing of personal experiences.

Benefits

If you agree to take part in this study, no benefits are reasonably expected to result from this study. We cannot and do not guarantee or promise that you will receive any benefits from this study. However, information gathered in this study may help the researcher understand more about the relationship between clinical supervision and therapist risk-taking behavior in graduate-level trainees. Your decision whether or not to participate in this study will not affect your clinical training placement or grades in graduate school.

Confidentiality of Information

Participants' contact information and consent forms will be stored separately from their data in a password-protected electronic dataset. Any participant names collected in the process of coordinating the interview will be immediately destroyed after the interview is

collected and all information gathered from the interviews will be de-identified. No other identifying information or contact information will be gathered for any other identification purposes related to the data. Contact information will only be used to provide compensation for participating in the study and to coordinate interviews. All data will be de-identified and kept separate from contact information. The link between your identifiers and the research data will be destroyed after the records retention period required by state and/or federal law

Limits to confidentiality

All of the information you provide will be confidential. However, if we learn that you intend to harm yourself or others, including, but not limited to child or elder abuse/neglect, suicide ideation, or threats against others, we must report that to the authorities as required by law.

Before you begin, please note that the data you provide may be collected and used by Qualtrics as per its privacy agreement. This research is only for U.S. residents over the age of 18. Please be mindful to respond in private and through a secured Internet connection for your privacy. Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

Your name will not be used in any report. Identifiable research data will be encrypted and password-protected. Your responses will be assigned a code number. The list connecting your name to this code will be kept in an encrypted and password protected file. Only the research team will have access to the file. When the study is completed and the data have been analyzed, the list will be destroyed.

The information that you give in the online questionnaire will be anonymous. Your name will not be collected or linked to your answers. With your permission, I would like to audiotape your interview so that I can make an accurate transcript. Once I have made the transcript, I will erase the recordings. Your name, the name of your supervisor, or the name of your clinical training site will not be in the transcript or my notes.

Because of the nature of the data, it may be possible to deduce your identity; however, there will be no attempt to do so and your data will be reported in a way that will not identify you.

Data Sharing

De-identified data from this study may be shared with research partners and the research community at large to advance research on supervision. We will remove or code any personal information (e.g., your name, date of birth) that could identify you before files are shared with other researchers to ensure that, by current scientific standards and known methods, no one will be able to identify you from the information or samples we share. Despite these measures, we cannot guarantee the anonymity of your personal data.

Incentives to participate
For those who complete the online questionnaire and are interested in compensation, participants will be entered into a drawing to receive a $10 Amazon e-gift card for their time. Participants will have a one in three chance of winning a $10 e-gift card.

Furthermore, for every participant who completes a follow-up interview, they will also be offered a $5 e-gift card for their extended participation. All participants who complete an interview will receive a $5 e-gift card, regardless of whether they also received a $10 e-gift card for completing the online questionnaire.

Gift cards will be delivered electronically to the email address the participant provided when signing the consent form. Payment will be delivered electronically within 2-4 weeks of completing the study.

Questions
For questions, concerns, or complaints about the study, you may contact the Principal Investigator, Aleis Pugia, M.Ed., MA, at aleis.pugia@du.edu or 480-772-8413. The faculty sponsor associated with this study is Maria T. Riva, Ph.D.

If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the University of Denver (DU) Institutional Review Board to speak to someone independent of the research team at 303-871-2121 or email at IRBAdmin@du.edu.

Consent to participate in study
Please take all the time you need to read through this document and decide whether you would like to participate in this research study.

By consenting to this study, you are consenting to participate in both the online questionnaire and the follow-up interview. After completing the online questionnaire, you may be selected for a follow-up interview with the principal investigator. Not all participants will be selected for the follow-up interview. Participants for the follow-up interview will be selected within 2 weeks of completing the online questionnaire. Additional compensation will be provided for participating in this follow-up interview.

_____ YES, I want to participate in the study (both the online questionnaire AND the follow-up interview). Enter email to coordinate follow-up interview:

____

_____ NO, I do not want to participate in the study (both the online questionnaire AND the follow-up interview).

<u>Consent to audio recording solely for purposes of this research</u>
This study involves audio recording of the follow-up interview. If you do not agree to be recorded for the follow-up interview, you can still take part in the online questionnaire part of the study.

______ YES, I agree to be audio recorded

______ NO, I do not agree to be audio recorded.

Appendix I: Sample e-mail Recruitment Letter

Dear potential research participant,

My name is Aleis Pugia and I am a doctoral candidate from the Counseling Psychology department at the University of Denver. I am writing to invite you to participate in my dissertation research study. This study is examining the relationship between therapists-in-training's experiences taking risks with their clients and their supervision experiences. **You are eligible to be in this study because you are currently a graduate-level trainee within the first two years of training in an accredited mental health program.** Additionally, you are currently receiving clinical supervision while you complete your first or second clinical practicum experience. You are receiving this invitation because I contacted the department chair and/or training director of your program and requested that this email be dispersed through your training program's email listserv.

This study has two parts: an online questionnaire and a follow-up interview, to be completed after you finish the online questionnaire. If you decide to participate in this study, you will respond to questions about the quality of your supervisory relationship, your perception of your counseling abilities, and about a time in which you took a risk with a client. Additionally, you will answer several demographic questions. Upon completion of the online questionnaire, some participants will be randomly selected to complete a follow-up interview as well. Not all participants will be selected for the follow-up interview. The interview will ask follow-up questions about your experiences taking risks with clients. If you participate in the interview, I would like to audio record the interview so I can more accurately analyze the data. Questions related to your risk-taking behavior will only be used to describe the types of behaviors that are considered risky by novice therapists-in-training. The questions are intended to be non-invasive and are not expected to produce emotional distress.

Upon completion of the online questionnaire, potential participants will be eligible to win a 1:3 chance of a $10 Amazon e-gift card. Furthermore, if potential participants are selected to participate in an interview, they will receive a $5 Amazon e-gift card. Your email address will not be stored in relation to any other personal information or data from your questionnaire. The only purpose your email address will be used for is to send you an online gift card.

Remember, your participation in this study is completely voluntary. You can choose to be in the study or decline to participate. Declining to participate will not affect your standing in your mental health training program or have any other consequences. If you have any more questions about this process or if you need to contact me about your participation, I may be reached at aleis.pugia@du.edu or 480.772.8413.

This research is under the supervision of Maria Riva, PhD (maria.riva@du.edu) and has been approved by the University of Denver Institutional Review Board.

The study may be accessed at the following URL:
https://udenver.qualtrics.com/jfe/form/SV_9X2cFtj47lZm9mt

Thank you very much.

Sincerely,

Aleis Pugia, M.Ed., MA
Doctoral Candidate, Counseling Psychology
University of Denver